GLOBAL SOCIAL TRUST.

Welcome to the ILO's

5 EURO Project

"The world does not lack the resources to eradicate Poverty, it lacks the right priorities."

Juan Somavia, Director General of the ILO

To Roger Beattie,

Austere Scotsman,
Walker in the woods,
Climber of Mountains,
Clarinettist,
Believer in Social Security for all.

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Part II: Background documentation

List of acronyms

ILO	International Labour Organization
ILO-FACTS	International Financial and Actuarial Service of the ILO
TRUST	GLOBAL SOCIAL TRUST
SSNIT	Social Security and National Insurance TRUST (Ghana)
OBSS	Office béninois de Sécurité Sociale
«Satellites»	Community-based organizations
«Hubs»	National social insurance or national social protection schemes
MHO	Mutual Health Organization
STEP	Strategies and tools against social exclusion and poverty (ILO Programme)
CIDR	Centre International de Développement et de Recherche
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome
HIPC	Heavily Indebted Poor Countries
MDG	Millennium Development Goals
PRSP	Poverty Reduction Strategy Paper

Introduction to the study

Institutional background

The 89th International Labour Conference (ILC) in June 2001 concluded a general discussion on social security with a renewed commitment of the International Labour Organization (ILO) to extend social security coverage and improve the governance, financing and administration of social security[1]. The conclusions and recommendations of the Conference also call for the ILO to develop "…innovative approaches in the area of social security to help people to move from the informal economy to the formal economy".

In line with the recommendations of the 89th ILC the Director General of the ILO has thus requested that the possibility of supporting the development of national social protection systems through international financing be explored. The ILO's International Financial and Actuarial Service (ILO-FACTS) has developed an innovative concept for a GLOBAL SOCIAL TRUST network (or "TRUST") which connects the global, national and community levels of financing for social security.

Mandate

This feasibility study will examine the potential scope of a GLOBAL SOCIAL TRUST, the rationale and purpose for the TRUST, the reasons for and risks of the ILO being involved in organizing and starting a GLOBAL SOCIAL TRUST, the options available to the Director General of the ILO and the next steps for operationalizing the TRUST. The ultimate purpose of the study is to recommend to the Director General *whether* and *how* to proceed with the promotion of a GLOBAL SOCIAL TRUST.

Approach and process

The introduction of a global fund to support the build-up of national social protection systems through international solidarity would constitute a major change in the way technical co-operation in social security is presently delivered by the ILO and other international or bilateral development aid agencies. The ILO assigned a project team of social security actuaries, economists and social security experts and set a fairly extensive agenda for the feasibility study. The team sought the widest possible consultation with international experts on the idea. The team was lead by William Newbrander, (Director of Health Services of Management Sciences for Health (MSH) in Boston and a former WHO health economist) and Michael Cichon (Chief of the Financial, Actuarial and Statistical Services Branch of the ILO) and consisted of:

— Sergio Arvizu, Actuary and Director of Investments, Mexican Social Security Institution,
— Derek Osborne, Actuarial adviser to the National Insurance Board, Bahamas,
— Raymond Wagener, Social security actuary and Director of the General Inspection of Social Security, Luxembourg,
— Peter Rosenberg, Social security economist and former Director General of Planning in the Ministry of Labour and Social Affairs of the Federal Republic of Germany,
— Rüdiger Knop, Senior social security actuary, ILO-FACTS,
— Florian Léger, Social security actuary, ILO-FACTS,

[1] See ILO (2001): Social security – A new consensus; p.1, Resolution and Conclusions concerning social security, International Labour Conference, 89th Session, 2001; paras 17-19.

— Karuna Pal, social security finance specialist, ILO-FACTS,
— Diane Vergnaud, statistical assistant and editor.

A short concept paper was presented in Stockholm in September 2001, to the delegates of the triennial General Assembly of the International Social Security Association, which brings together social security managers and decision makers from national social security institutions. This presentation, one day after the September 11 events, marked the launching of the study. The proposal received support from the majority of the delegates who attended the presentation as well as its chairman (Robert Holzmann, World Bank). Following this presentation the ILO organised a meeting of the study team with ILO social security experts and representatives of the ILO Bureaux for Workers and Employers Activities. The meeting resulted in a revised version of the basic concept and the establishment of terms of reference for the following four sub-studies:

- the first explored the feasibility of and the potential for voluntary contribution collection and the different means of contribution collection in a possible donor country. The country selected was Germany as the largest economy in Europe (author Peter Rosenberg in conjunction with Infratest-Sozialforschung);

- the second and the third studies explored the actual need for basic benefits in a limited number of communities in two African countries (e.g. Ghana and Benin) and the ways and means of delivering such benefits in the most efficient manner. Messrs. Knop and Léger prepared and backstopped the studies with the help of Cornelius Dzakpasu, Director of the ILO office in Lagos. Derek Osborne undertook the field study in Ghana and Raymond Wagener the one in Benin. The study teams were supported by Dr. Asuako-Ntomo Atakora, Mr. Daniel Boakey and Ms. Rita Abban from Ghana and Mr. René Houessou and Mr. D. Moussiliou Moustapha from Benin acting as local consultants;

- the fourth study, undertaken by Sergio Arvizu, explored the managerial and administrative requirements and options for the management of a major international TRUST fund.

Peter Lloyd-Sherlock (University of East Anglia) and Armando Barrientos (University of Manchester) contributed a background paper on the impact of non-contributory pensions on poverty levels in families, households and communities.

In addition to the above sub-studies a major effort was undertaken to solicit expert opinions on the feasibility of the GLOBAL SOCIAL TRUST. About 30 established experts in the social security field responded to the team's request for comments and feedback; their opinions were solicited on the basis of the zero draft of the concept. Diane Vergnaud of the ILO's Financial, Actuarial and Statistical Services Branch coordinated the survey and summarised the responses. Karuna Pal developed the follow-up project in Ghana. The final report was co-edited by Karuna Pal, Diane Vergnaud, Florian Léger, Rüdiger Knop, Michael Cichon and Ana-Maria Méndez.

Part II of this report contains a set of documents on the outcome of the individual sub-studies as well as a summary of the experts' opinions. The occasion of a sitting of the Preparatory Committee of the United Nations for the Conference on Financing for Development in January 2002 as well as the Conference in Monterrey in March 2002 itself were used to "float" the revised concept and obtain feedback from another group of experts. The reaction was positive and supportive.

A draft report of the feasibility study was reviewed by a tripartite group of international experts on the financing of social security who agreed a set of Recommendations to the Director General and the Governing Body of the ILO. The group met in May 2002 in Bossey/Geneva and adopted the Recommendations that are reprinted in this volume. The group was chaired by Ms. Lenia Samuel, Permanent Secretary in the Ministry of Labour and Social Insurance of Cyprus. The meeting constituted the final event of the feasibility study. The event was sponsored and supported by the Government of the United Kingdom. It was organised by Margaret Antosik and Karuna Pal of ILO-FACTS.

The nature of this report

This final report documents the development of the thinking in the ILO team and the review group, as well as many external experts on the topic of the GLOBAL SOCIAL TRUST. The process is not yet finalised, and the ultimate shape of the TRUST will probably only emerge after the completion of the first pilot projects. The project team decided to make this full set of documents available to a limited group of the interested experts, as many of the interim thoughts might explain how the official proposal of the ILO has taken shape. A shorter version will be made available to a wider public in November 2002 provided the Governing Body of the ILO agrees to a further exploration of the project.

Acknowledgements

This report is the result of a team effort. Many individuals volunteered generous support. Unfortunately we cannot list all those who offered ideas and reassurance at critical junctures, often modestly and without laying any claims on important contributions to the concept, or those who offered valuable evidence based on personal experience. Many thanks are also due to those who could not be identified here.

The team wishes to express its thanks to all friends and colleagues from a wide range of "walks of life and views" who shared their opinions in writing with the project team. Most of their opinions are reflected in the annex on the survey of expert opinions. The project team made no effort to "streamline" their views – regardless of whether they were in agreement or in disagreement with the views of the team or whether or not they were fully congruent with the values of the ILO. We want to document the full range of the debate on the complicated subject.

The contributions of all participants at the first brainstorming meeting in Geneva in September 2001(Cornelius Dzakpasu, Phillipe Egger, Krzysztof Hagemejer, Wolfgang Scholz, Melanie Glenat, Karuna Pal, Kenichi Hirose, Rüdiger Knop, Mariko Ouchi, Florian Léger, Anne Richter, Pierre Plamondon, José Tossa, Diane Vergnaud, Hiroshi Yamabana) and in particular the support of the experts from the ILO's Bureaux for Employers' and Workers' Activities (Frank Hoffer, Abdoulaye Diallo and Björn Grunewald as well as Deborah France) were invaluable in shaping the ideas on the GLOBAL SOCIAL TRUST reflected in this report.

Many other colleagues from the ILO and other organizations offered substantial feed back and support : Juan Somavia, Alejandro Bonilla, Annette Ching, Janelle Diller, Assane Diop, Maria-Angelica Ducci, Jean-Victor Gruat, Dominique Peccoud, Gareth Howell, John Langmore, Christophe Perrin, Stephen Pursey, Emmanuel Reynaud (all ILO), Stephen Browne (UNDP), Brent Wilton and Eric Oechslin (International Organization of Employers (IOE)), Ambassador Ivan Šimonovic (Croatia Mission to the UN), Valentin Klotz (German Mission in Geneva), Dieter Hebestreit of H2K Communications in Düsseldorf/Germany, Guy Ryder of the International Confederation of Free Trade Unions (ICFTU), Richard Exell of the UK Trade Union Congress (TUC), Bill Mansfield of the Australian Council of Trade Unions (ACTU),

Wilhelm Adamy of the Deutscher Gewerkschaftsbund (DGB), Thomas Moorhead, Charles Spring and Joan Makin-Barrett of the US Department of Labour and Timothy Deal and Phyllis Borzi of the US Council for Business, Marie Niven and Fiona Kilpatrick of the UK Department for Work and Pensions, Carl-Hermann Schlettwein and G. Tuli-Mevava Nghiyoonanye of the Ministry of Labour in Namibia, Lenia Samuel of the Ministry of Labour an Social Insurance of Cyprus, Alette van Leur and Anita Blom of the Ministry of Social Affairs in the Netherlands, Elisabeth Colotte, Jean-Marc Lentz, Jean Feyder and Minister Charles Görens of the Ministry of Technical co-operation in Luxembourg, Susan Paul of Global Action on Ageing and - last but certainly not least - Eveline Herfkens, then Minister of Technical Co-operation of the Netherlands.

Special thanks are due to the participants of the very constructive review meeting in Bossey, Geneva in May 2002 who formulated the Recommendations to the Director General. Their names are listed in Annex 7.

Recommendations to the Director-General and the Governing Body of the International Labour Office on the feasibility of a GLOBAL SOCIAL TRUST by the participants in an Interregional Meeting of Experts

(Geneva, 14-16 May 2002)[2]

Introduction

At the invitation of the ILO a group of 25 participants including 14 tripartite representatives and 11 independent resource persons and observers met in Bossey (Geneva) from 14 to 16 May to review the report "A Global Social Trust: Investing in the world's social future" which explores the feasibility of a GLOBAL SOCIAL TRUST.

The objective of this Meeting was to develop a recommendation to the Director-General and the Governing Body of the ILO as to the viability of the concept and the feasibility of its implementation.

The exploration of the TRUST concept is seen as part of the response of the ILO to extend the coverage and improve the governance of social security systems, and is consistent with the conclusions of the general discussion on social security adopted by the International Labour Conference in 2001.

Summary of conclusions

After intensive discussion, the participants of the Meeting reached consensus on the following issues:

(1) The group endorsed the view that the concept of a GLOBAL SOCIAL TRUST merits further exploration as an innovative measure to provide social security to meet basic needs to assist in combating poverty in developing countries. The proposal envisages that the TRUST would collect modest contributions on a voluntary basis from individuals, and possibly other sources such as institutions, including corporations and foundations, largely in industrialized countries. It would invest these resources in developing countries to build up and temporarily sponsor social security systems.

(2) The TRUST would operate according to the following guiding principles:

- the basic philosophy is the exercise of global social commitment by individual and possibly corporate or institutional contributors;

- it will build on initiatives taken in recipient countries which demonstrate the commitment to self-help;

[2] Interregional Meeting on Exploring the Feasibility of Financing Social Protection Benefits in Low-income Countries through International Transfers (GB.283/Inf.2).

- the TRUST will build on social partnerships in donor and recipient countries and on partnerships between organizations in donor and recipient countries;

- it will sponsor and support programmes tailor-made and responsive to the most pressing social security needs at a local, regional or national level;

- it will consist of a decentralized system of funding combined with a centralized system of project vetting, appraisal and support;

- it will maintain political independence and respond exclusively to priority needs;

- wherever possible it will utilize existing social administration structures in recipient countries and will help to foster sustainable pluralistic social security networks;

- it will support strategies for the extension of social security through a combination of investments in administration and time-bound subsidies, building on commitment at the local, regional and national levels;

- operations will be fully transparent, ethical, accountable and subject to regular performance and financial audits;

- support will be additional to existing social security resources as the TRUST is intended to provide resources that supplement what governments are currently able to provide.

(3) The TRUST would be organized as a system of national structures which would collect, hold and allocate financial resources directly to projects following their vetting and assessment by an independent international body, which would also audit the conduct, finances and outcome of projects. This body would maintain a small technical secretariat which would provide advice and support to all parts of the TRUST.

(4) The TRUST's activities would be demand driven. Social security schemes to be supported by the TRUST would be considered according to the national policy priorities of the applicant country, as reflected in its Poverty Reduction Strategy. The TRUST could, for example, support targeted benefits with a direct impact on the financing of community-based health services, basic pensions for the elderly, benefits for the sick and disabled, and family benefits, with particular emphasis on ensuring children's education. TRUST projects would be proposed, designed and submitted for financing by governments and/or other recognized institutions in applicant countries. These projects would have to satisfy a set of criteria, such as:

- they should have a direct measurable impact on poverty and/or health status;

- they should be compatible with other national anti-poverty and social protection policies;

- resources provided should be additional to pre-existing levels of national social spending;

- the schemes would have the objective of attaining financial independence from the TRUST by the end of the project.

(5) The concept of the GLOBAL SOCIAL TRUST fund would be tested and evaluated on a step-by-step basis. The first phase would be one or two pilot projects which would bring

together donor and recipient countries. These projects should demonstrate that adequate resources for such projects can be mobilized through voluntary contributions in donor and recipient countries and that an effective reduction of poverty levels and/or improvement in health levels can be sustainably achieved by supporting social security schemes that meet basic needs.

(6) If these pilot projects prove successful as measured by factors such as:

- effective contribution collection;
- effective governance;
- effective selection and delivery;
- measurable improvement in poverty levels and/or health status;

a permanent international body could be considered to organize the future work and development of the TRUST.

(7) The initial role of the ILO should be to promote the idea of the TRUST within its constituency and at an appropriate stage help establish the national structures and the international organization in collaboration with its tripartite constituents and other stakeholders. Any national organization and international body subsequently established would remain legally independent entities without any budgetary, managerial or administrative links to the ILO; however they would be expected to conform to the ethical and governance principles followed by the ILO. The TRUST could contract with the ILO to provide expertise to the technical secretariat for project vetting, appraisal and support.

(8) The ILO should establish a GLOBAL SOCIAL TRUST pilot project. The funding of the pilot project should largely come from extra-budgetary resources. Its implementation must be considered in the context of the priorities set by the outcome of the General Discussion on Social Security at the 89th ILC (2001). In addition to annual reports on development to the Governing Body, the progress of the pilot project is to be the subject of a significant evaluation initiated by the Governing Body prior to the end of December 2005 and further decisions taken as to the continuation of the overall proposal in March 2006. The project should have a small tripartite advisory board to be appointed by the ILO Director-General and Governing Body officers.

Recommendation

That the outcome of the Meeting be noted by the Governing Body.

That the Governing Body invite the Director-General to take action to implement the proposal of the Meeting that the ILO explore social security schemes to help combat poverty in developing countries by voluntary contributions along the lines set out above, in particular the establishment of a pilot project.

Geneva (Bossey), 16 May 2002.

Executive summary of the GLOBAL SOCIAL TRUST proposal

Background

As recent events have demonstrated to all of us, poverty somewhere is a threat to all of us everywhere. Poverty eradication will remain first and foremost a matter of national economic and social policies as well as good governance. However, there are a number of developing countries with per capita GDP levels of US$1,000 and below which will – if left to their own devices – not be able to escape the poverty trap cemented by malfunctioning governance and bad economic performance for a number of decades. Today, globalization is still largely a phenomenon of capital, goods and services, as well as labour markets. While poverty is widely discussed and multifarious initiatives have been undertaken to combat this problem on national and international levels, global social responsibility is not yet the mindset of most people. The world may be on the way to becoming a global village, but the villagers are not sharing enough of their resources to lift their less fortunate neighbours out of the most severe forms of poverty.

At the turn of the century the global community has adopted Millennium Development Goals (MDGs). The first and most prominent of these ambitious goals is to "eradicate poverty and hunger". This was concretized as "halving the proportion of people with less than one dollar a day". National social protection systems providing social security through schemes ranging from basic poverty alleviation to pensions and health-care schemes[3] are one of the most powerful means of alleviating and preventing poverty. However, according to ILO estimates only about 20 per cent of the world's population has access to some formal social protection. The "GLOBAL SOCIAL TRUST" (or "TRUST" for easy reference) aims at lifting people in the poorest countries – hitherto without access to social protection – out of pandemic poverty faster through the provision of basic social security. This proposal builds on a spirit of global social responsibility. The mission is to sponsor and invest in the build-up of sustainable social governance structures rather than support ad hoc initiatives. This has never been done before in such a concentrated form.

The basic idea, mission and objective

The basic idea is to request people in the richer countries, i.e. OECD countries, to contribute on a voluntary basis a rather modest monthly amount (say €5 per month or about 0.2 per cent of their monthly income) to a GLOBAL SOCIAL TRUST which will be organized in the form of a global network of National Social TRUSTs supported by the ILO, which will then:

[3] The terms "social security" and "social protection" were and still are often used interchangeably. However, it seems to be more or less generally accepted by now that the term social protection embodies a wider concept (see ILO: Social security – a new consensus, Geneva 2001, p.39). The terminology problem is aggravated by the fact that the Bretton Woods institutions also use the term "social safety nets", which generally refers to the core set of most basic forms of social benefits that are necessary to avoid destitution. More recently the World Bank developed the concept of "Social Risk Management" which is a wider concept that encloses all mechanisms that individuals, communities and societies have to safeguard the standard of living of individuals. In this report we pragmatically use the term basic social protection schemes (in the original meaning of the word), describing transfers in cash or in kind that provide some basic income security and access to essential health care and basic education to those in need.

- invest these resources to build up basic social protection schemes in developing countries; and

- sponsor concrete benefits for a defined initial period until the basic social protection schemes become self-supporting.

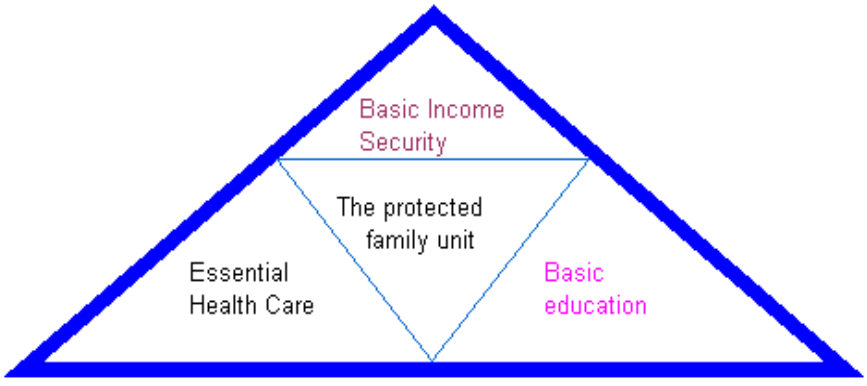
The mission of the GLOBAL SOCIAL TRUST Network is to systematically reduce poverty in developing countries through a partnership that invests in and sponsors the development of sustainable national social protection schemes for people and groups which have been excluded from the economic benefits of development. Social security is one prerequisite that enables individuals to fully develop their social skills and economic productivity. Hence, the TRUST would invest in the world's social future by seeking to alleviate poverty and thus promote social peace.

The objective of the TRUST is to reach 80-100 million people in the least developed and low-income countries, who are today excluded from effective social protection, within the next two decades – and more in the following decades. The underlying principles of the GLOBAL SOCIAL TRUST Network are global social responsibility and social partnership.

Benefits, benefit delivery, obligations of recipients

It is suggested here that the TRUST will support all national action that aims at extending the coverage of basic social security. The concrete set of benefits will be determined in line with national, regional or local priorities on a case-by-case basis. It is expected, however, that the main benefit systems supported through the TRUST will be combined national and community initiatives which finance essential health care, basic income security benefits and finance basic education. The beneficiaries are families as shown in the following basic family protection triangle. A promising avenue for rapid poverty relief for whole families that has emerged during the study appears to be basic "one-dollar-a-day" pensions for the elderly. These have proven to have beneficial effects for whole families.

The basic family protection triangle



It is expected that there will be contractual arrangements between community-based initiatives and existing national social protection systems aimed at building modest but sustainable, pragmatic and pluralistic nationwide social protection networks. The TRUST will operate through the implementation of major national assistance programmes in countries for a period of

between five and ten years. These programmes will be based on explicit agreements, between the TRUST and national governments or national agencies, which will stipulate the obligations of both sides. These contracts will be based on financial and operative transparency and tough monitoring and supervisory machinery. Two field studies exploring the potential chances for a successful, effective and efficient delivery of benefits through the TRUST came to the conclusion that the approach is worth testing. A small project in one country to test the linking of the national and community-based levels for benefit delivery will be launched during 2002 as a further step to collect practical experience for a successful launch of the TRUST.

Basic operational principles

The TRUST would operate according to ten major guiding principles:

- the basic philosophy is the exercise of global social commitment by individual and possibly corporate or institutional contributors;
- it will build on initiatives taken in recipient countries which demonstrate the commitment to self-help;
- the TRUST will build on social partnerships in donor and recipient countries and on partnerships between organizations in donor and recipient countries;
- it will sponsor and support programmes tailor-made and responsive to the most pressing social security needs at a local, regional or national level;
- it will consist of a decentralized system of funding combined with a centralized system of project vetting, appraisal and support;
- it will maintain political independence and respond exclusively to priority needs;
- wherever possible it will utilize existing social administration structures in recipient countries and will help to foster sustainable pluralistic social protection networks;
- it will support strategies for the extension of social security through a combination of investments in the administration and time-bound subsidies building on commitment at the local, regional and national levels;
- operations will be fully transparent, ethical, accountable and subject to regular performance and financial audits;
- support will be additional to existing social security resources as the TRUST is intended to provide resources that supplement what governments are currently able to provide.

Supplementarity

The TRUST does not intend to compete with other international or global funds or existing charities operating in the field of international development. It aims at different donors, follows a different rationale and has the distinct objective of investing in good long-term social governance as one prerequisite for development. It is a people-to-people trust that seeks long-term presence in the emerging system of global social governance.

As a rule of thumb - one contributor could on average help to protect two beneficiaries.
This is our basic people-to-people support formula.
By adding about 0.2%-points to the total social security contributions which a worker in an OECD country spends to secure himself and her/his family, s/he could protect two other people in the developing world.

While there are a number of global funds that have been established recently, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Global Drug Facility, each of these has a very specific focus on certain disease conditions. Traditional charities – often operating on a religious platform – address a donor community that has an emotional charitable approach to giving. The TRUST is aimed at people who understand and seek contractual agreements between citizens to reduce the income and welfare differences in the world and who believe that this is a beneficial investment towards global social peace in the long term. The TRUST will address the broader issues of human development and the environment and safeguards provided to facilitate human development. It will be undertaking work and funding for which at present there is no global fund and will facilitate improvements in countries rather than act as an implementing agency. It is anticipated that many of the NGOs currently working in social development may enter into partnerships with the TRUST.

Financial potential and impact

The TRUST could grow into a major international financial North-South transfer operation. If between 5 and 10 per cent of the employees in the OECD countries were to contribute an average of about €5 per month, then the TRUST could collect in its stationary state (i.e. after an introductory build-up phase of about one decade) between *€1 and €2 billion per annum*. This order of magnitude is equivalent to the present income of UNICEF and about four times the amount that the World Bank's International Development Association (IDA) annually disburses for investment projects in social safety nets. *It is estimated here that within the first 1.5 to 2 decades of its existence the TRUST could reach about 100 million people, i.e. help to lift them out of severe poverty through the provision of basic social security*.

Organization, governance and the role of the ILO

An operation of the envisaged order of magnitude requires a gradual build-up and the institutionalization of a tight system of monitoring. It also needs to ensure that it is not perceived as another mighty global institution uncontrollable by its financiers. It is thus suggested here to build the TRUST as a decentralized network rather than a centralized money collection and disbursement agency. The design suggested here favours the strong participatory responsibility of the individual financiers. The network approach envisages the gradual building up of national organizations (National Social TRUSTs) confederated in a global organization but with full national budgetary independence. National organizations would launch national membership campaigns, collect contributions, manage the funds, decide on the use of funds and audit projects financed by the respective national organizations. National organizations would be supported by a technical secretariat at the global level that would identify, prepare and implement country programmes under the supervision of a global board and be governed by a global assembly. The ILO would provide and host the technical secretariat. It would be represented on the global board

and it would hold the "franchising rights" to the organization and the brand name. However, it would not directly manage the funds.

While the ILO will thus have a key role in the design, the promotion, the start up and the funding of the TRUST, it will not be an "ILO fund". Rather, it will be a partnership demonstrating solidarity between workers, employers and governments of developed and developing countries. The ILO's role is fully consistent with its constitutional mandate to "promote social security" and its new focus on decent work for all. There can be no decent working conditions in the informal sector without at least a minimum of social security for families.

Post-September 11 donor fatigue?

While the events of September 11 may have resulted in more caution when donors are committing financial resources, they have also underlined the greater need to take assertive actions to redress income and welfare differences between countries. Through its novel approach to partnering, the TRUST will provide a unique opportunity and outlet for those who wish to contribute to making the world a more equitable and safer place.

Implementation

This study suggests a gradual step-by-step approach to the implementation of the proposals. To reduce risks of failure there are various points where the process can be modified should it become necessary. This feasibility study should be followed by a next step, a pilot project, to test the viability of the principles of the benefit delivery and the contribution collection. This pilot project would seek to test the viability of the benefit delivery concept in one developing country as well as the viability of the financing idea in one OECD country. Once the pilot is successful the process of building up a global organization may commence. This could take a decade.

Prerequisites for success

The building up of a major global organization requires strong commitments from "an agent of change" with potential access to strong national partnerships. The ILO, with its tripartite national constituencies and its constitutional and technical competence in the field of social security, would be ideally placed to adopt that role as "agent of change". Strong and lasting commitment is required – as well as institutional entrepreneurship. In more simple terms – basic investments (not huge but substantial) in terms of budgets and people are also required.

If these conditions are met, the feasibility study team considers the creation of a GLOBAL SOCIAL TRUST Network a bold, worthwhile and entirely feasible exercise.

A vision of the TRUST

The GLOBAL SOCIAL TRUST Network as envisaged here is a complex administrative and financial structure. A concrete image of it may help to understand the "soul of the new machine". That image is provided here in form of a newspaper article that may be written in some five years from now.

The International … Tribune
Friday, x. June 2007

A vision come true –
The Global Social Trust
changes life in an African village
and in a town in Holland

Today is Moussa Latifov's 65th birthday. He lives in a rural village in the south of Benin. As of today Moussa is a pensioner. To him that is a miracle.

Moussa has never contributed to any pension scheme in his life. He has always been a subsistence farmer; just made enough to look after his family. Paying contributions in cash to a social security scheme was out of his reach. Cash was only available when the crops were harvested and sold. His old age security were his son and daughter-in-law with whom he wanted to spend his old days together with his wife Aminata. Then came AIDS. Moussa and Aminata now have to care for their son and his wife, both ill, and their kids… Today, Moussa will walk the five miles to the next social security village office and wait with many of his friends for the armoured truck from Cotonou to arrive. He will than show his metal ID and receive – for the first time - this month's pension of 22,880 FCFA, the equivalent of 30US $. The armoured car will be white, covered with dust, and the doors will be sporting two logos: one of the OBSS, the national social security scheme and the other one will say in light blue letters GST, the acronym of the Global Social Trust, created by the ILO and its national constituents five years ago. The money will be enough to buy the food that they don't grow themselves and pay the school fees for the grandchildren. The monthly struggle for cash – which Moussa and Aminata lost so often in recent years - will be over.

Before Moussa can draw his pension this afternoon, two seemingly unrelated things happened yesterday in two totally different corners of the world. Joseph Niobe – teacher and part-time worker in the village social security office, which also has two logos on its white door had put Moussa's name on the list of 65 year old – the age being confirmed by the local priest. Then he had sent that list by e-mail to the OBSS head office in Cotonou. They notified the money transport company to take the extra 30US$ for Moussa on board when they left for the village. They will also take a small parcel with drugs that Moussa's son and daughter-in-law need so badly to survive for the next month.

At the same time at the other end of the world Ria Kamps (35) in Utrecht in the Netherlands had her bank account debited by 15 Euros – punctually as every quarter. She had that amount deducted from her account since years ago when her local union representative had recruited her as member of the Dutch GST section. She had signed up and forgotten about that regular small contribution. But today is a special day. When she checked her bank account this morning by e-banking from her office, the transaction reminded her again that tonight she will have to take her sports car and drive up to The Hague for a meeting of the GST committee into which she had been elected a year ago. Her qualifications as an accountant make her a valued volunteer - an asset for the committee.

Also about a year ago the Dutch committee of the GSN had decided to fund the project in Benin from Ria's contributions and those of about 300000 other Dutch employees. Within five years that project will establish a basic pension and pharmaceutical support scheme in Benin hoping to reach out to about 100,000 elderly which would also support other family members. Benefits would thus be spread to about 0.5 million people. The project will finance about 50% of the benefits for these 100,000 elderly. 100,000 victories against old-age poverty. At the end of the project the Benin government will take over the cost of the benefit in full. The cost will in part be covered by savings in the OBSS which will be realized due to the fact that GST cost and performance monitoring of the OBSS has led to a dramatic reduction of administrative cost.

Ria has been selected as one member of a monitoring team of five that will check the progress of the project against milestones that were agreed upon with the OBSS before the project started. "I never think of this as philanthropy" Ria says "for me, this is just an investment in a peaceful future" and she adds with a grin "…this is my equivalent to Bill Gates's billions for his TRUST".

Almost exactly 5 years after the UN conference on Financing for Development in Monterrey, Mexico, where the International Labour Office first floated the idea of a GLOBAL SOCIAL TRUST fund, the GST today has just reached its first 10 million beneficiaries in Africa. All over the OECD countries millions, mostly younger employees, pay their solidarity dues of about 5 Euros per months without much ado.

"A vision has come true in the last five years", says Juan Somavia the Director General of the ILO, "in another five years we hope to reach out to about 100 million people".

On his way home - humming a familiar old tune - Moussa knows nothing about this, and Ria in her beetle – with roaring hard rock coming from her audio machine - in the middle of the evening traffic jam in Utrecht does not think about it. And yet, the GST has changed their lives – for the better.

Part I: The proposal

1. Setting the scene: Background, justification and development policy context

The world is facing a crisis of human development due largely to poverty and its consequences. There are still shamefully too many people who are too shamefully poor. About 1.2 billion people live on less than one dollar a day.[4] However, poverty is a multi-dimensional phenomenon. It manifests itself inter alia in lack of access to education, lack of access to adequate health services, in malnutrition, in poor sanitation and in gender disparities. The causal links between working and living environment, education systems, health systems, social protection systems, human rights, poverty, and gender are fundamental to finding solutions that will remedy these problems. Improving education, health, environment, work opportunities, and available social security safeguards for poor people are essential strategies to realize international development targets such as the Millennium Development Goals (MDG). Ultimately all potential remedies to all dimensions of poverty have three common denominators: the availability of resources, established national policy priorities with regards to the use of resources and the effective and efficient allocation of available resources. If an economy generates a high enough national income, it also creates a tax base that should permit to devote enough resources to root out the many causes of poverty. Whether and to what extent these resources are actually used to combat poverty is a matter of national policy priorities. How effectively and efficiently they are used depends on the quality of governance.

Hence, the eradication of poverty remains first and foremost an obligation of national economic, social and fiscal policies. That task inevitably is easier in countries where the economic engine provides enough income that can be redistributed to alleviate immediate poverty and be re-invested in the economy and the governance systems to prevent the poverty risk in the long run. Other countries need external help to put governance systems on a policy trajectory to reduce poverty. This reports analyses whether such support could be provided effectively and efficiently through a GLOBAL SOCIAL TRUST.

Figure 1.1 encapsulates the basic rational of the GLOBAL SOCIAL TRUST approach to poverty alleviation. The bolder line describes the obvious relationship between per capita GDP and the prevalence of income poverty (measured as the headcount of people living on less than US$2 a day). Income poverty obviously steeply declines with increasing levels of per capita GDP. That is no surprise. That poverty is not completely abolished in countries with high per capita levels of GDP is a matter of policy priorities, although the regression line is obviously misleading towards the higher income level end. The US$2 per capita income level is an absolute poverty level and in most high income countries that level of destitution will be virtually non-existent. Figure 1.2. which relates national definitions of relative poverty to per capita GDP levels might be more relevant for higher income countries.

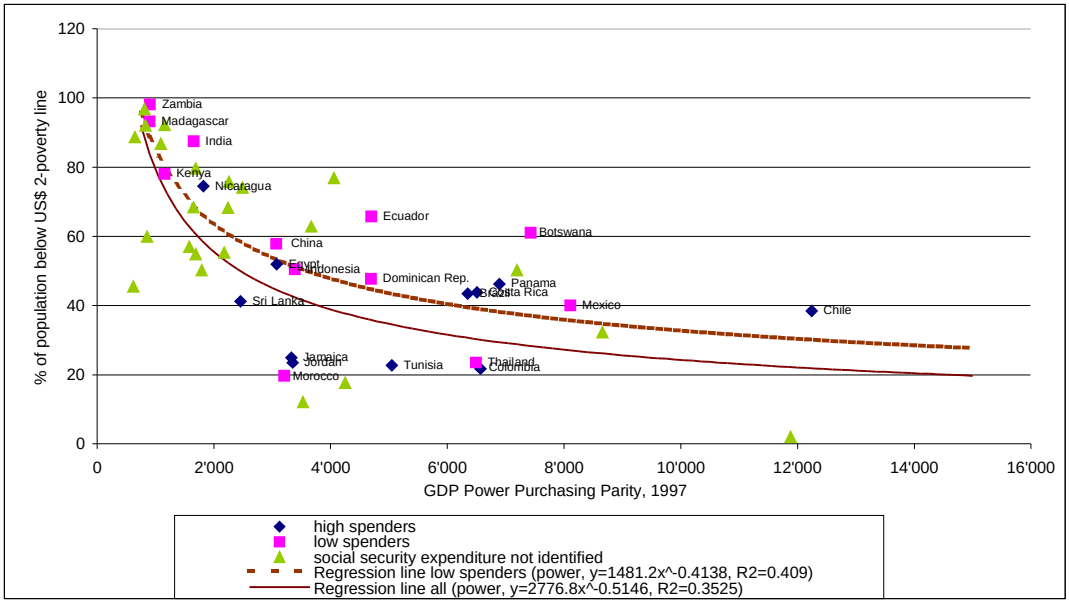
What the graphs also show is that at the same level of GDP per capita different countries can have greatly different levels of poverty. The difference in the level of poverty between these countries is thus not explained by different levels of economic performance but rather by policy and governance factors. One of these governance factors is obviously the spending on social

[4] See the "Zedillo report", New York, 2001, page 13.

security - or in other words how much of GDP is devoted to social transfers. The second line in both graphs plots the same relationship in countries with relatively low social spending[5] (as measured in public spending on social security as a percentage of GDP). Even if the regression fit is not very good it seems that social spending itself can push poverty rates down.

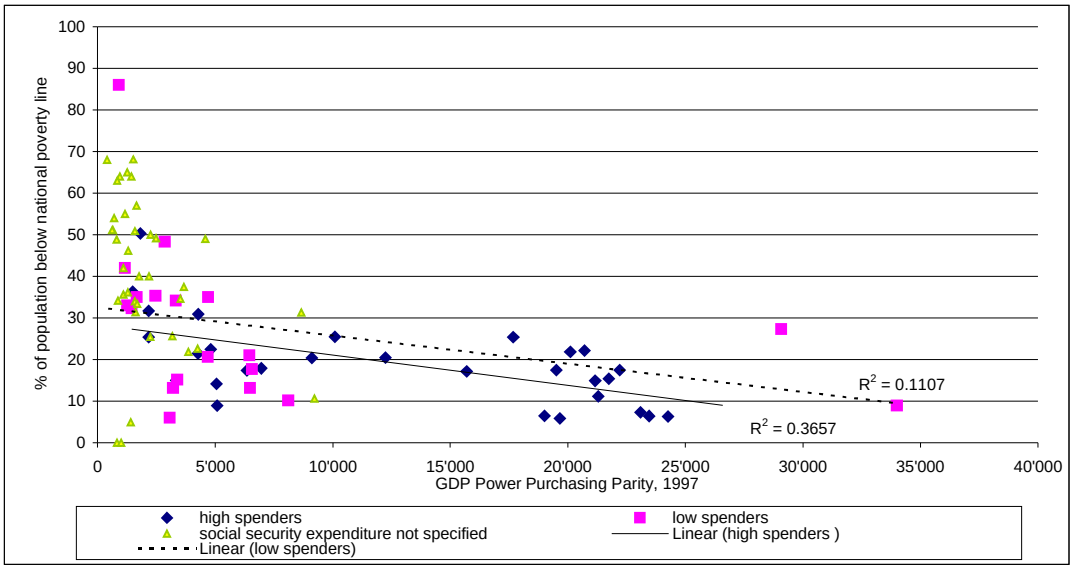
A cluster analysis of the relationship of absolute poverty rates and GDP per capita shows that countries with approximately US$5,000 per capita may still have poverty rates of about 50% but could also possibly achieve poverty rates well below the 20% level with the right policy priorities and good governance. At least their absolute poverty lines in theory need not be much higher than the relative poverty line in countries with a multiple of their per capita GDP. At the same level of per capita GDP China and Jordan, for example have very different levels of poverty. China is a relatively low spender (even though not all social security expenditure may be statistically captured here) which experiences a high poverty rate of more than 50% while Jordan's relatively high social spending seems to be able to push poverty rates down to well below 30%. However, the relationship between poverty and social spending is not as stringent as one might expect. Low spending Morocco seems to be doing as well as high spending Jordan. Within the overall redistribution through social transfer systems the degree of poverty targeting is also relevant. In general, substantial and well allocated social spending seems to be able to effectively push poverty rates down - even without a change in economic performance. The effect of social spending on overall absolute poverty rates is even more dramatic if one were to include the economic transition countries into the regression analysis.

Figure 1.1. Percentage of population below US$2 – poverty line versus GDP PPP per capita (1997); countries grouped according to high and low spending on social security (exponential regression); transition countries excluded



[5] 'Low' and 'high' levels of spending were determined in a two-stage process. First a regression line showing the dependence between social security expenditures as a percentage of GDP and per capita GDP were determined. Low and high spenders were defined as countries below or above that line.

Figure 1.2. Percentage of population below national poverty line versus GDP PPP per capita (1997); countries grouped according to high and low spending on social security (linear regression)



However, while some countries with relatively low levels of GDP appear to be able to maintain systems of good governance and endogenous redistribution there are a number of low income countries with an annual GDP per capita of below US$1,000 which do not seem to be able to invest substantial amounts of resources in the build-up of national social transfer systems as a means to combat poverty. They appear to require an external "kick-start" to build a solid social transfer system.

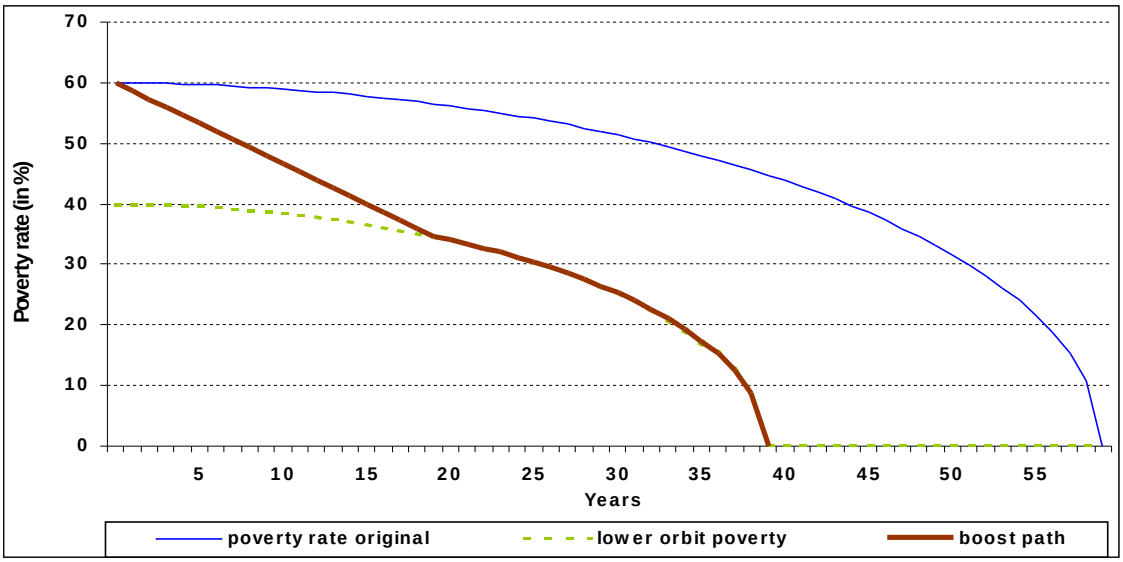
Economic growth alone and the expected associated increases in public revenues would probably only after decades permit substantial investments in the social transfer sector. For a given country, if one were to leave the development of good social governance to the "natural" development path while GDP increases from a level of US$1,000 to US$5,000 per capita and the poverty rate declines from say – 80% to 20% - that process would take about three and a half decades, even assuming an optimistic average annual rate of real growth of 5%. This is still much too long a period to be ethically and politically acceptable. It is not the mission of the TRUST to create and maintain higher levels of economic growth directly. Its main business would be to reduce the level of poverty faster than economic growth alone could achieve. It is assumed, however, that these lower levels of poverty will have a positive "knock-on" effect on individual productivity and hence long-term growth.

The mission of the GLOBAL SOCIAL TRUST is to financially support efforts of national social protection systems in such countries, which generally cover only a minority of the population, to reach out to uncovered communities and groups in the population. The introduction of universal social protection coverage in many poor nations, communities or groups often faces a critical hurdle that prevents it from taking off: the resource gap. Setting up schemes has inevitable costs, that can often not be covered from own resources. National governments in most poor developing countries simply do not have the fiscal or administrative capacity to organise a nationwide institutional social protection network. The lack of national resources in particular

hampers the creation of governance skills that would permit successful implementation and operation of national social protection systems. Neither do these countries at present have the capacity to maintain social transfers to the very poor. Communities or occupational groups have to step in and to fend for themselves. However, they are often faced with a vicious circle: They cannot ask members of the community to contribute to a transfer system, without being able to provide these transfers immediately or without providing a full range of transfers immediately. If these schemes are not able to provide the full range of most needed minimum services they lose credibility and collapse. The resource gap does not allow them to train their staff, invest in local infrastructure or finance costly benefits from the start. This is due to the fact that financial reserves and the delivery capacities have to be built-up over a longer period.

External support is required. The objective is to leap-frog the natural pace of the extension of social protection coverage and associated poverty reduction. It seems that dropping down from a natural poverty reduction curve to a curve that has approximately a 20%-points lower poverty level appears possible if investments in good governance and possibly limited external transfers were possible. The duration of the countries' fight against pandemic poverty might be reduced by about 20 years. While the figures quoted here are only illustrative the following graph encapsulates what the GLOBAL SOCIAL TRUST tries to achieve: A faster reduction of poverty through the launching of the poorest countries onto a lower "poverty orbit" by an initial external boost.

Figure 1.3: The poverty reduction "boost"



The boost would come from substantial external investments in the build-up of a national social protection system and a transitional cost sharing of some of the critical well targeted anti-poverty benefits. These external investments could come from the GLOBAL SOCIAL TRUST which should be fuelled by resources from richer countries.

Ideally the TRUST would be financed by regular contributions from member countries. Recognising that state support for the financing of development will inevitably be limited in the near future, the ILO will seek the voluntary support of individual citizens. It will promote the creation of a network of decentralized funds which will be financed by voluntary contributions from employees and possibly enterprises in the industrialized countries (i.e. through average

monthly contributions of 5 Euros per month or 0.2 % of monthly income). The resources will then be used to invest in national social protection systems in low-income countries. This will be aimed at sponsoring, for a limited period, the operations of these systems, while enhancing their capacity to attain full sustainability as well as extending coverage to lower income groups of the population.

The TRUST offers individuals around the world, global citizens, whether they are employees, self-employed, employers, pensioners or corporate entities the possibility to explicitly accept an individual share of global social responsibility. They will – on a rational rather than emotional basis - invest a small part of their income – and possibly some of their time - on a voluntary basis into enhancing global social justice and hence social peace. This may not have immediate tangible benefits for the contributors but may well contribute to safeguarding the lives of their children. Social peace is a public good that can only be "produced" by widespread solidarity.

The GLOBAL SOCIAL TRUST initiative would also complement other worldwide initiatives to alleviate poverty. Under the IMF and World Bank initiatives on debt reduction in the poorest countries (HIPC- Heavily Indebted Poor Countries), the governments of these countries prepare the poverty reduction strategies. The aim is not only to unblock and stimulate economic growth but also to ensure that this growth is an equitable one, that it reduces poverty through a system of social transfers reaching those most vulnerable. The aim of the GLOBAL SOCIAL TRUST is to put in place and enhance exactly this type of transfer systems. For example, the Poverty Reduction Strategy Paper (PRSP) prepared by the government in Ghana foresees that the social security institution (SSNIT) will organize a mutual health insurance scheme, which is a chance to extend the social protection coverage to those not covered until now and thus not only to reduce poverty but also to prevent it for a large number of people. This is the type of activity which would be supported by the GLOBAL SOCIAL TRUST.

The ILO also sees all activities of the TRUST as contributions to the achievement of the Millennium Development Goals (MDG) which are seen as an outcome of the "world conferences organized by the United Nations in the last decade and have been commonly accepted as a framework for measuring developments progress"[6]. Effective basic social protection mechanisms can help to achieve at least six of the eight goals. Cash transfers to the poorest families, for example, will have a direct impact on poverty, hunger, primary education (if school fees are paid out of income transfers), gender equality and the empowerment of women (if family cash transfers are paid to women), child mortality (if family benefit are tied to the utilisation of ante-natal care) and the effects of HIV/AIDS (if basic cash or health care benefits are provided to victims and their families). The TRUST would thus also be a tool to mobilize the potential of social protection to the achievement of the Development Goals and as well be compatible with all other initiatives that are needed to achieve these goals.

[6] See http://www.developmentgoals.org. The MDGs – to be achieved by 2015 - are: 1. Eradicate extreme poverty and hunger, 2. Achieve universal primary education, 3. Promote gender equality and empower women, 4. Reduce child mortality, 5. Improve maternal health, 6. Combat HIV/AIDS, malaria and other diseases, 7. Ensure environmental sustainability, 8. Develop a global partnership for development.

2. A possible blueprint for a GLOBAL SOCIAL TRUST

The following sections describe a model for the TRUST that appears to be the most plausible at this stage of the exploration of the concept. The individual characteristics were delineated from the findings of the individual sub-studies - as well as the many opinions from experts that were received during the consultation process of the feasibility study. The main characteristics of the blueprint for a GLOBAL SOCIAL TRUST – as they reflect the thinking of the study team and incorporate the basic ideas of the review group - are outlined in the following 10 sections. Needless to say that all of them might have to be modified if the concept were to be explored further.

2.1. The basic idea

The basic idea is to request people in richer countries, i.e. OECD countries, to contribute on a voluntary basis a rather modest monthly amount (say €5 per month or about 0.2 per cent of their monthly income) to a Global Social TRUST which will be organized in the form of a global network of National Social TRUSTs supported by the ILO.

The TRUST would address the twin problems of poverty and social insecurity through:

- ***Investments*** **in social governance structures to enable basic national social protection systems to function independently in the longer-term and become financially self-sustainable through securing adequate national resources (leveraged investment) and**

- ***Timebound and targeted subsidies*** **in the short- and medium-term to support social transfers to population groups that are not covered by formal social insurance mechanisms.**

This initiative will bring together social partners and governments as well as local communities in developed and developing countries. The TRUST would largely be financed by small, voluntary, solidarity contributions from individuals and if possible employers in the rich countries – thus extending first world social solidarity into the developing world and creating an effective global social partnership for social development. The TRUST will provide seed-support to self-help initiatives without creating long-term dependency.

The TRUST will need strong partners in all individual countries – on the donors' side as well as on the recipients' side. Major partners will be employers and workers organizations. The unique tripartite structure of the ILO can be used to mobilize support from workers and employers in ILO member countries. The capacities of the Office will be used to design and monitor project activities.

2.2. Mission and objective of the TRUST

> ***The mission of the GLOBAL SOCIAL TRUST is to systematically reduce poverty in developing countries through a partnership that invests in and sponsors the development of sustainable national social protection schemes for people and groups which have been excluded from the economic benefits of development.***

The objective of the TRUST is to reach 80 to 100 million people in the least developed and low-income countries within the next two decades - and more in the following decades. The underlying principles of the TRUST are global social responsibility and social partnership.

Hence, the TRUST would invest in the world's social future by seeking to alleviate poverty and thus promote social peace.

2.3. Potential benefits for the socially excluded

The purpose of the TRUST is to make significant and sustainable contributions to enhancing social programmes which will facilitate the extrication of people from poverty by providing and supporting opportunities of self-help.

The key activity will be the investment in and the sponsoring of the set-up or extension of **social transfer schemes for groups or communities which have hitherto been excluded from adequate social security coverage** (inter alia due to the fact that they do not belong to the organized formal sector). However there should be tight eligibility conditions for TRUST support and a categorical limitation of the types of benefits to essential social protection needs.

2.3.1 Eligibility conditions

The crucial and inalienable prerequisite for the TRUST's support to national initiatives would be the financial and organisational commitment of communities, groups as well as national governments. There would be no 100% financing of initial investments or benefits of sponsored schemes. Community commitment would in principle be demonstrated through the initiative to set-up, organise and to a substantial extent finance community-based insurance or social assistance schemes. National commitment could be demonstrated through budget financing of - at least - a part of the benefit cost. This budgetary commitment could be re-financed, for example, through the charging of an extra contribution for social development to the members of national social insurance schemes. For community or national schemes to qualify for technical support and temporary subsidies they would have to meet certain minimum criteria:

- benefits provided must have a direct and measurable impact on poverty and or the health status of the population served;
- compatibility with other national anti-poverty and social protection policies;
- clear proof that the resources provided by the TRUST are additional to pre-existing levels of social spending;
- open enrolment, i.e. the schemes would have to refrain from screening their membership for "good risks" and would basically have to admit all people that express an interest in joining a scheme (to avoid moral hazard on the part of the members, waiting period till the first benefits are due might be acceptable);
- commitment to achieve the widest possible population coverage, which should be demonstrated through particular support for the most needy members of the community (by helping them to afford membership);

- focus on the most urgent social security needs of the community, as demonstrated by a needs assessment study;

- commitment to transparent administration and accounting, as demonstrated by a clear set of rules for benefit entitlements and contribution obligations, clear administrative procedures and a minimum set of accounting and budgeting rules;

- a clear objective and potential for long-term self-sustainability or financial independence from the TRUST at the national level.

2.3.2 Nature and types of supported social protection benefits

TRUST sponsored social protection benefits are benefits that provide directly or indirectly some basic social security for whole family or household units, in that they should aim at helping the family or the household to cope with the risk of poverty and/or ill-health. The prime addressees of benefits should thus be groups of people that are living together as an economic unit in a household and are coping with income shocks and other risks of life together. This would not exclude people living alone, as they would be regarded as a one-person household. By their nature such benefits are social assistance benefits for families and households rather than the classical social insurance benefits which are generally based on individual entitlements.

Some of the benefits mentioned in this chapter – as possible targets for TRUST support - may appear to have the classical social insurance character of individual benefits, such as basic one-dollar pensions. However, these benefits have strong "trickle down effects" to whole families. Pension cash income, often the only type of regular cash income available to poor families in non-cash economies, is generally shared in the household. One might also tie the payment of that benefit to conditions which would directly benefit other family members such as the school attendance of children or the maintenance of a small savings account for the purchase of essential drugs for family members.

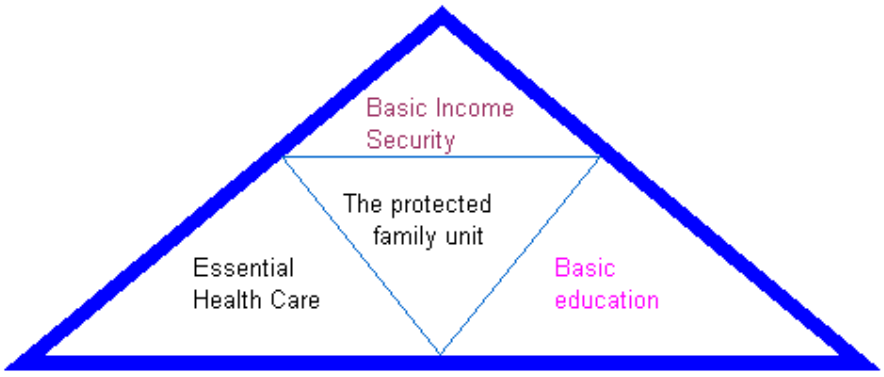
Contrary to its initial intention, the project team gave up the idea of defining one or two specific tangible benefits that would be supported by the TRUST such as, for example, basic health care benefits. In the course of the country studies as well as discussions with experts it became apparent that actual benefit needs may vary widely between countries and even within a given country. It is not appropriate for an international organism like a GLOBAL SOCIAL TRUST to prescribe the benefits that will be provided to communities. Not defining a specific tangible benefit would ensure greater relevance and responsiveness to needs in recipient countries.

However, a categorical definition of benefit schemes to be supported is necessary to maintain public confidence that the contributions are spent where they are most needed. The study team and the review group thus limited the schemes "eligible" for support by the TRUST to schemes that provide basic family security benefits or benefit packages that fall within the triangle of:

- **basic income security benefits**, providing cash or in kind relief to families and individuals facing poverty due to income shocks triggered by a loss of earnings capacity (e. g. in case of old age, disability, sickness);
- **essential health care**, providing family members with care that is medically necessary, nationally available and not affordable to the family;

• **basic education**, ensuring a minimum duration of school attendance up to a defined age for children in supported families through coverage of school fees and sponsoring of e.g. school uniforms.

Figure 2.1: The basic family protection triangle



Supported benefits need not necessarily fall within one category of the triangle. One benefit might actually belong to two or even all three categories. For example, a cash benefit for a disabled family member might be used to purchase essential health care or could be made conditional on school attendance of the children under age 16 living in the same household. All possible benefits that fall within the above triangle have a direct or indirect, immediate or longer-term impact on poverty. Basic income security cash benefits provide immediate relief, essential health benefits relieve tight family budgets or help to maintain the long-term earnings capacity of family members, and basic education helps to ensure future earning capacity.

While there can be no one-type-fits–all approach to benefit delivery, one would normally envisage that benefits be delivered at the community level by either independent community-based insurance-type arrangements with financial and monitoring links to a national centre or a community-supported branch of a national institution (see also paragraph 2.4). The following section provides some examples of benefits and schemes that could be supported by the TRUST.

2.3.3 Some typical examples for interventions by the TRUST

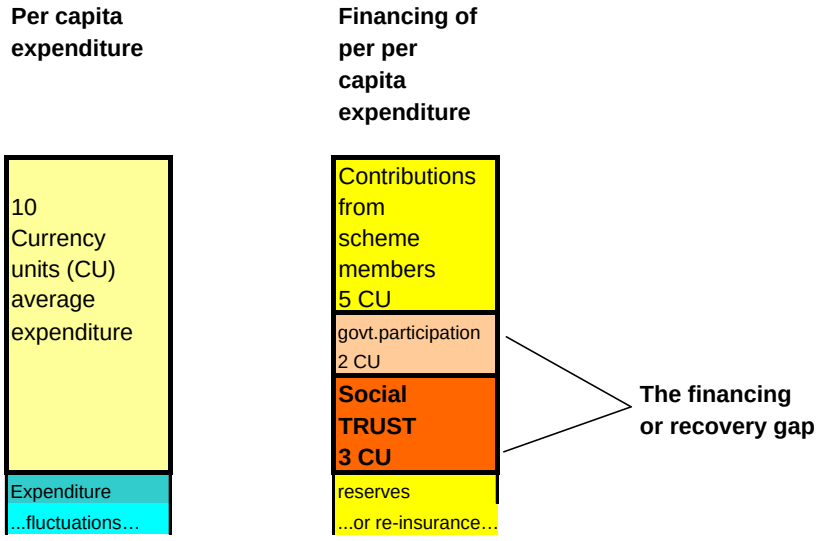
Benefits and benefit schemes which could be supported would include community-based programs for education, health, and/or cash benefits for particular groups such as the sick, the old, the disabled, widows, children and orphans. The TRUST may facilitate improved access to health services, or allow for the education of children who are currently working, or provide death benefits that allow widows, widowers, and families to recover economically after the death of a key family member, or it might provide basic pension benefits to the elderly who have to accept care responsibilities for AIDS stricken younger family members. Some of these possibilities are illustrated below. These examples are illustrative rather than exhaustive and are of course different from case to case.

Example 1: Support for community based health care schemes

At present many community-based health care schemes face an insurmountable recovery gap. Local communities simply do not have the financial capacity to finance a comprehensive set of

most urgent health or cash benefits. Hospital care, for example is often out of the financial reach of local voluntary health insurance schemes. While these schemes may be able to reinsure against irregular expenditure variations, they are not able to recover the full cost of a reasonably comprehensive benefit package, unless they exclude many poor from coverage and concentrate on the better off in the community. As a rule, the larger the coverage, the bigger the recovery gap or in other words the higher the premium (the smaller the recovery gap) the lower the coverage. The **GLOBAL SOCIAL TRUST** could help close that gap until the scheme is able to close the recovery gap through own means. Figure 2.2 illustrates a possible initial cost-sharing arrangement for a local health and social security scheme.

Figure 2.2. Closing local financing or recovery gap – an illustrative example



Example 2: Supporting the introduction of universal basic pensions

Another option could be the temporary cost sharing of a universal pension for all residents after a certain age or a benefit conditional on care responsibilities of the elderly in families. This option has for a long time been considered as un-affordable in many developing countries. If such a benefit were to be introduced nationally and were to be administered in a decentralized way by a community based organization and the benefit were to be limited to US$1 per capita, per day or 1 Euro per capita, per day level and communities were to co-finance the benefit, then the impact on the most severe forms of poverty might be immediate and substantial. Such a scheme could be affordable at least in some developing countries. Local communities could demonstrate commitment by administering the sponsored old age benefit and complement them – for example - by community based invalidity benefit payments. This type of benefit would have a series of direct positive effects for the elderly as well as indirect positive "trickle-down" effects for families in which the elderly live. It would de facto be a multi-purpose family benefit that would generate some form of cash income without being too big a deterrent to employment, it :

a) would enhance the status of the elderly in the family,
b) might help to keep children out of employment since families might be able to afford to send them to school rather than to work,

c) could enable the elderly to spend time to care for sick members of the family rather than seek *ad hoc* employment to generate some cash income in the families.

The paper in Annex 2 by Barrientos and Lloyd-Sherlock evaluates the experience with basic non-contributory pensions in 10 African and Latin American countries[7]. The paper analyses national experiences along three dimensions: the impact on poverty and vulnerability of older people, impact on more aggregate levels of poverty (inter alia poverty levels in households and communities in which the elderly are living) and the impact on household investment. The paper concludes "… *that cash transfer programmes do indeed have the potential to make a significant contribution to reducing poverty and vulnerability among the old and their households, as well as reducing the intergenerational transmission of poverty. Thus, the experience of the countries reviewed confirms that these programmes are able to deliver in all three dimensions, and with the right design and financing features, they could constitute the embryo for more embracing social protection systems in the developing world. The available evidence from these cash transfer programmes shows they have a significant impact upon old age poverty, and on the status of older people. In terms of their impact upon aggregate poverty, this depends on the extent of co-residence, and on the cultural norms and practices regulating intra-household distribution of income. Cash transfers to the old may be a less effective instrument in reducing aggregate poverty if, as is the case in transition economies or middle income countries in Latin America, a growing minority of older people start to live alone. However, there are no signs of this occurring on a significant scale in low income countries. Cash transfer programmes to the old also provide an important stimulus to economic activity, and can act as valuable insurance against risks to household consumption and investment. These programmes have the potential to make an important contribution to the development process."*

So far, basic tax-financed pensions were deemed unaffordable in most developing countries. However, recent indicative calculations by the ILO and others[8] show that modest universal basic pensions (one US$ per day or less) could possibly be financed in at least some African countries by about 1 per cent of GDP. This, of course, would require substantial public spending shifts in countries with an overall tax revenue of the Central government between 10 and 20 per cent of GDP.[9] In some countries national financing might be possible, others – almost certainly - would require transitional foreign financing from the TRUST.

The TRUST would not only help to set up the machinery to distribute the benefits and monitor their delivery; it might also develop a long-term financing plan together with the competent government authorities or social partner organizations and other organizations in the country. It is obvious that this type of benefit would require in the long-run a strong financial commitment of the government. A potential financing model for a TRUST supported rural pension scheme in Africa is provided in Box 11 in chapter 3.2.

The following box describes a concrete experience, the universal pension scheme in Namibia, which is by no means a rich country and can afford a nationwide modest universal pension scheme. This example shows that this benefit might be one of the most powerful tools that a national social protection system has at its disposal in order to eliminate one of the hard cores of poverty – old age poverty - and at the same time support families in need.

[7] See Annex 2, Table 1, the countries are Botswana, Mauritius, Namibia, South Africa, Cots Rica, Argentina, Chile, Brazil, Uruguay, Bolivia. Further experience on the effect of basic pensions in Africa and Latin America can be found for example in Case and Denton (1998) and Schwarzer and Delgado (2002)

[8] See Willmore (2001), p. 14.

[9] See World Bank: World Development Report 2000/01: Attacking poverty, Washington, 2000.

Box 1. Universal pensions in Namibia

The Universal Pension Scheme in Namibia, which was established in 1992 by the National Pensions Act, is providing a flat rate benefit regardless of other income for rich and poor alike. Four types of benefits exist in the universal pension scheme: Old-age grants, disability grants, child maintenance grants and foster parent grants. Everybody who is a Namibian citizen and ordinarily resides in Namibia and is aged 60 years or more is entitled to an old-age benefit from the scheme.

The non-contributory Universal Pension Scheme (in March 2001) provided 111789 benefits, thereof 96 767 benefits of the amount of N$ 200 (US $18) per month to persons aged 60 or older. Currently about 98000 persons are 60 years or older, therefore the total coverage of elderly persons is almost 100 per cent.

Presently the expenditure for old-age benefits without administrative cost is about N$230 million per year, that is 0.8 per cent of GDP. If an annual adjustment of benefits in line with inflation is assumed this share is expected to steadily decline to 0.55 per cent during the period 2040 to 2044, thereafter it will start increasing. In the year 2050 it is calculated to be 0.6 per cent. This also shows that ageing does not always and everywhere pose an insurmountable obstacle for the financial viability of a universal pension scheme. The chosen example also demonstrates, that (almost) universal coverage of anti poverty measures for elderly is possible and affordable.

The main rationale for the Namibian Government to introduce a universal flat rate pension scheme is that of redistribution. The Government designed the pension scheme to be redistributive in order to guarantee adequate retirement income for retirees who were un- or under-employed, in low paid employment while working, or whose accrual of pension benefits was reduced because they were temporally out of work for reasons such as sickness, unemployment, or family responsibilities. Redistribution between generations is also seen as desirable in order to share the benefits of economic growth.

Currently, the authorities intend to have the payments of the universal scheme means tested, in order to be able to pay higher benefits to those who are actually in need of it. In addition the government intends to establish a contributory pension scheme, in order to better address the needs of invalids, widows, and orphans and to provide higher old-age benefits than the basic anti-poverty measures of the universal pension scheme.
Source: ESS-Paper No.6, Namibia's Universal Pension Scheme: Trends and Challenges; Geneva, ILO,2002; and own calculations. Box taken from a Paper contributed by the ILO to the Second World Assembly on Ageing (Madrid 2002).

The TRUST does not envisage freeing local communities or national governments or institutions from their responsibility to cater for their own social security needs. It would provide matching grants conditional upon local communities and the government accepting their fair share of the overall burden. It is intended as a contribution to the strengthening of the portfolio of anti-poverty risk management tools that individuals in the informal sector have at their disposal. It also would not accept open-ended commitments. That means – for example - that unforeseen extraordinary expenditure of a health care scheme - triggered for example by a malaria epidemic – will have to be catered for by the schemes' own arrangements, either through the build-up of a contingency reserve or by taking out a re-insurance arrangement. Benefits from the GLOBAL SOCIAL TRUST will be time-bound. They would be contingent on the agreement of state or regional governments to take over the benefit delivery structures or guarantee the financial viability of the schemes at a certain point in time when the economic and fiscal situation permits full responsibility for the programmes locally.

The benefits of the TRUST would take the form of a contract between the government, the social security institutions involved and (if applicable) local communities and the National Social TRUST organizations. The following box contains the description of a typical benefit package.

Box 2. A typical benefit package of the GLOBAL SOCIAL TRUST

Let us assume that a government in an African country wants to set up a basic community based cash benefit scheme for AIDS affected households in rural areas. It requests help from the GLOBAL SOCIAL TRUST, as it would not be in a position to set up the scheme within its present budget constraints.

The benefit envisaged would be an amount of US$1 a day per infected and actually sick person to be paid to the carer. It is estimated that of the total rural population of about 1million about 50,000 would suffer from the symptoms of HIV/AIDS. The total benefit cost at the present level of infection would thus be in the order of 18.25 million US$ per year. The benefit would be developed through a system of community based cash benefit insurance schemes which could collect a contribution of about 6 million US$ per year. The start-up cost of the delivery system would be in the order of 1 million US$.

The national social insurance scheme for formal sector workers would act as a partner for the community schemes. It could collect a small solidarity contribution of about 3 million US$ from its members. The government spends today an estimated amount of about 5 million US$ in ad hoc cash support for poor AIDS affected families. It could devote that amount of money to the setting up of the new scheme. Together the available resources still leave a financing gap which the fund will cover for a period of 10 years in addition to the set-up cost.

The GLOBAL SOCIAL TRUST project could establish a contract for this country which specifies in particular the following elements:

- ten year social budget projection for all government expenditure on social protection benefits; this is to ascertain to the extent possible that the government will not simply spend the money that it receives from the TRUST to reduce its overall financial commitment to the social sector;
- commitment by communities to a certain level of cost-sharing;
- commitment from the government to increase its financing share for the scheme till full cost recovery after year 10;
- an agreed upon 10 year financial plan for the benefit which could look as follows, assuming that the benefit amounts would stay constant and that the number of eligible person would increase by 1% per year and the number of contributors in the formal sector would also increase by 1% per annum and their wages by 2% in the formal sector.

Typical financial plan for a GLOBAL SOCIAL TRUST benefit package (milli. US$)

Year	1	2	3	4	5	6	7	8	9	10
Expenditure:										
Estimated Benefit cost	18.3	18.4	18.6	18.8	19.0	19.2	19.4	19.6	19.8	20.0
Estimated start-up cost	1	0	0	0	0	0	0	0	0	0
Administrative cost	1.8	1.8	1.9	1.9	1.9	1.9	1.9	2.0	2.0	2.0
Total expenditure	21.1	20.3	20.5	20.7	20.9	21.1	21.3	21.5	21.7	22.0
Financing:										
Communities	6	6	6	6	6	6	6	6	6	6
Soc. Insurance scheme	3	3.1	3.2	3.3	3.4	3.5	3.6	3.7	3.8	3.9
Government	**5.0**	**6.0**	**6.5**	**7.0**	**7.5**	**8.0**	**8.5**	**9.0**	**10.0**	**11.5**
Global Social Trust	**7.1**	**5.2**	**4.8**	**4.4**	**4.0**	**3.6**	**3.2**	**2.8**	**1.9**	**0.5**
Total income	**21.1**	**20.3**	**20.5**	**20.7**	**20.9**	**21.1**	**21.3**	**21.5**	**21.7**	**22.0**

The financial plan would thus envisage a total commitment of the TRUST for the cost-sharing of the set-up (the investment part) of the scheme and the benefit subsidies for the 10 first years of about 37.6 million US$ (without interest). If the people in the donor country would contribute on average about 5 € per month then about 120,000 contributors would be needed to finance the expenditure of the first year. That number would decline gradually thereafter.

2.4. Envisaged administrative and organisational structures

The administrative and organisational structures would be built on a complex global social partnership, which would connect citizens in all parts of the world through a "social network". The income side of the network would consist of National Social TRUST organizations which would be involved in collecting the contribution of their members. The National Social TRUSTs would manage these funds and release them for specific projects rather than transfer their resources to a central Fund that would then allocate resources centrally. The financing of the TRUST is detailed in section 2.4.2 of this report. Projects would be identified, planned and implemented by a Technical Secretariat. Over the life-span of a project financed by the TRUST, the National Social TRUSTs would provide information to the contributors on how their funds have been used, audit the use of those funds, and monitor the impact from the use of their contributions. On the beneficiary side the network would preferably use existing social protection systems and build on existing community commitment. The TRUST would thus develop people-to-people partnerships between contributors and beneficiaries through National Social TRUSTs and community based and national social protection schemes.

2.4.1. Organization and management of benefit delivery

On the delivery side the TRUST will seek to use existing community groups and national social protection structures rather than create new organizations or mechanisms. These existing schemes must demonstrate a willingness and desire to solve their own national and/ or community problems and promote social sector development. The primary reason for this is sustainability. Creation of new mechanisms may create a dependency, which will result in failure once the TRUST phases out its support for such endeavours.

Satellite social insurance schemes in informal sector communities could be one of the preferred delivery mechanisms "on the ground". These would be community-based organizations (the "satellites"), run and partly financed by the community, which are mentored and supported financially through existing national social insurance or social protection schemes (the "***hubs***"), without being a formal branch of these national systems. And yet– the so far, primarily formal sector oriented social protection schemes – would have to develop a portal to reach out to informal sector. The linking of the global, national and community levels through the GLOBAL SOCIAL TRUST is illustrated in Figure 2.3. The idea of the satellite insurance schemes is described in more detail in Part II Annex 1.

The participation of national schemes (hubs) would be decided by either the government or the TRUST and would be subject to quality controls to ensure that minimum standards are met for participation. These national schemes would have to be pre-qualified in order to apply for grants and technical support from the TRUST. This pre-qualification would require a description of the scheme and who it is serving, a review of the financial soundness and accuracy of independent financial statements of the scheme, and a description of the governance and management of the scheme. That information would be reviewed by the Technical Secretariat of the TRUST against specific criteria in order to pre-qualify a scheme or disqualify it. Those schemes which pre-qualify would be eligible to submit an application to the TRUST. The basic idea is to develop a quality standard for national schemes (which could be called ILO 2002, see box 3) that would be used to pre-qualify participating hubs, but could also be used for future auditing of their delivery performance.

Meeting the quality standards could involve the applicant submitting documentation on its soundness through:

- audited financial statements;
- reporting on the benefit delivery and contribution collection performance;
- accepting the participation of donor National Social TRUSTs in providing technical expertise, auditing or other in-kind contributions in addition to financial contributions;
- being accountable to contributors for the use of resources through open and transparent financial reporting.

The national schemes in turn would have to ascertain the quality of administration of the satellite schemes. In countries where no national social protection schemes exist other organizations might be eligible for participation.

TRUST activities supporting national implementation of benefit schemes will be organised in the form of technical co-operations projects. These projects will set-up national project offices for the duration of the projects and will be guided by national project steering committees. Project steering committees will be composed of representatives of stakeholders. Core members will be representatives of governments, employers associations and unions. Other members of the steering committee might include representatives of communities and service providers such as doctors, hospitals, social workers teachers etc.

Box 3. The idea of an ILO quality standard (ILO 2002) for national schemes

The Financial, Actuarial and Statistical Services Branch of the International Labour Office (ILO) has started to develop a set of quantitative performance indicators which can be used by managers and supervisory bodies to assess the performance of social protection schemes.

The quantitative indicators can also be used to develop a system of "minimum performance points" that a Hub or a Satellite has to achieve if it were to qualify for support from the TRUST. This point system would then constitute a quality assurance tool (i.e. the "ILO 2002" standard) that would be used to ascertain that the participating schemes on the national and community level are fulfilling their mandate effectively and efficiently (i.e. without corruption).

The system of indicators was applied to two schemes in Europe in a field test but more piloting would be needed before the system can be used as a standard quality assurance instrument in the TRUST operations. The following list describes the indicators that are deemed necessary to judge the performance of a social security scheme.

A set of tentative quantitative indicators

Quantitative indicators aiming at the mapping of the performance of social protection schemes are classified into three main categories, i.e.

(L) design and legislation,
(G) governance and administration and
(F) finance.

Between ten to twenty different indicators are being examined in each category, with the detailed areas of performance assessment being:

(L) coverage, contribution ceilings, age structure, replacement ratio, contribution period, indexation in benefits, etc.;
(G) registration, enforcement and compliance, inspection, contribution collection, record maintenance, benefit disbursement, administrative cost, etc.;
(F) GDP ratio of expenditure and income, liquidity ratio, relative level of contribution rate, dependency ratio, investment, etc.:

The tentative list of quantitative indicators is:

(L) Indicators on design and legislation

- (L-1-1) Legislative coverage rate for insured population
- (L-1-2) Legislative coverage rate for employers
- (L-2-1) Level of contribution ceilings 1
- (L-2-2) Level of contribution ceilings 2
- (L-3) Age structure of insured persons
- (L-4-1) Average replacement ratio of benefits in payment
- (L-4-2) Average replacement ratio for newly awarded benefits
- (L-4-3) Average contribution period
- (L-5) Real indexation in benefits
- (L-6) Age structure of beneficiaries
- (L-7) Take-up ratio of benefits

(G) Indicators on governance and administration

- (G-1-1) Percentage of registered population
- (G-1-2) Percentage of registered employers
- (G-2-1) Percentage of actual contributing insured population
- (G-2-2) Percentage of actual contributing employers
- (G-3-1) Percentage of employers inspected
- (G-3-2) Percentage of successful inspections
- (G-4-1) Percentage of contributions in arrears
- (G-4-2) Speed of collection of contributions in arrears
- (G-5) Record keeping ratio
- (G-6) Percentage of outstanding benefits
- (G-7) Average claim-handling time of benefits
- (G-8) Ratio of incorrect payments
- (G-9) Ratio of public enquiries and complaints
- (G-10) Level of administrative cost
- (G-11) Percentage of personnel cost
- (G-12) Staffing level
- (G-13) Salary level of the staff

(F) Indicators on finance

- (F-1) GDP ratio of expenditure and income
- (F-2) Liquidity ratio
- (F-3) Pay-as-you-go contribution rate (with and without government subsidies)
- (F-4) Relative level of contribution rate
- (F-5) Funding ratio
- (F-6) Dependency ratio
- (F-7) Annual average rate of return on investment
- (F-8) Percentage of safe assets
- (F-9) Liquidity of assets
- (F-10) Percentage of government assets

In addition to this general list, a specific list of performance indicators would have to be developed that enables the TRUST to monitor the use of the TRUST resources for the support of local community schemes. Reports on the performance regarding that specific list would than have to be submitted regularly to the sponsoring National Social TRUST organization and would be subject to audits by that organization.

This feasibility study has conducted two field sub-studies in Africa (in Benin and Ghana) which tried to establish whether the hub-satellite mode of delivering benefits could work in the administrative and organisational context of these two developing countries. The countries were selected since they both have fairly well established national social insurance schemes as well as an active movement establishing an increasing number of community based social insurance schemes largely in the form of Mutual Health Organizations. The results of both studies are summarized in the following box. More details are documented in the reports of the consultants on the individual studies which are provided in Part II (Annexes 3 and 4). Both studies demonstrated that the emerging community based social protection schemes (largely health insurance schemes) as well as established or new central level social protection systems would be eligible candidates for further field testing of the satellite delivery system. Both sub-studies stressed the relative instability of the community based schemes and their need for financial as well as longer-term technical back-up. In both countries the central level social insurance schemes have a fairly low population coverage and little or no experience in reaching out to the informal sector. It is obvious that fairly heavy investments would be needed before a governance system will be operating that truly reaches out to the hitherto unprotected groups. Funding for a small pilot project to test possible forms of operations of the validity of the satellite concept has in the meantime been found. The project will commence in September 2002.

Box 4. Studying the feasibility of a satellite delivery system in two African countries

Feasibility study Ghana

Background

Community based health insurance schemes are not new to Ghana. The oldest and largest Mutual Health Organization (MHO), as they are officially called, began operations in 1992, and is the model that almost all new schemes emulate. In recent years there has been significant growth in the number of new schemes, with 47 schemes counted in a study conducted in the 2nd quarter of 2001, of which 14 were described as "fully functional". While many of these schemes receive financial and technical support from external donors, the Government of Ghana encourages their formation and has in fact, initiated a few of them.

Benefit needs

Most of the community based schemes are focussing on health benefits which seems to reflect the dominant need of the enrolled persons. However, some schemes also provide basic cash benefits such as marriage and funeral grants and child allowances. An extension of the prevailing benefit packages to basic cash benefits thus appears possible.

Candidates for satellites

There is agreement among those directly involved with community based health insurance schemes that they have the potential to make medical care more accessible and affordable. There has been difficulty, however, in translating that perception into increasing enrolment. Even the largest and oldest scheme has only been able to insure around 30% of the residents, with some newer ones having much lower coverage rates. Common problems encountered by schemes in its catchment area are risks of adverse selection, moral hazard, fraud, underestimation of premiums, cost escalation and limited capacity to manage these schemes. While the experience in Ghana is not extensive, there is sufficient evidence that, with support from governments and external donors, schemes can be relatively easily established, the initial managerial and conceptual difficulties can be overcome and that chances are good that the schemes can be reasonably well managed. Possibly the most important keys to successful implementation and operation of community based health schemes are its design features and that it should be community initiated, community led and community run. To increase the chance of success the right community must be identified, an appropriate benefit package and premium structure established, the scheme must be properly marketed and its operations well managed. At the community level there will always be a need to enhance the capacities of leaders, scheme employees and managers. All in all the existing MHOs appear to be viable satellite candidates.

Candidates for hubs
Ghana has an established social insurance institution (SSNIT). It would be a feasible hub for the satellite approach but the public perception of the SSNIT that it is only interested to cater for the formal sector, would have to be changed. A second candidate for the role of the hub could be the new Ghana Healthcare Company. Its brief would perfectly match the role of a hub but it would be limited to supporting health benefit schemes. The same applies to the Ministry of Health, which could act as a hub, but would most likely be limited to supporting health care schemes. Moreover, the strict distinction of regular resources of the MOH and external resources from the TRUST may be difficult. In-depth negotiations would have to be undertaken with the different candidates before a final selection of the hub could be made.

Possible role of the TRUST
The TRUST could invest in and respectively sponsor the following activities:
- Training of both scheme operators and care providers. The greatest threat to collapse is likely to be failure to manage scheme affairs and finances properly and transparently. Therefore, proper governance structures should be put in place, qualified people should be hired and trained and regular audits should be conducted.
- Purchase of initial equipment. Most financial support of community based health insurance schemes will be needed at the start-up stage. Equipment will likely consume the largest share of the schemes' expenditure in the early stages.
- Guarantees for meeting operating deficits in early years and ensuring that an adequate reserve fund is in place. One of the Fund's objectives should be to have the scheme become self-supporting after three to five years. Following this the TRUST's involvement may be more in terms of in-kind support rather than in-cash support.

With assistance from one or more suitable local organizations a GLOBAL SOCIAL TRUST supported community health insurance scheme could make a significant difference to the lives of many people.

Feasibility study Benin
Background
Formal social security in Benin covers presently less than 10% of the population. With the exception of the civil servants, the wage earners of the formal sector are affiliated to the Office Béninois de Sécurité Sociale (OBSS). Health insurance is not part of the social security system, but the employer has to pay up to 60% of the health care expenditure of his employees and the dependent members of their family. Mutual health organizations (MHO) are rather new in Benin. They are small and all together their number of beneficiaries lies somewhere between 30 000 and 40 000 persons.

Benefit needs
With respect to the benefit needs of the informal sector, it seems that the combination of old age insurance with health insurance, as proposed by the Ministry of Labour for the "mutuelles de sécurité sociale" corresponds to the needs of the urban informal sector. In rural areas there is a glaring lack of access to health care services of good quality. Barriers to access are due not only to the prohibitive out-of-pocket cost of care but also to the excessive distances to the nearest provider units.
The emerging mutual health organizations aim to provide access to quality health care services to the insured. However, this is only possible if providers of health services are available to the local population and if the services provided are of acceptable quality. Studies in rural areas show that the schooling ratios in rural areas are very low and it is well known that low educational levels are linked to poor health status. Although no mutual scheme has developed activities in this field, it would be possible for mutual insurance schemes to develop activities to improve the educational situation of its members and their families.

Candidates for satellites
In recent years a significant number of mutual health organizations have been started in Benin and these could be candidates as satellite systems of the GLOBAL SOCIAL TRUST. These mutual organizations have been created only recently and are in general rather small and still not very robust. Nevertheless one should also note that three networks of rural MHOs do exist in Benin and that the oldest MHOs have been active for at least five years. In urban areas a network of mutual health and old age pension organizations is emerging through the "mutuelles de sécurité sociale" promoted by the Ministry of Labour for members of associations of craftsmen and small traders. These schemes for the informal urban sector are still in the embryonic stages. For a pilot study, one should limit the support of the TRUST to those local schemes that are past the initial stage of organising and which have been reasonably stabilised. In the case of Benin this condition seems to limit the participation of the TRUST to the mutual schemes of two of the three existing networks.

Candidates for hubs

Unfortunately the Benin social security scheme does not include a health insurance branch. Therefore, OBSS has only very limited experience in the field of health insurance in its industrial injuries branch. Nonetheless at the national level, the OBSS is interested in being in charge of the national responsibility for distributing benefits of the GLOBAL SOCIAL TRUST in Benin and supervising these. To be able to discharge these additional tasks successfully, OBSS would have to establish a special MHO unit in collaboration with an organization having a deep understanding of mutual health insurance schemes, such as for example STEP (Strategies and tools against social exclusion and poverty – an ILO programme). The MHO unit would be accountable to the GLOBAL SOCIAL TRUST for the use of the funds that it receives and distributes to participating MHOs.

Building on the experience of the Centre International de Développement et de Recherche (CIDR), a French NGO, and with the help of STEP[10] the MHO unit could:

- negotiate contracts with MHOs to co-finance benefits through the TRUST;
- define procedures for distributing funds to the participating MHOs;
- define accounting procedures for registering the use of the funds of the TRUST;
- define procedures for auditing accounting and preparation of financial documents concerning the use of the funds coming from the TRUST;
- define a regular statistical reporting system on the activities of the MHOs.

The MHO unit of OBSS would need to offer the staff of the participating MHOs systematic training sessions on themes such as:

- setting contribution rates;
- determining benefit packages;
- marketing and communication;
- choosing and negotiating provider payment mechanisms;
- assessing appropriateness of care provided;
- accounting;
- statistical reporting.

The MHO unit would also need to promote the exchange of experience between the mutual insurance schemes, as well as contacts between the mutual schemes and national Ministries. To help the development of the mutual health insurance schemes, the MHO unit, in collaboration with the participating schemes, could also work out proposals for a legal framework adapted to the activities of the mutual health insurance sector.

Possible role of the TRUST

The support given by TRUST to the mutual schemes should be sustainable in the medium and long run and help to promote solidarity and social insurance. Therefore it is not necessarily recommended to subsidize directly contributions of the members of the schemes, which could blur the link between the contributions of the members and the benefits that may be financed with these contributions.

Taking into account the condition that the external support should help mutual schemes to become sustainable, possible support from theTRUST could be used for:

- Financing health promotion and health education programs, to help members understand the importance of preventive health care and health insurance;
- Organising and financing training of the schemes' staff;
- Financing programs to improve the quality of health care available to members;
- Financing supplementary benefits on top of those financed by contributions, for example cash anti-poverty benefits. However close attention should be given to the sustainability of financing these benefits.

[10] As well as perhaps other organisations like, for example, the "Alliance Nationale des Mutualités Chrétiennes de Belgique", which is present in Benin in the health sector.

2.4.2. Organization and management of contribution collection and fund management

On the contributor side, a minimum of new structures is needed. The contribution collection has to be organised, resources have to be managed, projects audited, the overall institution has to be governed. Based on many discussions during the study period, the study team abandoned the idea of a central fund that would accumulate all contributions from participating individuals in different donor countries and then dispense it to national projects.

It appears preferable to decentralise the organization through the creation of a **Network** of **National Social TRUSTs**, governed by **National Boards**. **The GLOBAL SOCIAL TRUST** (or **TRUST** as it is referred to in this report) could thus be more appropriately named **The GLOBAL SOCIAL TRUST Network.** The National Social TRUSTs would hold national resources until such time that the national boards have agreed to finance a specific project. This should enhance transparency and the trust of the contributors. It is hoped that volunteers recruited largely but not exclusively from amidst officials of national social security institutions in OECD countries would accept to carry the bulk of the burden for the management of national boards. This should include the auditing of projects funded from national contributions in the respective countries. National Boards would be composed of representatives of main groups of contributors (i.e. employers associations and unions as well as other groups, such as national associations of pensioners – if a sizeable number of pensioners in richer countries chose to contribute). Members of national boards could be elected in the similar way as the members of alumni associations of American universities are elected, i.e. by mail voting. The actual financial management of funds would have to be delegated to reliable financial institutions (Fund Managers) hopefully for a reduced fee.

National Social TRUSTs would be members of the GLOBAL SOCIAL TRUST Network, which would maintain a small technical secretariat that would undertake the technical project work, organise regular global assemblies and serve as a secretariat to a Global Board.

National Boards would also send members to the Global Assembly. The Global Assembly would elect a Global Board that could also include independent advisors. The ILO would act as a Technical Secretariat to the Board. The following Box sets out a possible governance structure of the TRUST and the basic roles of the key actors in that structure. The Box draws largely on the work done by the sub-study on TRUST Fund management but adapts its suggestions to a decentralized overall structure of the TRUST. The operating principles of the TRUST, as described in the sub-study on Fund management[11], for a centralized rather than decentralized Fund (which reflected the thinking when the sub-study was commissioned) were adapted to the decentralized network structure of National Social TRUSTs and its international superstructures (i.e. the Global Assembly, the Global Board and the Technical Secretariat). Crucial for the TRUST are sound operating principles that achieve among donors the confidence and trust that is needed to maintain a certain level of participation in the donor countries. The sub-study on TRUST Fund management describes these principles in full detail.

The Technical Secretariat would also encourage active participation by the contributors to the TRUST activities. For instance, there would be the opportunity for in-kind contributions of technical expertise. A social security office in a developed country may provide a technical

[11] See Arvizu, S.: "Governance and Management of a Major International TRUST Fund: Issues Study", mimeo ILO 2001. A full copy of the report is available from ILO FACTS (contact actnet@ilo.org or vergnaud@ilo.org).

expert to a country in order to assist with an assessment of the social security mechanisms in place or those planned, or labour unions whose members are contributing to the TRUST may provide expertise in accounting to an employee organization in the developing country. National organizations would also be in charge of fielding auditing missions to project sites, which should enhance the confidence of the individual donors that monies are spent wisely and responsibly. These in-kind contributions would provide the links between contributors to and recipients of funds from the TRUST and hence create the global partnership that the TRUST seeks to facilitate.

Box 5. The basic governance structure of the TRUST

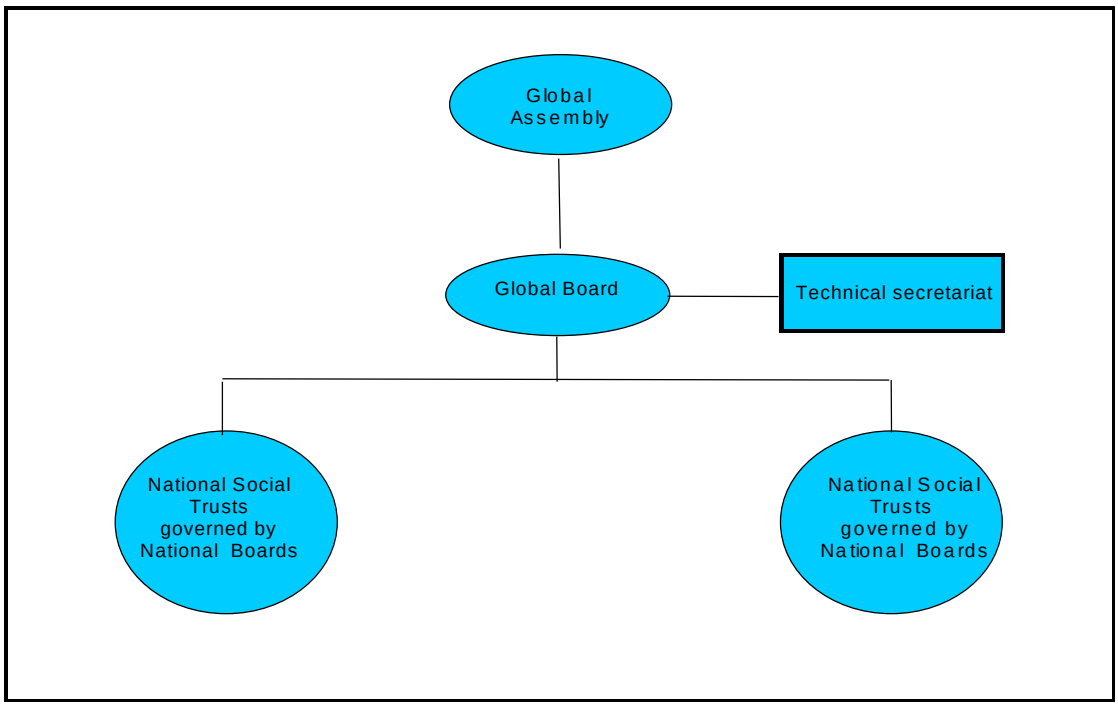
The design of the governance structure should reflect the interests of a broad range of stakeholders: donors from the private and public sectors, NGO's, participating governments and social security institutions, representatives from recipient communities, representatives from ILO's tripartite structure (union's, employers, government), ILO's Social Protection Sector, etc. Additionally, the governance structure should reflect the:

- international nature of the benefit delivery programs;
- potential diversity of benefit programs;
- geographic dispersion of operations;
- ILO's important role as promoter and "supervisor" of this initiative;
- need to be efficient and to operate with minimum resources and in-house staff;
- need to adopt the high standards in transparency, reporting, and accounting (to establish and maintain public trust);
- potential participation of different national social security institutions, satellite schemes and communities;
- gradual launching of the TRUST (in stages, starting with one or two pilot sites);
- initial scarcity of funds to mount a full-scale operation;
- diversity in nature, size and national origin of the collecting agencies (i.e. governments, national social security institutions, employers, the private health and life insurance companies, banks, etc.);
- participation of teams of experts from national social protection schemes in auditing the Fund's operation;
- need for an independent professional Fund manager.

The following multi-layer governance structure proposal (Box figure 1) considers the above requirements and is congruent with principles and guidelines of corporate governance[12]. The role of the key elements in the governance structure are outlined in the following figure. All national organizations and international bodies subsequently established would remain legally independent entities without any budgetary, managerial or administrative links to the ILO; they would, however, be expected to adhere to the ethical and governance principles followed by the ILO.

[12] As already mentioned, codes, guidelines and principles from different countries and from international organizations (World Bank, OECD and IMF) were reviewed and relevant concepts were applied.

Box figure 1. Proposed Governance Structure of the GLOBAL SOCIAL TRUST (Network of National Social TRUSTs)



Global Assembly

The Global Assembly would be composed of representatives from the Boards of the National Social TRUSTs as well as a defined number of representatives from potential recipient countries, independent experts in social protection and the ILO as well as other international agencies. The composition of the Assembly would always ensure a majority for representatives of the National Social TRUSTs. As the number of National Social TRUSTs increases the membership of the Global Assembly would increase.

The main responsibility of the Global Assembly will be to determine the statutes of the GLOBAL SOCIAL TRUST, to establish its vision and mission, to approve the strategic plan developed by the Board, and to exercise leadership in directing the TRUST to achieve its short and long term goals, in a manner based on transparency, accountability, probity and social responsibility. The Global Assembly will also decide on the admittance of new national member organizations. It will audit the conduct of national member organizations to protect the reputation of the Global Social TRUST and to ensure its credibility. In the rare event that the TRUST were to be dissolved, only the Global Assembly would have the power to decide it by a consensus decision. As a general rule, the Global Assembly would convene every two years. The ILO could host the Global Assembly at its headquarters or at one of its Regional Offices.

Global Board

The Global Board constitutes the management authority of the TRUST and could be composed of representatives of Boards of the National Social TRUSTs subject to confirmation by the Global Assembly. As with the Global Assembly, the membership of the Board would increase with the number of National Social TRUSTs. The Board could select an independent chairperson who need not be a member of a national board.

In general terms, the Board will be responsible for defining the strategic plan of the TRUST. The Board also would do the following:

- identify and select with the help of the Technical Secretariat projects eligible for TRUST support,
- decide to suggest project proposals to one or a group of National Social TRUSTs for funding,
- organize multi-national audit teams in case projects are financed by more than one National Social TRUST,
- appoint officers of the Technical Secretariat,
- decide on the structure of the TRUST including the creation of Board Committees as it my see fit (i.e. Regional, Audit, Officers Evaluation and Compensation, Donation Applications Review Committees, etc.).

As a general rule, the Board would meet twice a year.

Technical Secretariat

The Technical Secretariat would be responsible for the identification, the preparation and the implementation of country programmes. It will as well develop basic methodologies of quality control and auditing. The Technical Secretariat would be accountable to the Global Board and serve as its secretariat. In essence, the Technical Secretariat would act as the TRUST's *operational hub.* The Technical Secretariat will be composed of a compact team of professionals (could be officers from the ILO (who can either be assigned on a temporary or definitive basis to the secretariat)). Until otherwise decided by the Global Assembly, the Technical Secretariat will be based in Geneva, Switzerland, and hosted by the ILO. The technical secretariat will be financed by small contributions from the National Social TRUSTs. It will be directed by a Secretary-General who will be appointed by the Global Board.

National Boards

National Boards are the governing bodies of the National Social TRUSTs. National Social TRUST organizations are legal entities (most likely NGOs that conform with national legal requirements for non-profit organizations) that – compliant with laws in the donor countries – are collecting contributions and are allocating them to particular projects. The composition of National Boards will depend on the specific circumstances of each country but core members should be representatives of employers associations, unions and governments. National Board members could be elected by individual contributors (from specific lists that would ensure at least a tripartite structure of the Board) and would be responsible for the supervision and evaluation of TRUST projects that are funded by the respective national organization. Each National Board will elect its Chairperson. National Boards would meet on an ad hoc basis, but not less than twice a year. A National Board may decide to invite representatives of the Global Board or the Technical Secretariat to participate in its meetings, when the performance of a particular project is being evaluated.

The National Boards will be responsible for

- the organization of contribution collections including the organization of public relations campaigns and their financing,
- deciding on the sponsoring or co-sponsoring of TRUST projects,
- managing the national funds collected through the appointment of a professional Fund Manager[13] and the setting of investment guidelines,
- organizing national audit teams in case projects are financed by only one National Social TRUST or assigning members of international audit teams on request of the Global Board,
- electing representatives for the Global Assembly and the Global Board

National Boards may create National Board committees as they see fit.

It may be the case that for certain projects National Social TRUSTs from more than one country would participate. In this case a project committee would be set up which would include representatives from the respective National Social TRUSTs and a representative from the Technical Secretariat. This committee will agree on the management of the funds which are to be allocated to the project, on the auditing and on the monitoring of the use of those funds. Decisions will need to be taken on a unanimous basis within the committee. The committee will be the donor counterpart with whom the recipient schemes in developing countries will communicate.

[13] The Fund Manager will be an independent cost-effective organization that will manage all resources and financial transactions of a National Social TRUST, including asset management and funds transfer. It is also envisaged that the National Social TRUSTs will invest a rather modest volume of funds, conceived purely as a buffer mechanism rather than a long-term capital administrator. Its role relative to investments will be to preserve and safe-keep the funds on a temporary basis before the funds are expediently routed to one of the benefit delivery programs. In any case, the Fund Manager will adopt a prudent and conservative investment guideline that will be reviewed and approved by the Board and that will also consider hedging needs.

2.4.3 The role of the ILO

The core role of the ILO is to enable the setting up of the GLOBAL SOCIAL TRUST Network with National Social TRUSTs as member organizations. It will in particular :

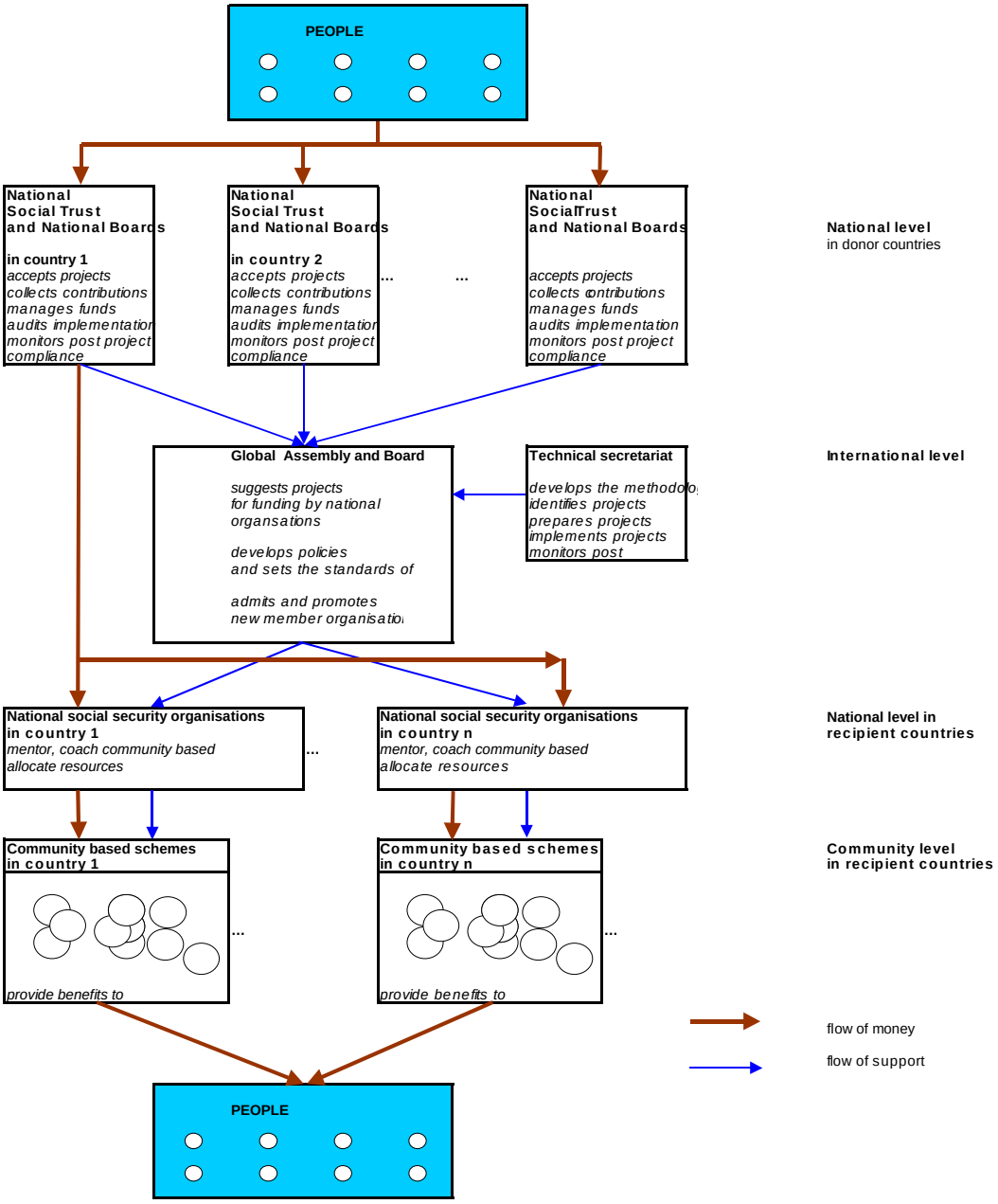
- hold the right to the name of the Network,
- develop a set of rules of conduct and guidelines for the statutes of national member organizations,
- develop the draft statutes for the Global Assembly and the Global Board,
- promote the concept of the Global Social TRUST in its member States with the help of its tripartite structure,
- host the Global Assembly, the Global Board and the Technical Secretariat (if so decided by the Global Assembly and the Global Board),
- it may – upon request of the Global Boards – second officials to the Technical Secretariat.

The Global Social TRUST Network as well as the National Social TRUSTs will be organisationally and financially independent from the ILO.

2.4.4. A summary of the main organisational features

The following figure provides a summary of the different roles of the main actors in the TRUST. The brown lines describe the flow of funds in the TRUST while the blue lines describe organisational relationships and/or lines of technical support. The key message of the figure is the relationship from “people to people”. In the long run there would be another “return-line” leading back from the recipients of today to the donors of today or their children and grandchildren. A return line that would describe the presently agreeably intangible benefits to be derived from a more stable social peace, from less risk of global epidemics, increased demands on global markets and less migratory pressure.

Figure 2.3. From people to people: Linking the global, national and community levels through a GLOBAL SOCIAL TRUST, National social protection schemes and satellite schemes



2.5. Tentative patterns of operations

The possible pattern of operations of the TRUST is best described by a typical cycle of operations from project identification, approval, financing, implementation, to monitoring and auditing.

Let us assume – for example – a country office of the ILO or the Technical Secretariat of the TRUST in Geneva itself is approached by a developing country requesting support for the build-up of a basic social protection scheme in rural areas. The scheme should be connected to community efforts to organise basic social insurance schemes. The request could be processed in the following steps:

(1) **Step 1**: The Global Board of the TRUST would authorize the Technical Secretariat to study the feasibility of the request and – if viable – prepare a project document.

(2) **Step 2**: The Technical Secretariat would field an exploratory mission, which would seek to establish :

- (i) the administrative feasibility of the proposal, i.e. it would analyse whether the co-operating partners in the country, i.e. the government, the social security organizations (or another centralized agent) and the community organizations are able to handle the suggested scheme without efficiency losses i.e. due to corruption, and whether the participating partners are accepting regular monitoring procedures;
- (ii) the compatibility, i.e. with other national anti-poverty and social protection policies and that the resources provided would be in addition to pre-existing levels of national social expending[14];
- (iii) the potential impact of the proposal, i.e. the mission will seek to establish which short- to long-term effect the schemes would have on the level of poverty in the country or the implicated regions;
- (iv) the long-term sustainability, i.e. the mission will try to establish whether the scheme is likely to survive once the direct support from the TRUST will cease,
- (v) the cost of the project, i.e the annual and total amount of the TRUST's involvement.

(3) **Step 3**: The Technical Secretariat will design a project and develop a project document, that will establish the exact Terms of Reference for the project, i.e. inputs, outputs, expected outcomes, timetables, a budget, monitoring procedures, and draft contracts between the TRUST and the government as well. The draft contract would contain a post-implementation clause which will oblige the participating government or institutions to maintain the benefit schemes that were sponsored by the TRUST. Should the government/institution not honour its obligations the TRUST's investment might be turned into debt that would have to be repaid.

[14] Ascertaining that TRUST resources will be a net addition to domestic resources spent on social is not an easy task. A proxy method will have to be employed. The secretariat will use the social budgeting methodology to establish the present an likely future social protection spending without the financial assistance of the of the Trust. These approximate figures have to be agreed between the secretariat and the government before the financial engagement of the TRUST can be decided upon. The Social Budgeting methodology is explained in full detail in Scholz et al. (2000).

(4) **Step 4**: The Technical Secretariat will submit the project document to the Global Board who will either adopt it, reject it or ask for further information. If the proposal is technically approved, the Board will develop a financing proposal, i.e. it will recommend the project to one or more of the National Boards for financing.

(5) **Step 5**: The National Board may or may not accept the proposal. In case of refusal, the Global Board will seek other sponsoring national organizations. In case of acceptance the National Boards will develop a financing plan and will assign members of a monitoring team that could consist of volunteers knowledgeable in the field of social security.

(6) **Step 6:** The Technical Secretariat will establish a project implementation team composed of international and national professionals (in recipient countries) who will commence with the implementation of the project according to the timetable outlined in the project document. It will report to the Global Board and the National Board on a six monthly basis.

(7) **Step 7:** The monitoring team from the sponsoring National Social TRUST will visit the project at least once every 12 months, but has the right to further *ad hoc* auditing missions. Its report will be the basis for a decision by the National Board to release a further tranche of financing for the project. If more than one National Social TRUST is sponsoring a project, the team will be composed of representatives from each of the sponsoring National Social TRUSTs.

(8) **Step 8:** The Global Board and the National Board will close the project officially, once the terms of reference have been achieved or no further progress can be expected.

(9) **Step 9:** The Technical Secretariat and the national monitoring team might monitor whether the government and the collaborating agencies are complying with their post-project obligations (such as the continuation of the new scheme).

It is the objective of the TRUST to invest in the build-up of sustainable long-term social governance structures, hence the above project cycle might take a decade to complete. Precision, accuracy and transparency should take precedence over the understandable desire to show quick early results.

2.6. Financing

The **GLOBAL SOCIAL TRUST** would – first and foremost – be a **People-to-People Fund** where voluntary contributors were people: employees and private entities, possibly and desirably solicited with the assistance of employers and possibly national governments during the start-up phase. It would rely on the support of existing national social insurance schemes, private health and life insurance companies, banks, possibly credit card organizations, employers and trade unions in Europe and OECD countries to support the collection. In the context of wider corporate responsibility enterprises may also choose to contribute directly.

The TRUST, however, will only ever co-finance a project. It is envisaged in all cases that the respective national governments, or possibly the national social insurance schemes for the formal sector as well as community-based organizations in recipient countries contribute to the financing of TRUST projects. The social insurance institutions (for example, pension schemes

for public and/or private sectors) could for example charge small additional contributions as a token of national solidarity, which would formally match the requested international solidarity.

The actual method of contribution collection in donor countries may vary from country to country for legal reasons. According to the feasibility study on contribution collection in Germany, a simple deduction of an additional voluntary 0.1% to 0.2% of insurable wages through the statutory social insurance institutions does not appear possible, since the social insurance institutions are forbidden by federal insurance law to conduct any other than their core business. However, they would be allowed to promote the idea of the GLOBAL SOCIAL TRUST through their regular publications which they send to every member. In some countries there may be collection through credit card institutions, such as a fixed or marginal surcharge on consumption, which may also achieve a certain progressiveness of contributions. In other countries the voluntary contributors may authorize their employers to deduct a certain amount from their wage. Some employers may choose to match worker's contributions. In others, a simple standing order to banks to transfer the individuals' contribution to a National Social TRUST may be the preferred and legally simplest solution. To enhance the level of contributions, enterprises might make donations and use the label "Member of the GLOBAL SOCIAL TRUST " in their product advertising.

In any case it is critical to create a regular pattern of individual contributions, which underscores the basic difference of this TRUST from charities that collect donations on an *ad hoc* basis and it would aim to create the "image/feeling" of accepting an individual permanent responsibility for enhancing global social security through a global social insurance network. In most countries in the OECD, contributions will be tax deductible due to the non-profit nature of the National Social TRUST. Legal provisions on tax deductibility vary from country to country, thus the legal identity of the national organizations may also have to vary by country. This is another reason for the decentralisation of the TRUST into national organizations. In effect this turns the financing of the TRUST into a tripartite exercise. Through forgone taxes, governments participate in the financing of the TRUST. To what extent this is an additional "expense" for the government is not entirely clear, as it depends on the extent to which the contributions replace contributions that the individuals, respectively employers, would have made to other organizations that have tax deductible status. However, the promotion strategies of the National Social TRUSTs at the national level should aim at mobilising new resources rather than trying to compete with other charities for an existing limited pool of resources (see also point 2.8).

2.7 Administrative cost and cost of resource mobilisation

How fast the national organizations can reach their potential depends on the amount of start-up funds that can be mobilised for the initial country campaigns. Most of the start-up costs will involve the cost of initiating public relations campaigns. The cost of setting up a national NGO (i.e. the National Social TRUST) need not be enormous. It is anticipated that this could be undertaken through the tripartite sponsorship of employers, workers and governments.

However, the initiating campaigns will require substantial commitments from national organising committees. Campaign funds would have to come from institutional donors, such as governments or large corporations. It appears unlikely that organised labour or other charities can be approached for start-up funds. The ILO's tripartite structure should provide access to

potential campaign financiers. According to the campaign manager of the ILO's Child Labour Programme (IPEC) an initial campaign in a European country would cost about € 1 million. This may appear optimistic but could apply to a campaign that has established institutional partners in a country. The TRUST would have such partners (such as labour unions, employer's organizations or social security institutions). Furthermore, parts of nationally developed campaign strategies may be portable to other countries and thus development cost (such as fees of professional public relation companies) may be subject to some economies of scale. The national organizations could simply limit their initial campaign expenditures to say 0.25 Euros per potential contributor, which implies the assumption that the main national constituent organizations of the ILO (employers and workers organizations) would make their own public relation channels available free of charge. With that per capita amount, initial campaign costs in Austria, Belgium, Portugal, Sweden and Switzerland would be in the order of magnitude of one million Euro.

For a country of the size of Germany this would amount to expenses for the initial campaign cost in the order of 8 million Euro. The project team interviewed Dieter Hebestreit [15], an established public relations specialist in Germany, with regard to the potential cost of a potential awareness raising campaign in Germany. He quoted the following figures for the media spending of major charities in Germany (in million Euros): German Red Cross: 7.5; Brot für die Welt: 6.6; UNICEF: 6.3: Deutsche Aidshilfe: 5.3; Caritasverband: 5.1; Terre des Hommes: 4.4; Amnesty International: 1.8; World Vision Int's: 2.8; Naturschutzbund: 2.5; Ärzte ohne Grenzen: 2.2; SOS Kinderdorf: 2.0; Misereor 1.8; Deutsche Welthungerhilfe: 1.5; Care Deutschland: 1.4; Greenpeace: 1.4.. These figures refer to awareness-maintenance campaigns rather than initiating campaigns, but they might indicate that the per capita budget of 0.25 Euros might well be a realistic order of magnitude.

The long-term collection cost would be a part of the overall administrative cost of the TRUST. Again, given the specific circumstances and assumed substantial support from the ILO's constituents, specific costs for the contribution collection itself, are hard to predict. The following table reflects some of the administrative and fundraising cost experience of major established charities.

[15] The full text of the interview is available from ILO-FACTS on request.

Table 2.1. Transaction cost experience of major charities

Fundraising and administrative expenditure in selected charities 2000/2001

Organisation	Total income in mill. US $ (unless otherwise indicated)	Fundraising cost (incl. publ. awareness) in mill. US$	in % of income	Administrative support cost in mill. US$	in % of income	Total Overhead Cost in% of tot. Inc.
Catholic Relief Services US, 2000 (1)	373.2	18.2	4.9	12.9	3.5	8.3
Oxfam UK, 2001 (2)	264.7	32.1	12.1	33.54	12.7	24.8
World Vision, US,2000 (3)	469.1	50.9	10.9	27.6	5.9	16.7
World Vision, UK (4)	41.4	6.72	16.2	0.76	1.8	18.1
WWF, US,2001 (5)	119.9	6	5.0	15.6	13.0	18.0
Brot für die Welt (Germany in DM,(6))	249.8	15.5	6.2	13.1	5.2	11.4
Diakonisches Werk (Germany, DM, (7))	341.2	10.1	3.0	18.4	5.4	8.4
American Red Cross (8)	2421	96.8	4.0	145.3	6.0	10.0
Doctors without borders, US (9)	37.9	3.7	9.8	0.9	2.4	12.1
Greanpeace, Global (10)	29.4	1.18	4.0	4	13.6	17.6

Sources: (1) www.catholicrelief.com
(2) OXFAM UK annual report figures originally provided in UK £ (1£=1.413 US$), trading cost are included to achieve comparibility with other charities
(3) www.worldvision.org
(4) www.worldvision.org.uk, same excange rate as in (2)
(5) www.worldwildlife.org
(6) www. Brot-fuer-die-Welt.de
(7) www.diakonie-katastrophenhilfe.de
(8) www.redcross.org
(9) www.doctorswithoutborders.org
(10) www.greenpeace.org, original data in euros

It is assumed here that the overall administrative cost ratio of the TRUST can be kept at or preferably below 10% of the contribution income. As can be seen from the above table some of the charities have administrative cost in the order of under 10% of their income provided they have strong institutional affiliations (i.e. here churches). It seems that a strong organisational affiliation could help to cut administrative costs by about half. It is assumed that the affiliations that the TRUST could seek with workers and employers organizations as well as social security institutions in the donor countries could help to keep the administrative costs (including fund raising expenditure) under the 10% level. In addition, the 10% level is equivalent to the administrative costs of well run European social insurance schemes. Overhead costs in the order of 10% of income should be a declared long-term policy objective of the TRUST.

2.8. The competitive environment, potential partnerships and alliances

Infratest Sozialforschung calculated the potential revenues of the TRUST in Germany based on their observed propensity to contribute. The – still growing - volume of the German voluntary charity market is presently 4 to 5 billion Euros. A monthly donation of 5 Euros by 10 to 20% of the German workforce to the GLOBAL SOCIAL TRUST would mean an extra volume of 200 to 400 million Euros and represent a high potential market share of between 4% and 10%. This extra contribution for a GLOBAL SOCIAL TRUST possibly has to be realized in a competitive market situation where several large and a big number of charity organizations exist.

Penetrating the market on a competitive basis would possibly be costly and would create socially counterproductive opportunity costs. The objective of the TRUST should be to tap additional resources and hence avoid displacement competition which is also feared by a number of experts that responded to the survey of expert opinions. Infratest quotes experts of the charity market who observe a new generation of donors – particularly in the high income bracket - whose

priority with respect to contributing is no longer to "*ad hoc* help against misery" but "contribution to sustainable change". This new mentality matches the idea of the ILO to introduce a regularly and sustainable contribution by private supporters of the TRUST in contrast to the traditional annual "Christmas" charity. As a result of its analysis, Infratest recommends that the ILO adopt a publicity strategy that is primarily based on a "rational" charity concept and less on traditional collection of funds for charity concept. The German charity market is already highly penetrated by large charity organizations which pursue an emotional publicity strategy. The rational strategy should stress the two aspects of long- term change on the one hand and favourable consequences for the developed countries on the other hand (less immigration of the poorest and potential development of new markets).

On the delivery side the TRUST would seek alliances with other NGOs working in the field of social security. It will seek a wide network of partnerships to implement its objectives. Even if the TRUST reaches its full potential it would still not be able to reach all 1.2 billion people in abject poverty. Co-ordination with other initiatives would thus be indispensable. Likewise the TRUST will not set out to compete with other ILO activities but rather complement them. The experience from STEP or ILO-AIDS should be utilized to implement and execute concrete projects in TRUST activity countries. In the long-run the supported schemes should seek help from a Social re-insurance programme that could be introduced by the government or another government agency.

The research team sought to establish the possible reaction of the World Bank to the possible introduction of the TRUST. Robert Holzmann, the Director of the Bank's Social Protection Network agreed to a talk about the issue in April. His main ideas are reflected in the following interview. His main concern was to ascertain that the TRUST initiatives in specific countries were compatible with the national anti-poverty strategies as developed in the national Poverty Reduction Strategy Papers (PRSP). However, it is inconceivable that the TRUST would compete with National Anti-poverty strategies which national governments have developed and negotiated with the Bretton Woods institutions in order to obtain a debt relief package. The study team would see TRUST projects – and notably the government commitments to maintain the established schemes after the end of the main project – as a part of the overall national poverty reduction strategy.

Box 6. An interview in Geneva with Robert Holzmann,
Director of the World Bank's Social Protection Network, 11 April 2002

SOCFAS: Welcome to the ILO's Five EURO project. Robert, you are aware of the concept of the GLOBAL SOCIAL TRUST which we are exploring on request of the Director General. Since September 2001 when you chaired the first public brainstorming session on the TRUST during the General Assembly of ISSA in Stockholm, the concept has gone through various alterations. It now looks as follows (the present state of the concept is outlined)...

HOLZMANN: First of all, I have to say that the concept has indeed become clearer since I heard you present it the first time. What I like about it are three things: the focus on the investment in good governance, the principle of co-financing of national or community based social protection initiatives, and the emphasis on strict monitoring and auditing. I hasten to say - tongue in cheek - that I never thought the ILO would ever design anything that vaguely would smack of conditionality... Where I see potential problems are in the - obviously intended - lack of focus on one or two precise benefits in cash or kind. I think it may be easier for the public to support a system that has a clear cut focus. What you mention rather as a footnote - i.e. the grand parent benefit (i.e. a basic universal pension at the US$ 1-per day level, SOCFAS) - captures my imagination - even if it leaves out some of what I call the most vulnerable groups (such as widows or elderly living alone). Grandparents in poor families could indeed be used as agents for the delivery of basic anti-poverty benefits. Quite independently of the TRUST, I would like us to explore the concept together. There is already good research on the positive effects of a basic pension in South Africa.

SOCFAS: I explicitly ignore the passing reference to our old debate on conditionality... We deliberately refrained from defining an exact benefit as we want to keep the freedom to respond to specific local and national benefit priorities. Where would you see the main obstacles to its public acceptance and implementation?

HOLZMANN: On the public acceptance and implementation side you may be confronted with questions that you would have to answer convincingly if you want the TRUST to succeed. Such questions are: What makes this thing different from other ongoing technical co-operation projects? Why would we need another Global Fund and what are the experiences with current initiatives, such as on health? Can you really deliver a corruption free benefit and assistance package? And if so, how do you do that in least developed countries where all government structures have virtually collapsed. Regarding the latter we have positive experience with our Social Funds and their administration- even if we are sometimes criticised for setting up a parallel governance system. I would be less optimistic about your concept of using the existing Social Insurance Schemes in all country contexts. Many of them will not have the administrative capacity or the efficiency to handle this business. If you fail in one project because your agent in the recipient country is corrupt, the TRUST loses its credibility which is its only real own capital. Your only safeguard against that is unconditional transparency, including the use of strict and public criteria, open bidding process, transparent selection process through an international committee, full information about progress, etc., best provided on a fully accessible web-site. Your plans to design and audit quality standards may be one answer to the problem.

SOCFAS: We think we are different from other technical co-operation activities in that we - for the first time - have the financial muscle to implement five to ten year programmes consisting of investments and concrete financial subsidies rather than providing short-term expert advice which cannot be backed up with real financial transfers. We are different from other funds in that we target our investments exclusively in social governance. We see no other source of - hopefully - one billion EURO per year for investment in social governance. Do you see any opposition from other agencies, such as ...your own?

HOLZMANN: I think you would run into stiff opposition if the TRUST were to implement social governance structures that would not be part of national PRSP (Poverty Reduction Strategy Papers). We - that is the Bretton Woods institutions - have invested a lot of effort in this device as a government-driven development process and product and as a co-ordination tool for international technical co-operation. I don't think you should operate in isolation from national PRSP processes.

SOCFAS: We recognize the importance of PRSPs - despite their teething problems. We will not seek any competition to any other major anti-poverty measure. We rather see the TRUST as building the delivery structures which help a number of other activities to succeed. We would see the TRUST Programs in recipient countries as part of a policy matrix that could be developed in the framework of a PRSP. Robert, how is your overall opinion of our 5 EURO project?

HOLZMANN: It may have the potential to invest a substantial amount of money into social infrastructure if you succeed to avoid that you simply substitute government resources, that they would have invested anyhow and if you can avoid to simply replace existing sources of AID. It will obviously not be the panacea against poverty. I see this as a complement to a whole concert of national and international efforts such as debt relief, reduction of trade barriers, design of more rational national social transfer and labour market policies and more. I am not necessarily speaking for my organization, but as a social sector economist I would support trying it out.

SOCFAS: Will we succeed?

HOLZMANN: You won't know until you try. What does the ILO have to lose?

2.9. Public acceptance

Achieving interest in the TRUST in developing countries, i.e. in the potential recipient countries appears obviously to be less of a problem than motivating the public in potential donors countries to support an ambitious new institution. However, it must be assumed that once the full set of conditions for the implementation of TRUST projects in a given country becomes obvious, enthusiasm might also diminish in some countries.

It is obvious that participating parties in recipient countries will have to sign a legally binding contract with the TRUST which will stipulate a series of conditions for the launching of a project. The government of the recipient country will have to:

(1) approve the project implementation plan;
(2) accept to deliver a series of inputs at specified times during the project implementation;
(3) accept monitoring and auditing missions during the implementation phase,
(4) accept the obligation to continue the delivery of services through the newly social protection systems after the end of the project,
(5) accept post implementation monitoring by the TRUST for at least five years after the completion of the project.

These conditions may be unacceptable to some governments or institutions. Should this be the case then the respective country or region will not be eligible for TRUST financed projects.

More critical during the early years of the TRUST is the support from the general public and opinion leaders in potential donor countries. The sub-study on the feasibility of contribution collection in Germany, which was used here as a representative of the donor community, basically observes a positive feedback. The following box summarizes the main results. More details may be found in Annex 5. The results may be biased as the study explicitly focussed on the support for the build-up of a health care financing infrastructure – a focus which was subsequently dropped during the feasibility study. The most surprising result appears to be that the general public as well as the social security experts in the government and workers organizations seem to support the idea whereas the technical co-operation professionals in the Ministry of Technical Co-operation seem to be more reluctant to create a new major agency in the existing concert of AID agencies. Some of that reluctance may be a consequence of a German particularity of charity financing. The federal government seems to match each Euro in donations by the general public by one Euro in tax subsidies for a range of major charities. A new major player on the scene would force the Ministry of Technical Co-operation as well as the Parliament to review that procedure.

In any case, it appears obvious that the TRUST requires strong national support from established societal groups, otherwise the start-up investment for building the credibility which is a prerequisite for the collection of contributions would be prohibitive. The UN enjoys sound credibility within the general public in Germany. About half of all Germans consider that the technical co-operation activities of the UN system are effective, an amazing 40%-points more than the proportion of people that know about the work of the German GTZ, and consider it effective. However, that credibility of the UN system as a whole cannot easily be taken for granted for an initiative of the ILO, which is a virtually unknown organization in Germany. A German national contribution collection organization would thus have to build an alliance preferably with unions and employers based on the country's long tradition in social partnership.

The need to build national alliances is another argument for the gradual build-up of a network of national organizations rather than a central International Fund. The period for promotion of the concept and the idea will vary according to countries. It appears advisable to start the process in the relatively small but affluent and economically successful economies in Europe.

Box 7. The study on the feasibility of collecting contributions for the GLOBAL SOCIAL TRUST in Germany – Summary of results

One of the four sub-studies of this report analysed the feasibility to collect contributions from the public in Europe's biggest economy – Germany – for the GLOBAL SOCIAL TRUST. The author also organised the already mentioned survey concerning the general public's propensity to contribute and conducted a series of interviews with representatives from the government, employers and workers organizations to assess the reactions of opinion leaders in relevant societal groups. The author's main findings can be summarized as follows:

(1) The potential volume of contributions

The author assumes that after an introductory phase a volume of between 70 to 100 million Euro per year can be collected in Germany on a permanent basis. This is about half the volume that was estimated in Table 3.1 but is compatible with the rather more conservative exercise in table 3.2. A higher amount appears unrealistic as presently only about 500 million Euro of donations per annum are collected for development aid in Germany.

(2) Public acceptance

While the reaction of the general public was relatively positive (up to 30 percent of the interviewed individuals said they were willing to contribute to the TRUST, see also chapter 3) the reaction of opinion leaders was mixed. While the project found positive reactions in the Ministries of Labour, Health and representatives of trade unions as well as the Federations of Local Sickness Funds, officials in the Ministry of Technical co-operation and representatives of the Federation of Employers were less supportive and rather sceptical. Individual representatives of industry showed a more positive entrepreneurial attitude, as did a representative of the Catholic Church.

(3) Legal conditions

German tax law envisages the possibility to grant tax exemptions to organizations that collect donations for the purpose of technical co-operation in international development. However, the collecting agency needs to reside legally in Germany. In addition tax exceptions are granted to individual donors.

(4) Organization of the contribution collection

German social laws prohibit the use of the institutions of social security as collection agencies. Their administrative system can exclusively be used to conduct their core business. However, these institutions can be used to communicate the idea of the TRUST to their members through their regular publications. This is not a negligible asset – in terms of credibility - for a new and unknown organization. Contribution collection itself should proceed through standing orders from personal bank accounts. Contacts with contributors should be kept by a national organizations that maintains a certain level of national visibility.

(5) Public relations

The public relations campaign should be professionally designed and multi-dimensional. It should have a concrete message for the general public, while the campaign for enterprises should focus on the concept of building sustainable social infrastructures. For both groups the conceptual new approach to development policy has to be emphasized.

(6) General summary

The study shows that the concept did not meet with unconditional support from all sides. However, criticism never referred to the objectives of the TRUST but rather concerned organisational questions which the author considers as surmountable. The financial potential appears substantial. Financial support from the general public appears certain, financial support from enterprises can probably be generated.

The idea of a People-to-people fund is not entirely new. Some 25 years ago, UN staff members in Geneva got together to found the 1% - Fund for development. All members contribute on a voluntary basis approximately 1% of their monthly salary for development projects (see Box 8). The oldest fund in Geneva now has 25 years of experience. In the ILO alone membership oscillates between 5 an 10 % of staff - an obvious achievement for a Fund that is operated entirely by volunteers, cannot organise extensive membership campaigns and asks people (in relative terms) to contribute about 5 times as much as the GLOBAL SOCIAL TRUST would do. This is a small scale but real life experiment that may support our 10% assumption for the potential contributor ratio in OECD countries.

Box 8. The 1% for Development Fund of the UN Staff

What is it?

An association of staff of the United Nations system and other intergovernmental organizations who have chosen to allocate 1% or more of their salary to development projects in underprivileged countries. The first 1% Fund was set up in Geneva in 1976; others were established in Rome in 1983, New York in 1985 and Vienna in 1986. Though their objectives are the same, each 1% Fund operates independently.

Why 1%?

In resolution No.2626 (XXV) of 24 October 1970, members of the United Nations agreed to transfer 0.7% of their GNP from developed to developing countries. Frustrated at the inertia of most member countries and of the UN system, a small group of international civil servants decided to start practising what their governments preached, by contributing 1% of their salary to development projects. Members do a self-assessment of their contribution amount and arrange for this to be credited to the Fund's bank account on a regular basis.

How does the Fund provide support?

A committee of Fund members evaluates proposals, all of which emanate from the people in the places concerned; funding is approved at general assemblies twice a year. Each funded project is required to report on results. When possible, Fund members and their colleagues also visit project sites during their spare time on working trips.

What percentage of members' contributions is spent on administration?

The *entire amount of members' contributions is allocated* to development projects. The Fund , in fact, incurs no administrative costs because it is administered entirely by its members as volunteers.

What has the Fund done so far?

In 25 years the Fund has spent about 6 million Swiss francs in support of more than 500 community development projects in about 50 countries, mostly in Africa, Latin America and Asia.

And the Fund today?

The current membership is 260, made up of both serving officials (from 18 organizations) and retirees who have chosen to continue contributing. The average age of Fund members is rising and several members now leave the Fund each year when they retire. A lack of promotional activities over the past few years (one must remember that all members of the Management Committee are volunteers with full time jobs) has been responsible for the trend of falling membership but now a promotion group is becoming more active and this trend is being slowly reversed as new younger members join the Fund. The long-term objective is to achieve a participation rate of about 10% of the staff of the participating UN organizations.

If the current objective of increasing and rejuvenating the membership can be met, there is no reason to think that the Fund should not continue its good work for at least another 25 years!

2.10. The name

'GLOBAL SOCIAL TRUST' is the current working title. The final name could be selected by means of market research. It would be preferable, however, to have a name that would not require translation into most languages, like Amnesty International or Greenpeace, and at the same time spells out clearly what the TRUST does. This might seem difficult as the purpose and activities of the TRUST are more complex than that of other organizations. Names like "Solidarity International" or close derivations thereof are already taken by other organizations. However, the GLOBAL SOCIAL TRUST sets out to invest in the build-up of social protection systems in developing countries, i.e. it tries to build basic social safety nets in these countries. Another name for the TRUST could thus be Global Social Net or the International Social Net, implying that we are trying to span a net that helps all people and at the same time alluding to the fact that the system builds on a network of people. Some members of the review group preferred more paradigmatic names like "Global Neighbours" or the "Blue Roof". The matter remains undecided for the time being. The donor country staging the first pilot project might in effect decide on a name for a National Social TRUST and thus de facto limit the choice for the global organization and other National Social TRUSTs. This is the prerogative of a trail blazer. The ILO will continue to use the working title, which has already attracted some prominence among Governing Body members and within the ILO constituency.

3. Financial potential and possible impact

The financial potential of the TRUST is difficult to establish with certainty as there is no direct relevant experience to draw on. The overall amount of income can only be estimated but there is reason to believe that it could be substantial. The overall impact of the TRUST critically depends on its financial potential.

3.1 Estimated financial potential

The possible volume of contributions critically depends on the propensity of the population to contribute. That propensity of individuals to contribute cannot be predicted with certainty. The feasibility study thus had to develop a survey strategy to assess the number of potential contributors before the possible financial volume of contributions could be estimated.

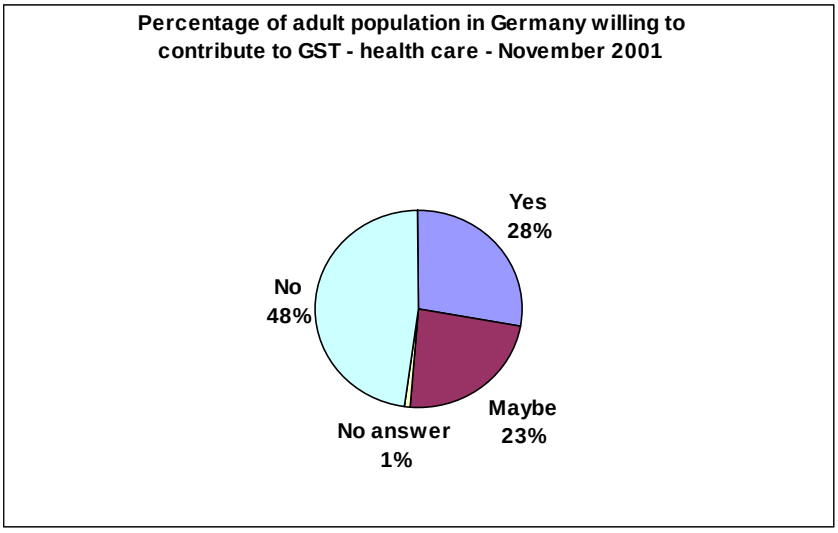
3.1.1 Assessing the propensity of individuals in OECD countries to contribute

The sub-study on the contribution collection included a two stage opinion poll by the renowned institute *Infratest Sozialforschung* in Germany. Opinion polls cannot predict contribution behaviour with certainty, but they are the only way to find out whether people would consider to contribute. Considerable caution should still be exercised when interpreting the results. The calculations only take the survey results as a point of departure.

The first set of telephone interviews were conducted in November 2001. In order to limit the complexity of the questions, the survey asked for contributions (5 € per month) that would go towards financing basic health care in developing countries. The poll asked an emotional question as well as a more rationally formulated question. In both cases a representative group of 1000 people was interviewed by telephone. Despite the fact that the emotional questions returned a higher positive response, the following results quoted here are those related to the rational question, as it was considered that a rational public relations campaign would be most appropriate for the TRUST.

The poll concluded that approximately 28 percent of the population would be willing to contribute 5 Euros per month for a period of three years to such a fund (see Part II, Annex 5), 23% “may ” do so and 48% showed definitely no interest in making financial contributions (1% with no opinion).

Figure 3.1.



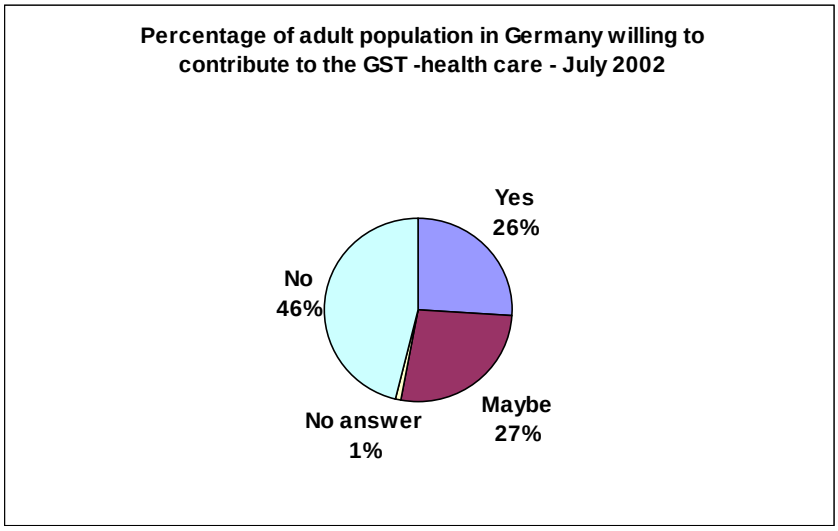
Source: Infratest Sozialforschung 2001, N =1000

The highest percentage of people willing to donate to a TRUST can be found in the age bracket between 35 and 59 years. About 35% say that they are definitely ready to make a donation. A very high percentage of definite supporters of a GLOBAL SOCIAL TRUST can be found in another important target group - people with high incomes (46%). Furthermore the idea of global partnership finds particular support among higher educated women (46%).

Following the discussions within the review group in May the poll was repeated in July 2002. The review group feared that limiting the questions to health care as well as the reliance on only one observation point might paint too optimistic a picture. It was also feared that the proximity to the 11 September events might have biased the results. This time the (rational) health question was repeated to establish whether there was any systematic bias or trend within the two results. In addition a second question was asked referring to the willingness to support a basic old age pension system in developing countries with €5 per month. The basic old age pension was selected as a representative of the family of potential "basic income security" benefits to be supported by the TRUST. It was assumed that pensions with a focus on old age might be the least attractive benefit to the public and thus referring to pension in the questions would provide the team with a conservative estimate of the propensity to contribute.

Figure 3.2 summarizes the results of the health care question of the year 2002. While there were some shifts between different population groups the overall percentage of "yes" responses dropped slightly to 26% - a difference which can be considered to be in the normal range of uncertainty of polls of this size. The "yes" and "maybe" responses together account - as in November 2001 – for more than 50% of the respondents.

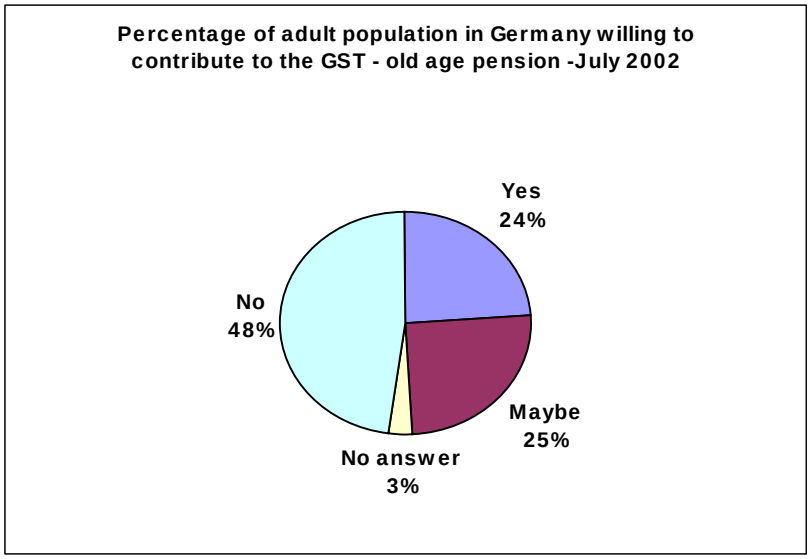
Figure 3.2:



Source: Infratest Sozialforschung, July 2002, N= 1000

Figure 3.3 shows the results of the questions regarding the propensity to contribute to the financing of a basic old-age pension.

Figure 3.3:



Source: Infratest Sozialforschung –July 2002, N= 1000

The proportion of unconditionally positive responses is only slightly smaller than in the case of the health question. This is somewhat reassuring – as it had to be expected that "alleviating poverty in old age" as a use of voluntary contributions was thought to be substantially less attractive to potential contributors than health care.

The survey institute thus concluded that a considerable percentage of the German population showed a positive attitude to "global partnership" between citizens of rich and poor countries

and that the propensity to contribute to the support of basic social protection systems was rather stable.

The following box summarizes the most important results in ten key figures.

Box 9. Who would contribute in Germany? An answer in ten figures

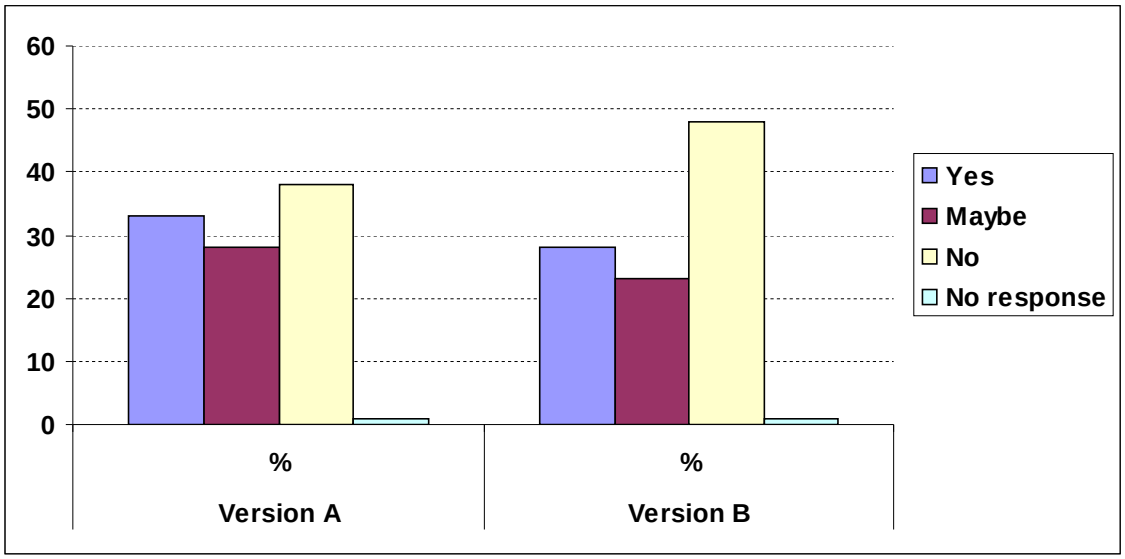
In November /December 2001 Infratest Munich conducted in parallel two independent telephone surveys to test the propensity of the public in Germany to contribute to a GLOBAL SOCIAL TRUST. Each sample had a size of 1000 people. Two polls were necessary to test the possible impact of an emotional versus a rational promotion strategy for the TRUST. The questions asked were:

Emotional Version A:
You may know that many people in the poorest developing countries have hardly any money for their health care. The competent sub-organization of the UN in Geneva plans a worldwide solidarity fund, to finance health care for the poorest of the poor. Would you be willing to contribute say for 2 to 3 years about 10 DM (i.e.5€) per month to that Fund?
a) Yes
b) Maybe
c) No

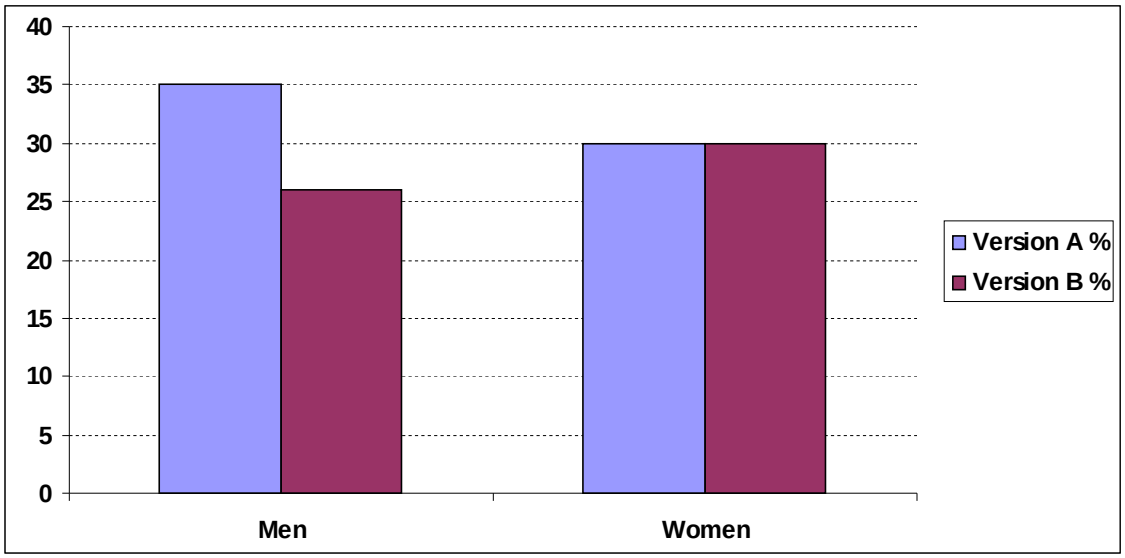
Rational version B:
Some developing countries are not able to provide any meaningful health care for their population. The International Labour Organization of the UN in Geneva plans a Global Solidarity Fund to finance Health Care in such countries. The resources for this Fund should come from private contributions. Behind this is the idea of a global partnership between citizens of rich countries with people in poor countries? What do you think of this? Would you be prepared to contribute for say 2-3 years a monthly amount of say 5 €?
a) Yes
b) Maybe
c) No
The main structural aspects of the answers are summarized in the following points

· ***Emotional vs. rational appeal***
The aggregate answers for the two versions were as follows

Box figure 1. Emotional versus rational appeal (in%)



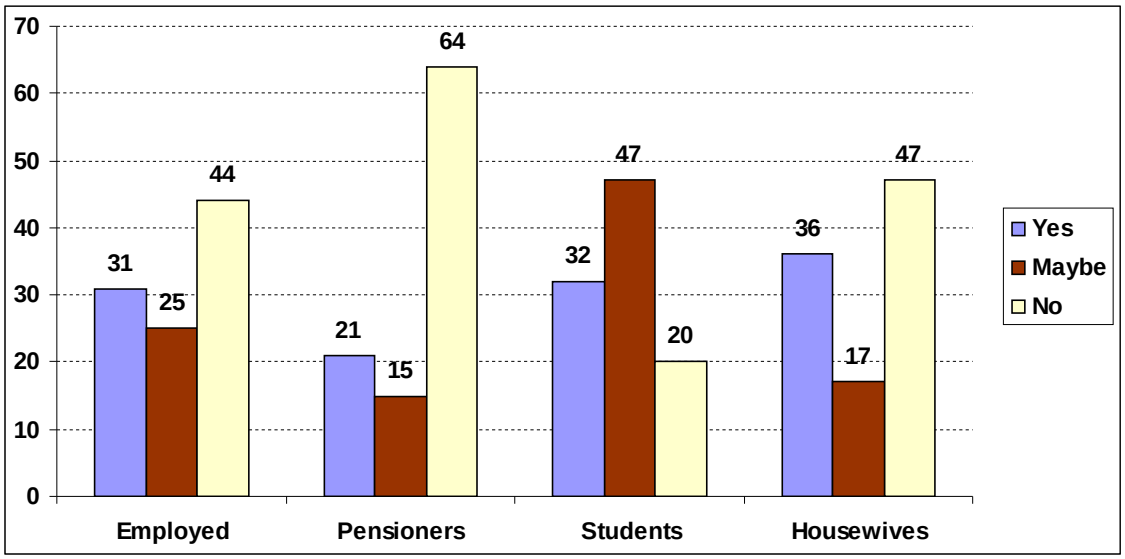
Box figure 2. Yes – by gender (in %)



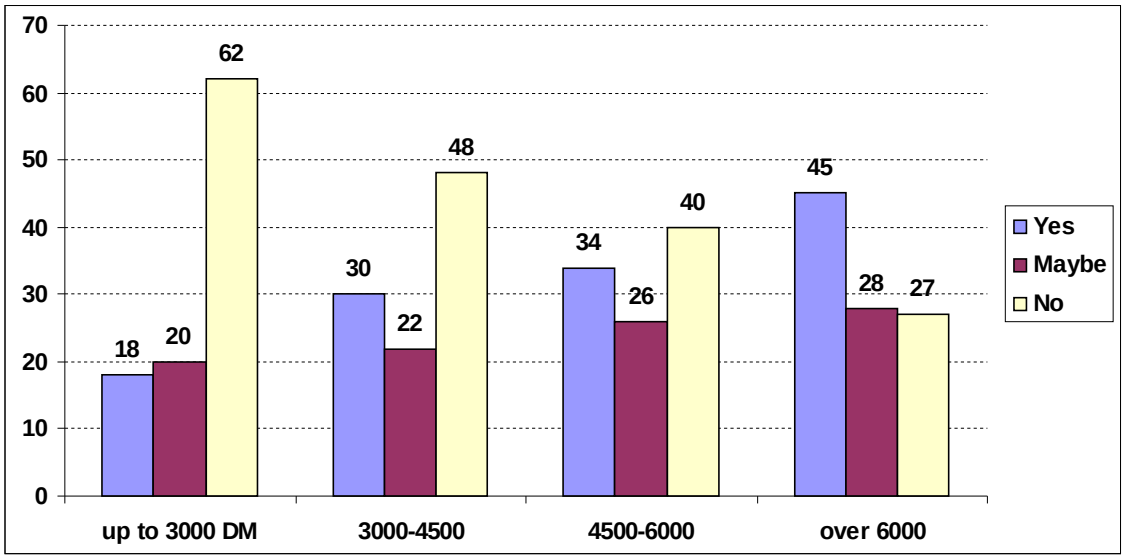
The results show an unconditional agreement of 33% for the emotional approach and 28% for the more rational approach. Women appear to be less susceptible to an emotional "dressing" of the questions. Further analysis shows that the highest unconditional propensity to contribute is reached in the age group 45 to 59 (the highest income group) with 36% for version A and 35% for version B. Based on an analysis of the competitive situation on the charity market Infratest recommends to pursue the rational promotion strategy. The following results thus refer to version B.

· ***Willingness to contribute by employment status and income***
Results show an obvious positive correlation between the willingness to contribute and the level of household income (Box figure 4) as well as the relationship between employment status and willingness to contribute (Box figure 3).

Box figure 3. Employment status and willingness to contribute (in %)

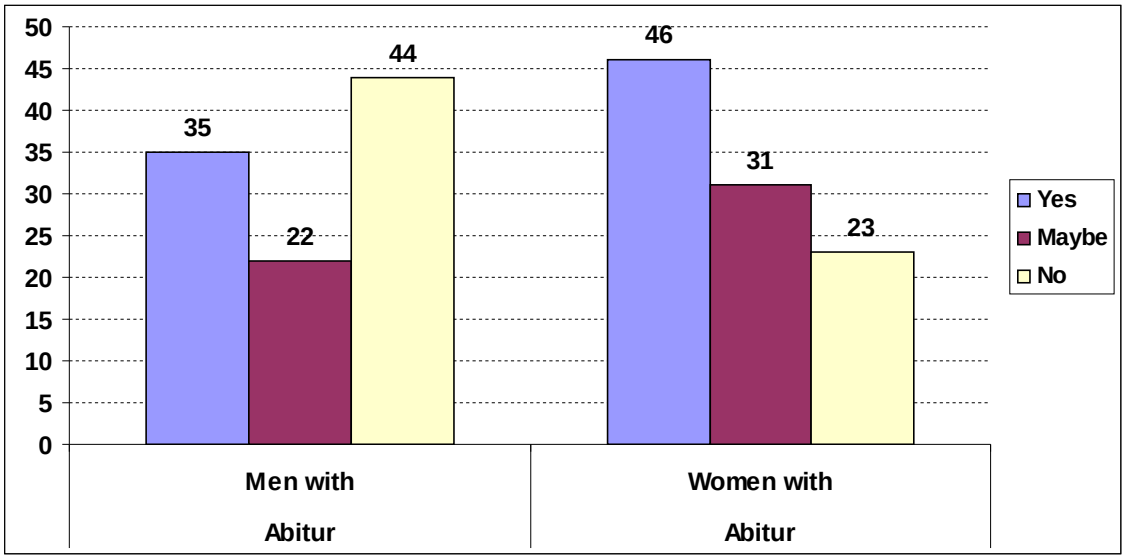


Box figure 4. Willingness to contribute and monthly gross household income (in %)



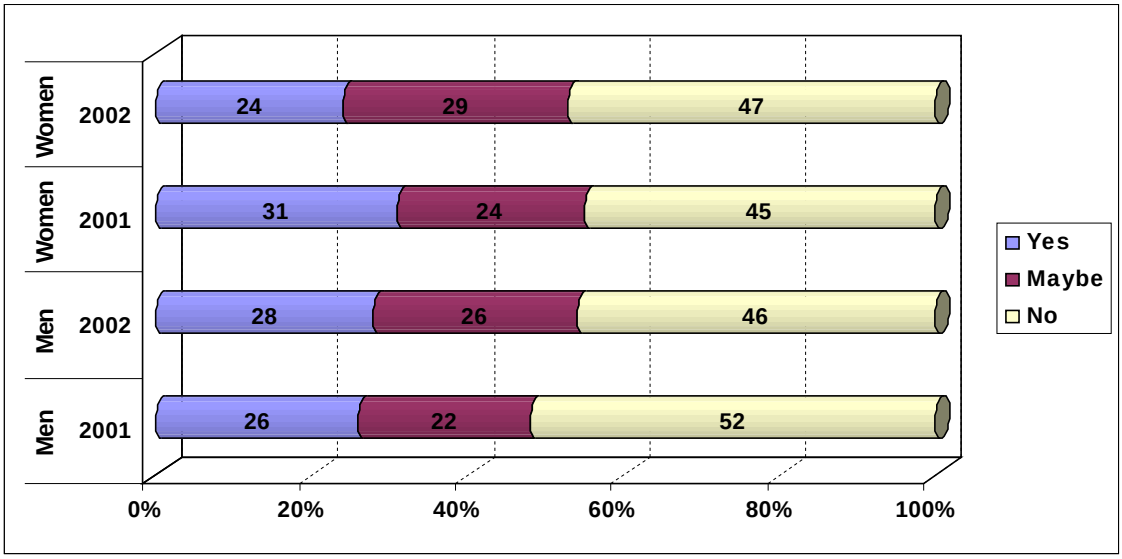
• ***Gender and educational level***
Women show a generally higher readiness to contribute (see Box figure 2). Women with a high educational status (Abitur = Baccalaureat) show the highest willingness to contribute. Their consent with the concept of the TRUST reaches almost 50% which is more than 10% higher than that of men.

Box figure 5. Willingness to contribute by gender and high educational attainment (in%)



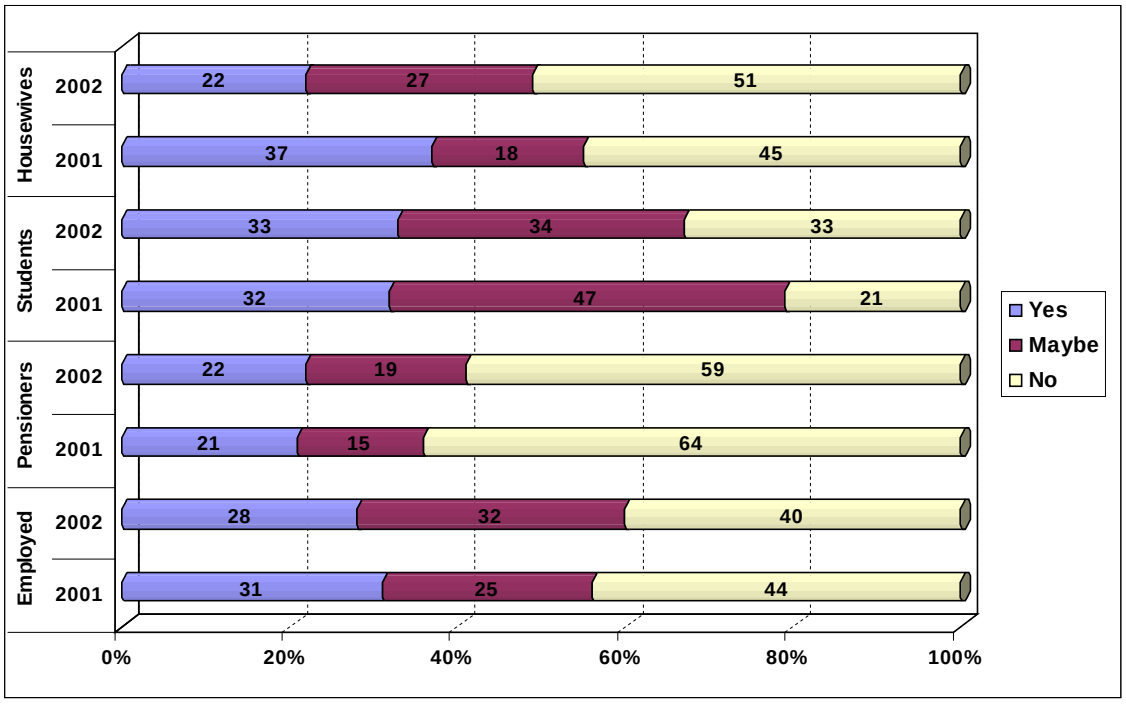
· **General shifts in propensity to contribute between November 2001 and November 2002**
In July 2002 the rational health care question was almost identically repeated in another round of 1000 telephone interviews. The main results compared to the November 2001 survey are displayed in box figures 6 to 8.

Box figure 6: Willingness to contribute to the financing of basic health systems by gender November 2001 vs. July 2002

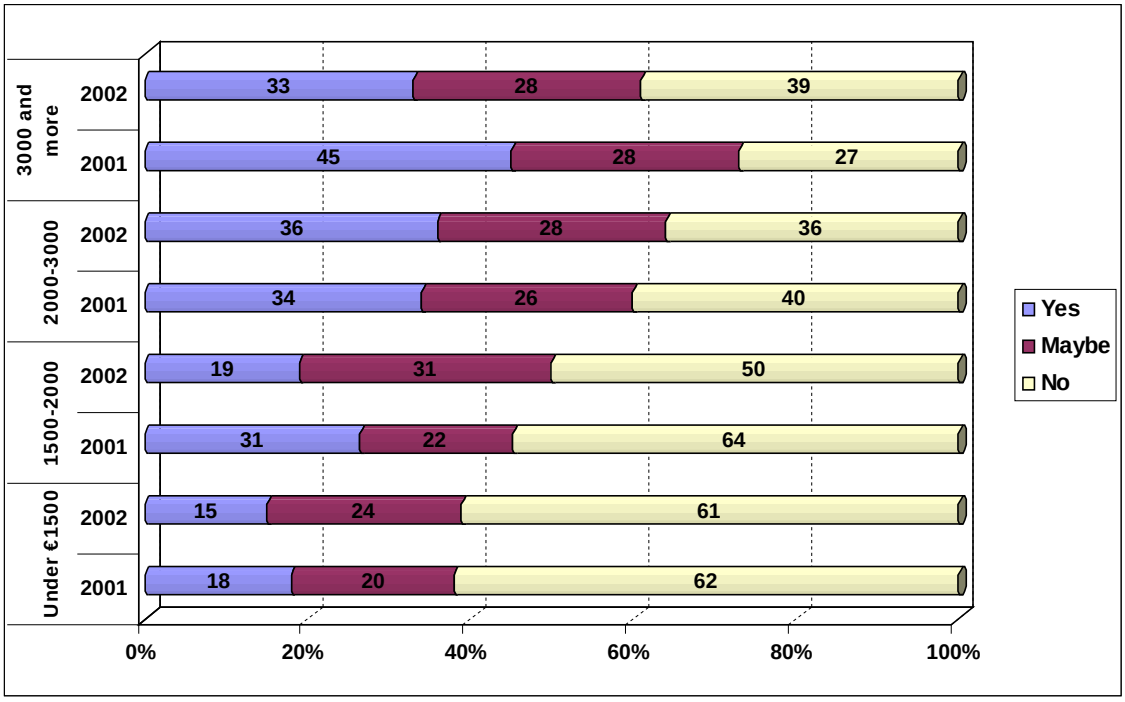


The proportion of firm "yes" has increased slightly for men but decreased substantially (partly in favour of "maybe") in the case of women. On the whole the proportion of people considering contributing (Yes Plus Maybe) hovers around 50%. The fairly substantial shift for women can largely be attributed to a dramatic shift in the attitude of housewives as Box figure 7 indicates. They may be more nervous about the present economic down-turn in the country than blue and white collar workers. The overall reduction of the "yes" can be attributed to the lower propensity to contribute of the high income earners. The self-employed are highly represented in this group. Their more cautious attitude may also be based on economic reasons.

Box figure 7: Willingness to contribute to the financing of basic health care systems by employment status, November 2001 vs. July 2002



Box figure 8: Willingness to contribute to the financing of basic health care systems by household income – November 2001 vs. July 2002



• **Differences in willingness to contribute for health care vs other benefits**

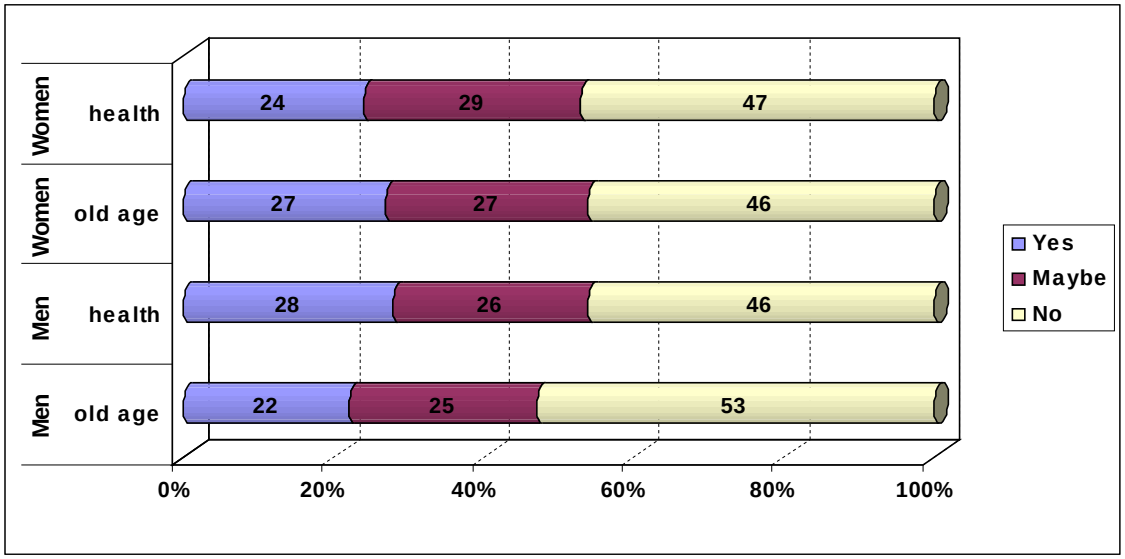
In order to test the sensitivity of the survey results to the nature of the benefit to be financed, a second question asking for the readiness to contribute to the financing of basic old age pension schemes was fielded in parallel to the renewed health care question. The question was:

Some developing countries are so poor, that practically no old age pension scheme exists and not even a minimum standard of living can be guaranteed for the elderly. However, even very small amounts of money can help to alleviate the poverty of whole families. The International Labour Office of the United Nations in Geneva is thus planning to introduce a Global Solidarity Fund to finance modest pensions for people older than 65 years in developing countries. Financial resources should come from private donations. The plan is based on the idea of a global partnership between people in affluent and poor countries. What would you think: Would you be ready to contribute to this Solidarity fund of the UN for 2 to 3 years say 5€ per month:

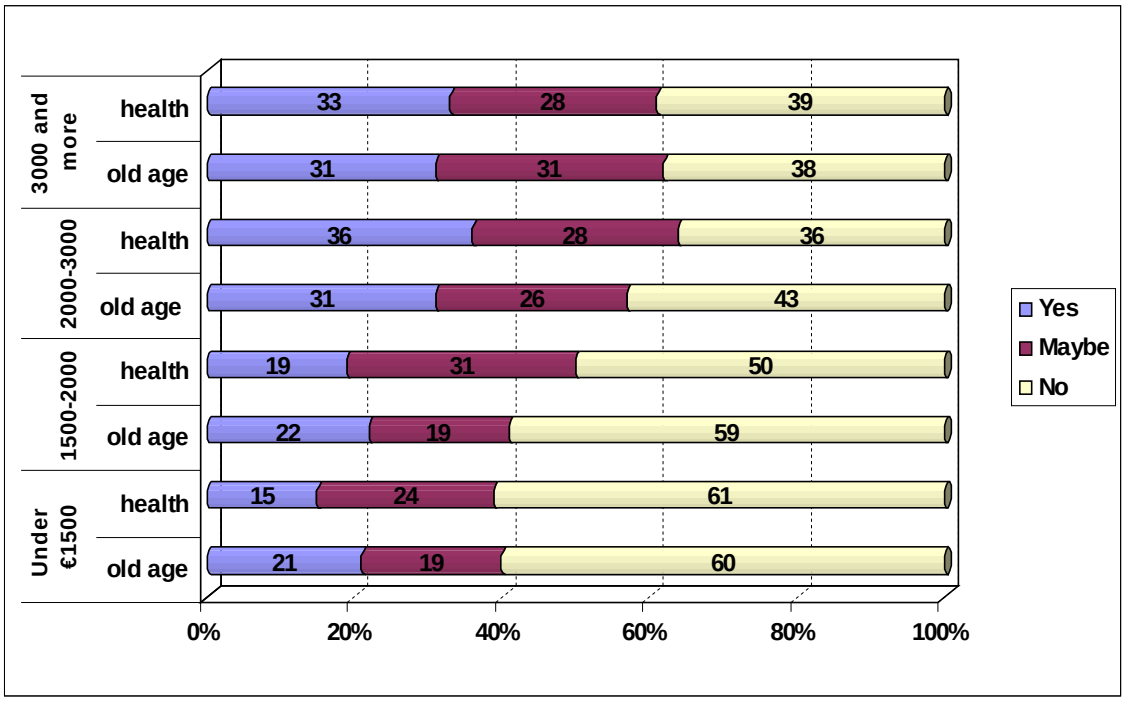
a) Yes
b) Maybe
c) No

Overall the propensity to contribute to the financing of a pension scheme is slightly less than that to contribute to the set-up of a health care scheme. The following two graphs highlight the main structural differences by gender and by age. Generally it appears that women and lower income groups have a lower preference to contribute to health care schemes than to old-age pension schemes.

Box figure 9: Willingness to contribute to the financing of old-age vs. health care benefits by gender, July 2002

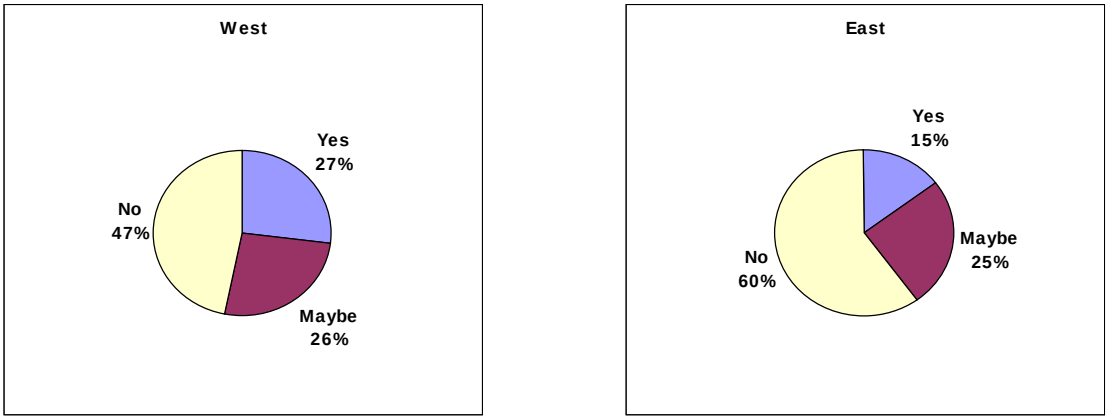


Box figure 10: Willingness to contribute to the financing of old-age vs. health care benefits by income, July 2002



While it is not clear whether these attitudes are representative for other countries in the OECD, the survey also reveals some indications about the elasticity of the willingness to contribute to levels of per capita GDP. The following figure shows that there is a marked difference between the propensity to contribute to old age pension projects between East Germany and the richer West Germany (the per capita GDP of East Germany is only about 60% of that in West Germany). One might conclude from this that the propensity to contribute in the less well-off OECD countries might be substantially lower than the indicative survey figures for Germany as a whole.

Figure 3.4: Willingness to contribute to financing of old age pensions schemes - East and West Germany, July



Surveys are always subject to errors. People's responses on the telephone might differ from their real life behaviour. On the other hand surveys do not really simulate well the behaviour of people who have been subject to publicity campaigns. In view of the remaining uncertainty about people's behaviour as well as the potential difference in the propensity to contribute between countries with different levels of per capita GDP, a conservative assumption was made concerning the average participation rate in the OECD countries. It was assumed that even in the stationary state of the TRUST, i.e. after one to one and a half decades when it has reached its "cruising" speed and all possible National Social TRUSTs have been set up, the average participation rates would only reach about 10 % of all employed persons.

3.1.2 Estimating the potential volume of contributions

Based on the above assumption the potential contribution income of the TRUST in its stationary state can be estimated. It is hence assumed that a participation rate of 10% of all employed persons may be achievable on average across all OECD countries if they are asked to contribute about 0.2% (or 5 Euros) per month of their wages. This is equivalent to two thirds of the "yes" response rate in East Germany. Further contributors may be recruited from the self-employed. One can tentatively assume that their contribution rate would be equal to that of employees. Additional contributions may also come from enterprises and better-off pensioners. No educated guess on the potential was possible and the potential income from the latter three sources is considered a safety margin which may compensate for lower propensities to contribute in some of the OECD countries.

Table 3.1 assesses the contribution potential to the TRUST by calculating the potential income from 10% of all employees and alternatively that of all employees plus the self-employed. This calculation would yield between 2.4 and 2.8 billion € as annual contribution income.

Table 3.2 tries an alternative – more prudent - way to assess the financial potential of the TRUST. It assumes that only people in the established and relatively rich industrialized economies in the OECD would contribute and that participation rates would only be between 5 and 10 % of all employees[16]. In this case the potential amount of contributions would lie between 0.8 billion € and 1.6 billion €. For comparison the table provides the annual income of UNICEF from the public and private sector in the respective countries. It is obvious that the TRUST could have an income equal or higher than that of UNICEF.

On the whole it appears that in the stationary state one could expect a potential volume of total income of the TRUST in the order of between 1.0 and 2.0 billion Euros per annum once all national organizations have been built up. However, that income would gradually build-up over time. The pace of the build-up depends on the pace with which the national organizations can be founded and achieve their individual state of full potential.

This is a substantial amount in comparison to the estimated volume of aid resources that are flowing into the social protection sector. According to the latest World Bank Development Report[17], NGOs globally administered around US$ 10 billion in development assistance per annum in the late 1990s of which about 50% were public resources. According to the OECD, official development assistance allocated directly by governments accounted for around US$ 55 billion in 2000[18]. It is not known exactly how much of the total global development assistance goes directly to the social sector. However, estimations based on OECD data indicate that it may be in the order to 4 to 5 billion US$. This means that in the stationary state, the Trust could increase the present level of global development assistance for social protection by about 25%.

It appears safe to say that in the stationary state the TRUST would make a substantial contribution to development assistance that is devoted to social protection. An assumed average annual income of €1 billion would be equivalent to about:

— 110 times the estimated technical co-operation resources for social security of the ILO per annum in the biennium 2002/03[19] and
— about 4 times the World Bank's International Development Association's (IDA) annual disbursements for investment projects in social safety nets in 1998[20].

There is reason to believe that the TRUST could become the single biggest global investor in social governance.

[16] The views on the potential propensity of workers to contribute vary widely among experts. A representative of the British TUC alerted the project team to the fact that probably less than 1% of British workers are contributing to OFFA (a voluntary Fund that supports the unemployed). Workers and employers' representatives' from Luxembourg were more optimistic. Ultimately the propensity to contribute can only be tested in a real life experiment. There might be a wide range of participation rates between different countries.
[17] See World Bank: World Development Report 2000/01: Attacking poverty, chapter 11, Washington 2001.
[18] Computed on the basis of tables from the OECD Development co-operation report 2001.
[19] See ILO: Programme and Budget for the Biennium 2002/03, Information Annex No. 4, Geneva 2001.
[20] See World Bank: IDA Social sector lending, http://www.worldbank.org/ida/socialsector.htm

Table 3.1. Yearly contribution potential (values in € as of the year 1999)

Year 1999 (*)	Country	Employees	Self-employed	10% of employees contribute 5 Euros per month	10% of employees and of self-employed contribute 5 Euros per month	Annual gross wage in Euros	contribution in percentage of annual gross wage
		in 1'000		Annual contribution			
1	Australia	7'380	1'274	44'280'000	51'924'000	24'121	0.25%
2	Austria	3'231	398	19'386'000	21'774'000	22'616	0.27%
3	Belgium	3'118	565	18'708'000	22'095'000	28'253	0.21%
4	Canada	12'890	1'595	77'338'800	86'907'600	21'920	0.27%
5	Czech Republic	4'024	660	24'144'000	28'102'200	4'502	1.33%
6	Denmark	2'428	221	14'568'000	15'894'000	36'909	0.16%
7	Finland	1'966	305	11'796'000	13'626'000	24'632	0.24%
8	France	20'509	2'471	123'054'000	137'880'000	20'787	0.29%
9	Germany	32'489	3'582	194'934'000	216'426'000	31'124	0.19%
10	Greece	2'296	1'262	13'776'600	21'348'600	10'466	0.57%
11	Hungary	3'140	561	18'840'000	22'206'000	2'891	2.08%
12	Iceland	126	27	757'200	917'400	23'189	0.26%
13	Ireland	1'280	283	7'679'400	9'378'000	20'584	0.29%
14	Italy	14'624	5'071	87'743'400	118'166'400	20'101	0.30%
15	Japan	53'310	7'540	319'860'000	365'100'000	34'765	0.17%
16	Korea	12'522	5'841	75'132'000	110'178'000	13'985	0.43%
17	Luxembourg	232	17	1'389'000	1'489'800	28'139	0.21%
18	Mexico	23'226	11'021	139'354'800	205'481'400	4'146	1.45%
19	Netherlands	6'762	797	40'572'000	45'354'000	27'008	0.22%
20	New Zealand	1'380	354	8'279'400	10'404'600	17'628	0.34%
21	Norway	2'058	166	12'348'000	13'344'000	31'995	0.19%
22	Poland	11'173	3'446	67'036'200	87'712'200	4'823	1.24%
23	Portugal	3'463	1'183	20'776'800	27'875'400	7'282	0.82%
24	Slovak Republic (**)	1'965	161	11'790'000	12'758'400	4'502	1.33%
25	Spain	10'790	2'634	64'740'600	80'544'600	14'437	0.42%
26	Sweden	3'636	419	21'816'000	24'330'000	25'077	0.24%
27	Switzerland	3'361	431	20'166'000	22'752'000	37'643	0.16%
28	Turkey	9'487	6'244	56'922'000	94'383'000	8'207	0.73%
29	United Kingdom	23'848	3'202	143'090'400	162'304'800	27'015	0.22%
30	United States	123'267	10'087	739'602'000	800'124'000	28'151	0.21%
TOTAL		**399'980**	**71'817**	**2'399'880'600**	**2'830'781'400**	**24'075**	**0.2%**

gross wage of the average production worker.

(*) in 1999, 1 euro = 1.06 dollars

(**) wage assumed equal to Czech Republic.

Table 3.2. Alternative assessment of contribution potential (values in mill. € as of the year 2000)

Country	Estimated revenues of the 5% part. rate; 5 € per month	Estimated revenues of the 10% part. rate; 5€ per month	For UNICEF revenues 2000		
			Governmental contributions	Private contributions	Total
Australia	22	44	22	5	27
Austria	10	19	2	2	4
Belgium	9	19	7	6	13
Canada	39	77	22	7	28
Switzerland	10	20	15	13	28
Germany	97	195	5	71	76
Denmark	8	15	32	2	33
Spain	32	65	2	25	26
Finland	6	12	14	4	18
France	62	123	8	35	43
United Kingdom	72	143	91	24	115
Ireland	4	8	5	1	7
Iceland	0	1	0	0	0
Italy	44	88	18	28	46
Luxembourg	1	1	1	1	3
Netherlands	20	41	55	39	94
Norway	6	12	59	1	60
New Zealand	4	8	2	0	2
Sweden	11	22	61	4	65
United States	370	740	269	44	313
Total	827	1653	690	311	1002

(*) in 2000, 1 euro = 0.92 dollars.

Source: OECD, EU and UNICEF data.

3.2. Potential impact

The benefits from the TRUST will accrue to individuals, families, communities, and ultimately national societies. In the long run global social solidarity benefits all – the contributors, the beneficiaries, the country, the economy, the donors, etc.– not just the immediate recipients. For instance, when the social situation in developing countries is improving, the benefits are felt not only by them, but also by the rich countries because of the benefits from an increased supply of global public goods. Additional benefits for all parties would include increased social peace, good governance, and better education. The resultant increased growth in the poorest countries would reduce the risk of a global spread of diseases, increase demand for goods and services in industrialized countries and reduce migratory pressure.

However, the central question of this feasibility study is what impact the TRUST would have on the social situation in developing countries. Essentially the build-up of sustainable social security structures will benefit the total population in the recipient countries in the long run. It will make their life more socially secure, reduce the risk of falling into poverty and will allow them to lead a socially and economically meaningful life.

Contributors rightly demand information about immediate impacts.

Assessing the immediate impact requires estimating the cost of a typical minimum benefit package in a community based social security scheme. The data situation is notoriously weak and of course highly dependent on national and regional circumstances. In addition the suggested policy of the TRUST is not to prescribe one uniform set of benefits for all. However, assessing the potential impact of the TRUST demands an estimate of how many people can be supported with the assessed 1 to 2 billion € that the Fund can hopefully collect per year.

A pragmatic way to assess the per capita cost of a typical basic benefit package thus has to be found. In the absence of reliable risk assessments in benefit expenditure, social security transfer systems tend to cash limit their expenditure. In view of the data situation this approach is pursued here. It is assumed here that the expenditure per protected person (not necessarily per direct beneficiary) and per month for a minimum benefit package including basic health benefits and a modest anti-poverty cash benefit (including administrative overhead costs) can be kept at € 2.50.

That figure is based on the following reasoning about an “average” support package which might be considered typical. It is assumed that the support package would help to provide a set of basic social security benefits that are provide by a community based social protection scheme. The package could consist of an essential health care subsidy and a cash benefit subsidy. The latter could be tied to the condition that all children in the household are attending school. Thus the benefit package would incorporate elements from all “corners” of the basic family protection triangle. The figures calculated here are indicative and refer to the initial amount of per capita subsidies for all protected people - not only for beneficiaries. The TRUST thus supports the protection of people, it does not just pay part of the benefits for the recipients of benefits. It is also assumed that the per capita subsidy level will be reduced over time.

The health component of a "typical support package"

The WHO Macro-economic Commission for Health estimates[21] that the total cost of health care per person in low income and least developed countries is in the order of US$35 per capita and year. The figure includes recurrent costs of health services as well as basic investments. Least developed to low income countries presently spend about US$13 to 14 on average per person and year. Required would thus be on average another US$21. Assuming that during the years sponsored by the TRUST a community based scheme can collect half that additional amount through contributions, i.e. on average US$10.5 or about 12 € (2001 exchange rate), the TRUST could cover the € 12 per person and year or one EURO per month. The following box supports that reasoning by referring to concrete expenditure and cost data of community based health insurance schemes.

Box 10: Calculating a typical per capita subsidy in community based health care schemes

The box table compiles the estimated per capita monthly full Pay-as-you-go cost (i.e. the cost covering premium) for 14 community based health schemes for which data could be found in recent studies. According to this - probably highly biased sample - and rough estimates, the average cost for the schemes could be in the order of US$0.6 to 1.8 per covered person (i.e. mean plus/minus 1.5 times the standard deviation) across all regions. Covering half the cost would lead to a monthly per capita health subsidy by the TRUST in the order of the € 1 per month as estimated above.

It should be noted in this context that the US$0.6 to 1.8 per capita cost certainly do not represent the full cost of health care. Government and other sponsors are still heavily involved in the financing of health care. The *cost* to the schemes for medical treatment represent *charges* in health facilities that they have to pay on behalf of their members. These charges usually do not represent the full cost of the care provided to the patient as direct government or other sponsor resources (like NGO resources or international aid) are de facto subsidizing the prices that the community based schemes are paying to the health care providers. In fact Bennett et al. (1998) showed that only about half of the schemes analysed in Asia and Africa covered more than 50% of the estimated full cost of care[22]. Thus the risk that through supporting community based schemes the withdrawal of government resources from health financing might be facilitated is not very high as long as the provider payment systems are not changed after the TRUST engagement has been agreed upon. The provider payment mechanism to be employed by the community based satellites can easily be agreed upon in the contract between the hub, the satellites and the TRUST. Our calculations assume that governments will not seek to reduce their per capita input for covered persons, i.e. in other words that government can be prevented from reducing their financial commitments to the health sector respectively the social sector in general.

It is difficult to estimate the impact of a subsidy towards the contribution rate of about US$1 or €1 per month per person. However, coverage rates are sensitive to premium levels. Again, the data base on the elasticity of coverage to premium levels is weak but one of the working papers of the WHO commission of Macroeconomics and Health contains a regression estimate on the elasticity for a rural district in Ghana[23]. It permits to conclude that a reduction of the per capita annual premium from 50,000 cedis (i.e. US$7) to about 7000 cedis (i.e. about US$1) could increase the potential coverage rate from 2 to 38% of all households in the district. The potential impact on the overall level of access to health care in the country would be substantial. The effect would be attained by providing half the level of average assumed cost subsidy by the TRUST.

[21] See Macroeconomic commission for Health: Macroeconomics and Health: Investing in health for economic development, WHO 2001 pp. 53 ff.
[22] See Table 7 in Bennett et al (1998).
[23] See Figure 2.3 ("willingness to pay for adult insurance") in Arhin-Tenkorang (2001).

Box Table : Amounts of cost covering premium per capita in selected community based health insurance schemes, late 1990s to 2001

Country scheme	Estimated monthly cost covering contributions per person in US$	in €	Benefits covered
Benin(1)			
MHO Kilobo, Quesse	1.8	2.1	inpatient and outpatient care (incl. small surgery)
MHO Tasso, Nikki	2.3	2.7	inpatient and outpatient care (incl. small surgery)
MHO Kalale, Kalale	1.5	1.8	inpatient and outpatient care (incl. small surgery)
MHO Toui, Quesse	1.9	2.2	inpatient and outpatient care (incl. small surgery)
MHO Gunagorou, Perere	1.4	1.6	inpatient and outpatient care (incl. small surgery)
MHO Sirarou, N'Dali	1.5	1.8	inpatient and outpatient care (incl. small surgery)
Ghana (2)			
Dangme West Scheme	0.2	0.3	inpatient and outpatient care (excluding subsidies)
Nkoranza Health Scheme	0.1	0.1	inpatient and outpatient care (excluding subsidies)
Uganda (3)			
Kiziisi Hospital Health Society	0.5	0.5	inpatient and outpatient, co-payments included probably heavily subsidized through collaborating hospital
Kenya (3)			
Chogoria Hospital Insurance Plan	1.8	2.1	inpatient and outpatient (medium coverage plan, group rate)
Tanzania (4)			
Community Health Fund in Singida D	1.1	1.3	calculated full cost per person including govt. matching funds and co-payments
Atiman scheme in Msimbazi	1.3	1.5	calculated full cost premium for inpatient and outpatient care
Philippines (5)			
ORT scheme	0.6	0.7	financing only part of inpatient and outpatient care; substantial part paid by social security
Tarlac scheme	0.9	1.1	part paid by social security
Unweighted average	**1.2**	**1.4**	
Standard deviation	0.4	0.6	

Sources:
(1) Benin sub-study, only schemes with more than 750 members were covered
(2) Ghana substudy
(3) Musau, S.N., Partnerships for Health reform
(4) Technical report No.34: Community based Health Insurance: Experience and lessons learned from East Africa, August (1999)
(5) Actuarial studies by Hioshi Yamabana of ILO SOCFAS
Calculations and estimates: ILO SOCFAS

The cash component of a "typical support package"

Based on the assumed expenditure ceiling of the TRUST of 2.50 € per assisted person per month, a typical community based schemes could then – after deduction of the health subsidy of €1 - afford to spend about 1.50€ per month and per capita on a basic income replacement/poverty relief cash benefit.

Assuming that

— a benefit of 1€ per day would provide a modest but helpful income replacement benefit under a basic cash benefit provision (in case of sickness, maternity, invalidity, or an old age pension) and the TRUST would cover 25% of that aspired benefit level during the initial subsidy phase;

— about 20 percent of all covered people in the community based scheme are eligible for a cash benefit (this could be composed of about 10% of the people receiving a cash benefit for invalidity and sickness and 10% for old age), then the monthly rate of benefit cost per capita could be kept at about 1.5€ (i.e. 20% of 30€ multiplied by the TRUST's subsidy rate of 25%).

The above reasoning gives an amount of about 0.75€ per month and per protected person for subsidizing a small old-age pension. The following box provides an example of a basic- anti poverty old age benefit system whose build-up could be sponsored by the TRUST. Initially the community based schemes will not be able to reach the aspired benefits levels of 1€ (or 1 US$) a day. This may be reached only after years of individual savings which have to complement the transfers from the TRUST and the National government. Many other cash benefit designs could be envisaged depending on the capacity of the government, local communities or other groups to finance or co-finance such a benefit in the long run. The aim of the example is to provide the possible financial development pattern of a rural pension scheme in a developing country as well as the development pattern of the TRUST's financial involvement. It does not intend to provide exact nominal values.

Box 11. A possible model for a TRUST supported rural pension scheme in Africa

Let us assume that an African government wants to increase its old age pension coverage in the entire country. It plans to provide ultimately a minimum pension of the equivalent of US$ 1 a day to all people hitherto excluded from coverage to be reached after a transition period of two to three decades, i.e. mainly the population in rural areas. However, the present fiscal situation and the expected development of government finances in the medium term will not allow an outright public financing of the benefit. The government develops a model that aims at a substantial co-financing of the benefit through the covered population. It thus agrees to co-finance the basic pension for all who agree to join local voluntary pension funds. The downside is that coverage will not be complete and that pensions have to be fully funded since other methods of financing are not feasible or equitable in a voluntary scheme. However, in any case the scheme will have a substantial impact on old age poverty and will also have trickle-down effects into the families and households in which the benefiting elderly live. In order to rapidly extend the concept throughout the country, its attractiveness has to be demonstrated almost instantly in order to achieve the necessary public acceptance. A further problem is that fully funded schemes take a long time to mature, as the ultimate level of benefits can only be reached after a full life-time contribution period unless the government provides extensive subsidies during the maturation phase. However, that is exactly what the government will not be able to afford within the next two decades. It will seek start-up financial support from the TRUST for a well defined - but longer than usual - project period of two decades. The following section describes in a stylised manner how the TRUST support could work in principle. It is assumed that the TRUST co-financing would only be provided to pensions of beneficiaries who have contributed to the rural pension scheme for a defined period of time, i.e. for about 25 years, or, i.e. at least for 90% of the time that the scheme has been operational (transitional provision). This aims at reducing moral hazard by limiting the co-financing only to persons entering the scheme as early as possible.

These rural pension schemes would be little more than elementary savings schemes where people would agree to contribute about 10% of their average monthly income (say in this case of US$ 45[24] per month) to the scheme. The scheme registers these contributions in individual savings accounts where they would earn interest. At age 60 the total accumulated sum of savings would be annuitized, i.e. converted into a monthly pension. Elementary invalidity and survivors benefit might also be paid but are ignored here to simplify the case. 50 % of the funds are to be placed with the social insurance "hub", while 50% can be locally invested by the administration of the scheme. The hub provides administrative and managerial support if required. The government guarantees a real rate of return of 3% and agrees to subsidize the scheme by matching each dollar of the pensions that is a result of the individual savings by exactly the same amount until such time that the individual monthly pension earned by savings would exceed US$ 15.

[24] The average monthly income may appear high, but the example is meant as a demonstration only. It demonstrates that assumed ultimate replacement rate of pensions for the poor is assumed to be about 2/3 of their income.

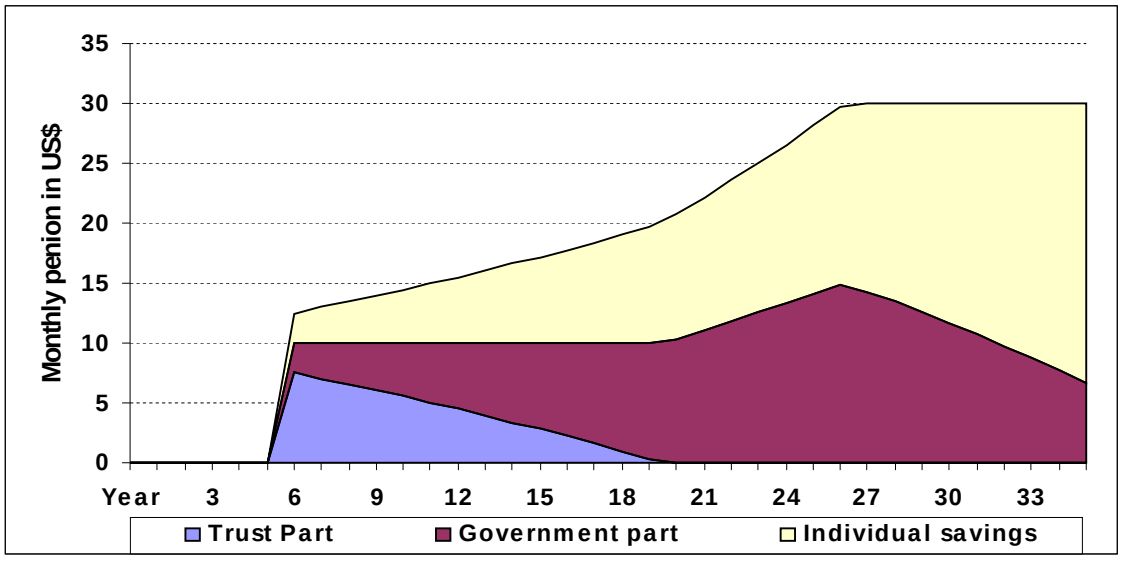
As the average pension amounts per retiring cohort earned from savings plus government subsidies would increase very slowly and monthly pensions would even a decade after the lapse of an initial waiting period of five years (during which no pension would be paid as the minimum savings period to qualify for government subsidies would be 5 years) only reach a level of about US$ 15 per month (i.e. half the ultimate targeted amount). The government could request a subsidy from the TRUST to bring initial pensions during the maturation period (which would be about 20 years) up to levels much closer to the minimum needs of the people as quickly as possible. The TRUST could decide to subsidize each pension by US$ 10 minus the government support until the total package of savings pension + government support + TRUST subsidy would reach US$ 20 (in real terms, i.e. 2/3 of the ultimately target amount).

Assuming no inflation, a real interest rate of 3%, and a life expectancy of 58 years at birth, the annual annuities (pensions stemming from savings) as well as government subsidies and TRUST subsidies are calculated for a male contributing on the basis of US$ 45 in the following box table 1. The table assumes that the years denote the number of contribution years as well as the age of the scheme. The grey shaded area marks the years in which the TRUST intervenes. The subsidy from the TRUST towards newly awarded pensions ceases in the 20th year. However, the subsidy from the TRUST towards the benefits awarded in the early years of inception of the scheme may continue until the 26th year. Box figure 1 shows the development of the average pension for newly awarded pensions and their composition. Box figure 2 shows the changing share of government and TRUST subsidy shares in these individual pensions. In this model calculation the pension generated by individual savings will account for almost 80% of the total monthly individual pension after 35 years. While the TRUST would definitely stop providing its subsidies after about 20 years when new pensions no longer need co-financing. Remaining obligations would be paid off through a lump sum payment of a present value of remaining subsidies until the agreed upon subsidisation period. The government obligation is less predictable. As with all fully funded pension schemes the amount of government subsidies or obligations stemming from deficit guarantees largely depends on the investment performance of the schemes which in turn is highly dependent on the performance of the capital market which is unpredictable over decades. Basically the rural pension scheme suggested here is a government commitment to finance a basic pension for all who are willing to contribute on a voluntary basis throughout their active years – a contribution financed pension with a tax financed minimum pension guarantee.

Box table 1. Average monthly amounts in US$ of newly awarded pensions to males according to the model for a rural pension scheme in an African country (real interest rate 3%, life expectancy at birth 58 years, pension age 60)

Contribution Year	Trust Part	Government part	Individual savings	TOTAL monthly pension
1	0	0	0	0.0
2	0	0	0	0.0
3	0	0	0	0.0
4	0	0	0	0.0
5	0	0	0	0.0
6	7.5	2.5	2.5	12.5
7	7.0	3.0	3.0	13.0
8	6.6	3.4	3.4	13.4
9	6.1	3.9	3.9	13.9
10	5.6	4.4	4.4	14.4
11	5.1	4.9	4.9	14.9
12	4.5	5.5	5.5	15.5
13	4.0	6.0	6.0	16.0
14	3.4	6.6	6.6	16.6
15	2.8	7.2	7.2	17.2
16	2.2	7.8	7.8	17.8
17	1.6	8.4	8.4	18.4
18	1.0	9.0	9.0	19.0
19	0.3	9.7	9.7	19.7
20	0.0	10.4	10.4	20.7
21	0.0	11.1	11.1	22.1
22	0.0	11.8	11.8	23.6
23	0.0	12.5	12.5	25.1
24	0.0	13.3	13.3	26.6
25	0.0	14.1	14.1	28.2
26	0.0	14.9	14.9	29.8
27	0.0	14.3	15.7	30.0
28	0.0	13.4	16.6	30.0
29	0.0	12.5	17.5	30.0
30	0.0	11.6	18.4	30.0
31	0.0	10.7	19.3	30.0
32	0.0	9.7	20.3	30.0
33	0.0	8.7	21.3	30.0
34	0.0	7.7	22.3	30.0
35	0.0	6.7	23.3	30.0

Box figure 1: Development of the composition of average newly awarded individual pensions (in US$)



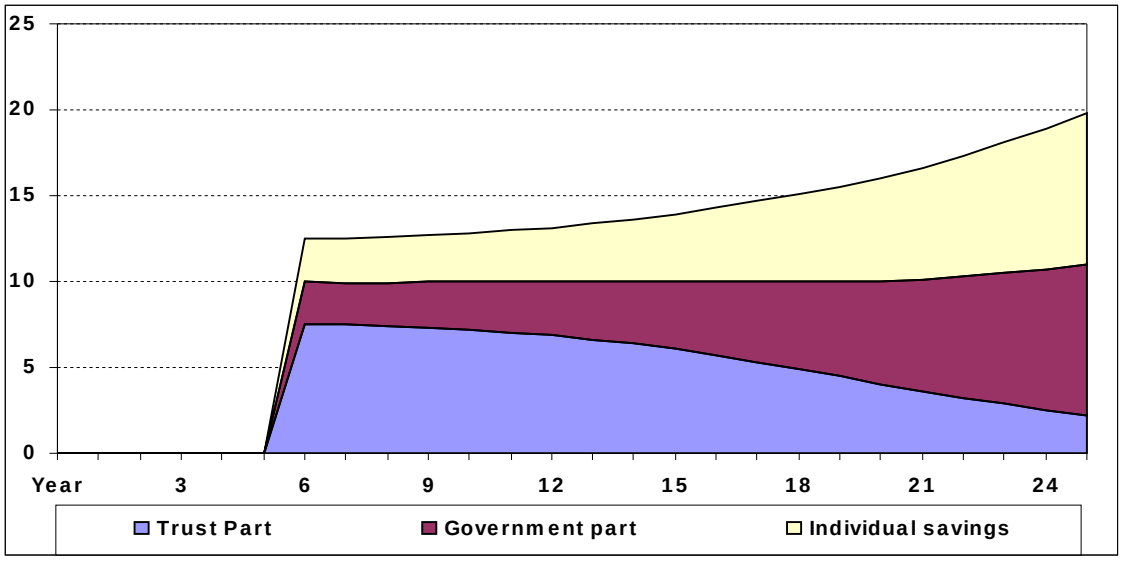
An actuarial model calculation was made for the case of a small rural pension scheme whose initial population of 1000 insured persons grows by an assumed 1% per annum and where after 5 years the first group of about 105 pensioners will receive a pension. It is assumed that the number of pensioners grows by about 2% per annum reflecting the ageing of the population modelled. The first group of new pensioners coming in after the five-year waiting period consist of new pensioners of all ages who have saved for 5 years. This is another simplification which overestimates initial expenditure. To simplify things further it is also assumed that male and female pensions are equal. The following box table shows that the share of the TRUST at total pension expenditure till its last year of involvement drops from 60% to 11% of the total benefit expenditure of the scheme, demonstrating first the substantial involvement of the TRUST and then the gradual disengagement of the TRUST from the financing of benefits. After that the subsidies of the fund have to be taken over by the government.

Box table 2. Model income and expenditure calculation for a rural pension scheme (in US$)

Contribution year	Number of contributors	Total Contributions	Number of pensioners	Total annual pension expenditure	TRUST EXPENDITURE			Annual amount of government expenditure	Annual expenditure financed from savings
					annual amount	in % of total expenditure	per insured person and month		
1	1000	54'000	0	-	-		0.00		
2	1010	54'540	0	-	-		0.00		
3	1020	55'085	0	-	-		0.00		
4	1030	55'636	0	-	-		0.00		
5	1041	56'193	0	-	-		0.00		
6	1051	56'755	105	15'762	9'462	60%	0.75	3'150	3'150
7	1062	57'322	107	16'113	9'615	60%	0.75	3'108	3'390
8	1072	57'895	109	16'512	9'731	59%	0.76	3'203	3'578
9	1083	58'474	112	16'962	9'806	58%	0.75	3'578	3'578
10	1094	59'059	114	17'468	9'835	56%	0.75	3'816	3'816
11	1105	59'650	116	18'036	9'814	54%	0.74	4'111	4'111
12	1116	60'246	118	18'669	9'738	52%	0.73	4'465	4'465
13	1127	60'849	121	19'372	9'602	50%	0.71	4'885	4'885
14	1138	61'457	123	20'151	9'403	47%	0.69	5'374	5'374
15	1149	62'072	126	21'009	9'137	43%	0.66	5'936	5'936
16	1161	62'692	128	21'949	8'799	40%	0.63	6'575	6'575
17	1173	63'319	131	22'977	8'386	36%	0.60	7'295	7'295
18	1184	63'952	133	24'094	7'897	33%	0.56	8'098	8'098
19	1196	64'592	136	25'302	7'328	29%	0.51	8'987	8'987
20	1208	65'238	139	26'656	6'729	25%	0.46	9'964	9'964
21	1220	65'890	141	28'204	6'146	22%	0.42	11'029	11'029
22	1232	66'549	144	29'950	5'581	19%	0.38	12'185	12'185
23	1245	67'215	147	31'900	5'039	16%	0.34	13'430	13'430
24	1257	67'887	150	34'058	4'523	13%	0.30	14'768	14'768
25	1270	68'566	153	36'427	4'035	11%	0.26	16'196	16'196

The following box figure shows the average subsidy of the TRUST and of the government per pension in payment till the end of the subsidy period under the above model calculation.

Box figure 2: Average subsidies for all pensions in payment (in US$)



Total typical per capita cost and impact

Assuming that the above per capita health care and cash benefit subsidies include the estimated administrative cost of about 10% of total cost (as well as possibly a potential full subsidy for health insurance premia for the elderly and the chronically sick) this would lead to a total per capita cost of 2.5 € per month. Investments in the initial infrastructure of the community based schemes or the capacity of the national schemes to function as a hub for the community based schemes would have to be accommodated within that amount. Payment of cash benefit subsidies may have to be delayed for some time in the start-up phase to permit the coverage of investment cost.

The same per capita subsidy could for example be realized by a project that supports only an old age pension scheme for rural families or households, provided that all children in the household are attending school. It is assumed that the TRUST would shoulder 50% of the initial per capita cost of the scheme. If one assumes that each pension supports indirectly about five further household members then the per capita support cost per month would also amount to about €2.5 (again assuming that the administrative costs are included).

On the basis of the above calculation assuming 10% of the workforce in OECD countries participate (which would be about 40 million people, see table 3.1), the TRUST could maintain reasonably sized subsidies for the social protection of about 80 million people in the stationary state at any given point in time. If further contributions (for example matching employer contributions) and contributors could be attracted in addition to employees then the number could go up to 100 million people. That potential would be reached gradually as the national organizations are successively being built up. If one were to start with one small country, say Luxembourg, then the first group of protected people may only be in the order of 50,000. Adding Ireland in the next one or two years could add about 250,000 and Sweden 720,000. It is assumed here that the full potential could be reached with one to two decades following the start of the first pilot project. If one were to make a much more conservative calculation on the basis of about 1.5 billion € annual income then the scheme could still reach about 50 million people at any given point in time. If one were to assume that subsidy programmes were time limited to five years, the TRUST could still reach out to 100 million people per decade. The TRUST is surely not the only response that a worldwide campaign against poverty and social exclusion requires but it would certainly be the biggest people-to-people operation ever launched.

Hence, - as a rule of thumb - one contributor could on average support 2 beneficiaries.
This is our basic people- to-people support formula.

In other words by adding about 0.2%-points to the total social security contributions which a worker in an OECD country spends to secure himself and her/his family, s/he could protect two other people in the developing world.

4. Options and next steps: Operationalizing the TRUST

4.1. Basic options

The basic options for the ILO in setting up or promoting the TRUST are either to proceed or not to proceed. The reasons to decide either way are manifold ranging from general considerations concerning the role of the ILO in the concert of international agencies to the political risk that is incurred if projects fail. Valuing these dimensions is not the subject of this feasibility study. This study simply sought to establish whether the set-up of a GLOBAL SOCIAL TRUST was feasible and reasonable. Ultimately risks remain, which have to be weighted in the political sphere. The main risks are that:

— the TRUST fails to attract a sufficient number of contributors, and just becomes one more small charity,
— the TRUST fails administratively and managerially, for example through sponsoring failing projects or through bad management of Funds tarnishing the image of the ILO.

These risks have to be weighted against the ILO's renewed mandate to extend the coverage and improve the governance of social security[25] and the potential risk to be challenged some years down the road on grounds of not having been innovative enough.

The above basic administrative and organisational features of the TRUST have been developed with a view to minimize the political and managerial risks for the ILO without compromising the potential impact of the TRUST. The main element in this respect is the move away from one centralized fund to a network of national funds, or National Social TRUSTs, organized in a global network and thus limiting of the role of the ILO to promoting the idea in national contexts as well as to hosting and supporting the Technical Secretariat of the Global Board of the TRUST.

A second safeguard is built in through the gradual phasing in of the TRUST over a number of years. The following section sets out a possible time-table. The project team reckons that there would be little merit in a further theoretical study. The process to set-up a new international network of National Social TRUSTs as well as the launching of big technical co-operation projects with a heavy focus on local benefit delivery enters into new uncharted territory. The validity of the concept now has to be subjected to a real live test.

4.2. Possible next steps

Provided that the Governing body gives its green light in November it is envisaged to proceed in a three-stage process with the further development of the concept. The next steps could be:

[25] See ILO: Resolution and Conclusions concerning social security, International Labour Conference, 89th session, 2001.

Step 1: Field testing the benefit delivery and contribution collection (2003-2005)

The first step should be the field testing of the main delivery idea and the feasibility of the contribution collection through the setting up of one or more field pilot projects, which would bring together one donor country and one recipient country.

On the benefit delivery this project would test the feasibility to set up lasting community based basic social protection systems through satellite arrangements with temporary external help. The government of Namibia has indicated that it would also be interested to host a pilot project for TRUST activities. In the framework of this project the following items have to be tested:

a) the corruption free flow of funds from an international donor to a national scheme and from there to the community based schemes,
b) the support for community based schemes through coaching by national entities,
c) the sustainable and equitable delivery of benefits at the community level,
d) the monitoring of the national agent and the community based scheme by using a strict performance standards (that have to be developed) in the course of the project.

At the same time the ILO will identify a donor country that would be willing to set up a National Social TRUST to finance a concrete benefit scheme in the country that is hosting the delivery test. ILO constituents, that is national workers' and employers' organizations, will try to create a national organization which would start to support the financing of a specific benefit scheme in the recipient country. The statutes and the governance principles would be developed and tested. The social partners of Luxembourg have shown interest in setting up an NGO which would function as a National Social TRUST. A further donor might be needed to shoulder some of the start-up costs.

The ILO would set-up a small temporary technical project unit (The "pilot project" office) at Headquarters in Geneva to backstop the project and support further development of the know-how base needed for the successful implementation of the delivery side of the project. The unit could ultimately be the nucleus of the Technical Secretariat of the Global TRUST. The Director General may wish to appoint a small tripartite international advisory committee. The review meeting has requested that the Director General report to the Governing body on the progress of the pilot project every year and seek in November 2005/March 2006 a decision on whether the concept of the GLOBAL SOCIAL TRUST should be promoted further by the ILO. At that time the pilot project will not be completed, but it is expected that its chance of success could be established with a reasonable degree of confidence.

Step 2: Promoting further National Social TRUSTs and developing the operational framework of the global organization (2006-2007)

With the successful completion of Step 1 the ILO would have a showcase which would facilitate the promotion of further National Social TRUSTs and their federation into a global organization. Provided that the Governing Body authorizes further activities in its March 2006 session, the ILO will establish a transitional tripartite working group to develop – with the help of the pilot project office - the basic guidelines and draft statutes concerning the operations of the GLOBAL SOCIAL TRUST. This would include issues such as the legal status, management structure, financial management systems, and processes for the TRUST to be able to initiate activities in countries. It would also clarify the administrative, operational as well as financial relations

between the national organization and the global organization. The following are aspects of the TRUST which will have to be defined by the transitional working group:

- Operating principles
- Governance and management, relations between the National Social TRUSTs and the Global Social TRUST Network, the role of the ILO
- Establishment of conditions for use of funds from the TRUST
- Operations
  - Application for access to financial and technical resources of the Fund
  - Means by which the TRUST will seek out appropriate opportunities
  - Review of applications
  - Decisions on the level of support to be provided
  - Monitoring of country and community based interventions — information systems, financial reporting, country visits
- Financial requirements

At the same time, the pilot project office at the ILO will continue to identify new country projects, implement the ongoing project(s) sponsored by the first generation of national organisations and monitor the execution of ongoing projects.

At the end of phase 2 (November 2007) the Governing Body will decide on whether to accept the role of the ILO as laid out by the transitional working group in the draft rules and regulations.

Step 3: Going Global (2008)

Provided that the Governing Body of the ILO approves the ILO's further role, the office can prepare and invite an inaugurating Global Assembly consisting of representatives of the founding National Social TRUSTs (provided that at least two have been founded in the meantime). It could seek to attract an internationally renowned Chairperson, whose reputation would enhance the chances for a rapid extension of the number of national organisations. It would adopt its statutes and possibly a mission statement, elect the first Global Board and commission the Technical Secretariat.

A major campaign supported by the Chairperson of the TRUST and the Director-General of the ILO would be launched to promote the founding of further national organizations. It is hoped that by around 2010 all major OECD member countries could have National Social TRUSTS.

5. Conclusion

The TRUST as described above would not simply be another charity. Its potential volume of income in the stationary state would far exceed that of most other charities. It would not appeal to emotional philanthropy. It would aim at "selling" a rational long-term global social investment strategy. Its major rational would be that social security is one means to contribute to social justice, and social justice is a prerequisite for social peace. In an increasingly interconnected world social injustice and unrest are no longer local phenomena. By investing in social justice, the TRUST would seek to reduce the worst forms of social injustice wherever they occur. That way it would contribute to reduce the habitats/nurturing grounds for global radicalism and violence. In effect every educated contributor would invest as much in the future safety and economic well-being of his/her own family as s/he invests in the future of a family in recipient countries. The TRUST appeals to global citizens, who personally accept a global social responsibility without waiting for governments to allocate a part of their taxes to global social justice. As citizens, they will increase - on a voluntary basis - their monthly tax and contribution burden to make sure that global redistribution and investments into global social peace are made outside of the day-to-day resource allocation battles of national budgets.

Instead of fighting a rearguard battle against globalisation the TRUST would adopt globalisation as a fact of life and use the potential of the global interconnectedness to bring people in the rich countries together with people in the poorer countries. Instead of operating in parallel or in many cases even in confrontation with national governance institutions, it would seek to strengthen national social governance institutions, building on the perception that in the long- run only strong and sound institutions of governance can create social security and contribute to the social stability that a country needs to prosper economically. At the same time it will use its financial independence from national governments in donor countries and the UN system, the fact that it is the TRUSTee of funds enTRUSTed by people – not anonymous government institutions, to execute a tight quality control and tight auditing of the use of funds. If projects were stopped or monies withdrawn due to observed misappropriations of funds in recipient countries, the TRUST would communicate the reasons to the affected population hoping to generate enough pressure to initiate positive changes in national governance practice.

The project team considers the introduction of a GLOBAL SOCIAL TRUST possible along the lines developed in the previous chapters. A gradual build-up of an international network of National Social TRUSTs appears to be the most prudent procedure. The ILO should focus on:

— promoting the idea in its economically most well-off member countries, using its influence on its tripartite constituency,
— serving on the Global Assembly of the TRUST,
— hosting and supporting the Technical Secretariat,
— hosting the Global Assembly and the Global Board.

In other words the ILO should seek a similar preferential (or special) relationship with the TRUST as it has with the International Social Security Association (ISSA), an NGO, which it founded in the 1920s. Therefore the ILO would not be solely responsible for the TRUST.

It appears that the TRUST would have a potential impact with respect to the improvement of national and international social governance. This would, in the mid- to long term, have a substantial impact on poverty alleviation and contribute substantially to the achievements of the

Millennium Development Goals. The TRUST would not compete with other technical co-operation projects or other Global Funds in the field of social security; it would rather seek to build national governance infrastructures that would help to enhance the chances of other projects to succeed.

The GLOBAL SOCIAL TRUST will not be an instant magic bullet solution to poverty. It can be part of a global answer. We believe, an important part. It can breathe new life into international co-operation on good governance.

This study can only be the first step of a long journey. A journey, we reckon, worth travelling.

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Part II:

Background documentation

Annex 1

New Business for old organisations: Extending social security coverage through Satellite Social Insurance Schemes ?

Second draft for discussion
(to be published)

Michael Cichon and William Newbrander

1. Introduction

This article is not primarily a factual report, but instead introduces a concept. Rather than inform the reader about the success or failure of existing programs, it seeks to trigger further discussion on concrete options to extend social protection coverage to hitherto uncovered populations. The most significant impact that this article could have is that one or more social insurance institutions in developing countries would volunteer to test the concept of community-based social insurance schemes for the informal sector, operating as satellites of established formal sector social insurance schemes. We are confident that the ILO, and anticipate that the World Bank, would be ready to support the trials.

2. Background

In many developing countries formal sector social security schemes fail to reach major parts of the informal sector. The widest theoretical population coverage is still reached by government public service health care schemes. But in practical terms they are more often than not underfunded; they may maintain buildings and staff but are not able to finance non-staff inputs such as pharmaceuticals and other medical technology. Hence health coverage is in many cases a theoretical construct. Social insurance schemes in general cover salaried employees and their dependents and have - or are believed to have - no means to reach out to the informal sector. Community based voluntary insurance schemes, where existing at all, deal with health alone, are often financially volatile, and again, more often than not, rely on systemic external subsidisation.

Many of these community-based schemes appear to be in systemic financial disequilibrium, as they try to finance the income expectations of formal sector providers through contributions paid by informal sector employees, with a per capita income which is often a fraction of the income that professional providers would expect. Consequentially they require

systemic subsidies. Early interim results of the ILO/WB/U Lyon Social Re project[1] indicate that only a part of the community-based schemes (i.e. those that receive a stable subsidy other than a stop-loss deficit coverage, or those that require no regular subsidy at all) can be stabilised through re-insuring random deficits alone. Community-based schemes relying on regular contributions of insured persons will not be able to reach out to the very poor. This leaves the problem of providing coverage to communities that require high systemic external subsidies due to the high prevalence of extreme unresolved poverty.

3. Principal problems of community-based health insurance schemes

Principal nature of community based schemes

Many community-based voluntary health insurance schemes have several common characteristics. The following observations were gleaned from first hand experience in Uganda, but from a review of recent literature it can be assumed that numerous other schemes in other countries suffer the same systemic problems[2].

Community based schemes often obtain services for their covered members from one single provider, either a hospital or a health centre. Even if provider facilities have been initially created by communities, most of them now benefit from substantial external subsidies. These subsidies may take the form of payment of the salaries of core health centre staff by national or district governments or foreign donors, provision and maintenance of buildings or equipment, or general subsidies (such as donations from the Anglican Church in the case of the Kisiisi Mission Hospital in Uganda). "Micro-insurance" thus in these cases signifies a *pooled pre-payment arrangement of user fees charged by a specific (or preferred) provider.* The schemes smooth out the potential financial consequences of illness for participating families on the one hand and stabilise non-subsidy income for the (preferred) provider units on the other hand. Except for systemic external subsidies, the schemes thus principally operate on HMO principles rather than classical insurance schemes.

The need and acceptance of community-based health care financing schemes

Discussions between ILO staff and members and representatives of communities in which the schemes operate, clearly underlined the need for community-based financial pooling. It is obvious that the government and external donors are not covering the full operational cost of the provider units. Provider units are thus dependent on the collection of user fees or on other forms of subsidies from the community they serve. Apparently health centres and hospitals in many regions are fairly strict when collecting user fees. This is a perfectly rational strategy, in particular for provider units which operate on their own or closely co-operate with an affiliated community-based HC scheme. Leniency with regard to the collection of fees would undermine the credibility of the prepayment schemes. Contribution collection rates are not easily determined in an environment with weak data, but there were statements from health centres and hospital staff in Uganda indicating that in spite of rigorous fee collection policies there is a relatively widespread bad debt problem. In all cases, debtors (i.e. patients or household heads)

[1] A joint ILO-WB-University of Lyon project team won a prize at the World Bank Development Market Place to explore the feasibility of stabilising community-based schemes through re-insurance arrangements (called Social Re). More details can be found on the Development Market Place web-site of the World Bank.

[2] For an extensive listing of micro-insurance schemes and some first hand assessment of their strengths and weaknesses see ILO (STEP Project): A compendium of micro-insurance schemes, Geneva, December 1999. Further assessments are provided by Bennet , S., Creese, A. and Monasch, R. : Health Insurance Schemes for People outside formal sector employment, WHO 1998.

are registered and if they make no further effort to repay their debt, they may *de facto* lose their access to the respective facility. Community people in Uganda, when interviewed, reported that access to hospital care is their main priority. In cases of hospitalisation, many people have to sell livestock or land to pay their fees if they can no longer borrow from family and friends, meaning that the serious illness of a family member may cost that family its means of existence. In such cases, one spell of illness can mean the difference between poverty and long-term destitution, and chronic disease is almost certainly a death warrant.
The principle of replacing a potentially catastrophic expense in the event of illness with modest recurrent prepaid amounts has clear appeal to many community members, notably to women (men appear to be less responsive to the option of averting potentially catastrophic risks for the family).

Systemic and solvable problems

Most community-based schemes are young, and inevitably suffer from a variety of problems. However, some problems appear more receptive to change, while others are more likely systemic. The key problems are:

(1) Management deficiencies

The operation of a health insurance or health financing scheme, regardless of its size, requires substantial managerial skills and specific health care related management experience, as well as basic accounting and statistical skills. These basic skills seem to be lacking in many schemes[3]. It is obvious that micro-insurance schemes like all other health insurance schemes cannot be started and operated successfully during the initial phase without support from an experienced professional health care administrator, who must be available for at least one year. Longer-term management problems can and should be solved through training and coaching.

(2) The "poverty wall"

There is generally very little information available on the actual income distribution of the population actually or potentially covered by the schemes. However, especially in rural areas, cash income levels are obviously low and irregular. Cash income is highest during harvesting. Many of the families who depend exclusively on income from subsistence farming reported that it would be simply impossible to contribute on a regular basis more than very small amounts. Many schemes that cover hospital services on a regular basis demand quarterly contributions, which are simply prohibitive. If no alternative (non-cash) ways are found which permit these families to contribute (for example through direct labour, which has to be remunerated by a third party sponsor), then the population coverage of community-based schemes at least in rural areas will have natural limits (i.e. population coverage will hit the "poverty wall"). The actual *premium level elasticity of insurance coverage* is unknown, but it is obviously negative, i.e. each increase in the amount of contribution will lead to a reduction in population coverage. Even poor

[3] The following example may serve as an illustration: Due to a Ush.10 mill. deficit accumulated during 1999, the ISHAKA hospital scheme had to suspend operations in February 2000. A team of the Uganda Community Health Finance Association (UCHFA) investigated the operations of the scheme. The findings and recommendations of the investigation team indicate that the scheme suffers from all administrative, managerial and conceptual problems that an inexperienced health care management team would be expected to have to wrestle with, such as adverse selection (for example through over-proportional enrolment of chronically sick members), imperfect registration procedures, deficient contribution collection, illegitimate use of facilities (as indicated for example by a utilisation rate of 30 contacts per family in one sub-plan) as well as a general underestimation of per capita cost (see: evaluation report).

people may be able to raise enough money to pay the user fees in the event of sporadic, isolated cases of illness of family or friends or may be able to sell some of their productive capital, but they will be neither willing nor able to recurrently raise money for the payment of insurance premiums through these channels. Overcoming the "poverty wall" thus requires some systemic external subsidisation, if high coverage at the community level is a policy objective.

(3) Systemic financial disequilibrium, or the recovery gap

All micro-insurance schemes that provide a full range of ambulatory and stationary services face a structural cost problem. Benefits have to be delivered by a core group of highly skilled formal sector workers and financed from the money income of informal sector employees. This leads to a *systemic financial disequilibrium.* The following example illustrates the point.

The systemic financial disequilibrium of a typical, small community-based health insurance scheme

It is assumed that a scheme covering around 2,000[4] people would require at least the services of one medical officer, one paramedic, and one auxiliary staff to provide ambulatory care, to which one would have to add about 25% for the non-staff costs of ambulatory care (investment in and maintenance of medical technology, and the general overhead costs of a health centre). The scheme would have to employ at least one administrator (or purchase administrative services equivalent to the staff cost of one administrator)[5] and would face about the same level of cost for inpatient services and pharmaceuticals as are required for ambulatory care.[6] The health care professionals and administrator would have an average annual income of about ten times the average annual income of the insured population; the average family would consist of five people with one person economically active in the informal sector, and the 400 economically-active people financing the scheme would, therefore, have to pay about 21 per cent of their money income to finance their health care.[7]

In a formal sector context where the income differential between providers and financiers is much lower (say in the order of 3-4), the relative cost of such a scheme could be kept to the order of 6 to 8.5 per cent of family income and thus an acceptable order of magnitude (in a developing country context). If the size of the scheme fell short of a population of 2,000, as many schemes do, then the relative cost of health care for each participating family would increase further as staff costs in medical care are not necessarily a linear function of the number of covered people. The provision of out-patient services for an insured group of one thousand people would probably require the retaining of approximately the same group of health care staff as a group of 2000 people. If one assumes that staffing for the first two thousand covered people would roughly be constant for outpatient care and that the cost of hospital care and pharmaceuticals would be directly related to the number of covered persons, then the pay-as-you-go cost rates (i.e. the PAYG contribution rates that theoretically have to be paid from the

[4] This is roughly the size of a British GP practice.

[5] This is a rather optimistic exercise. The German health funds, for example, required one administrative person per 220 members in 1989, cf. Normand and Weber : Social Health Insurance - A Guidebook for Planning, WHO/ILO 1994, p.97.

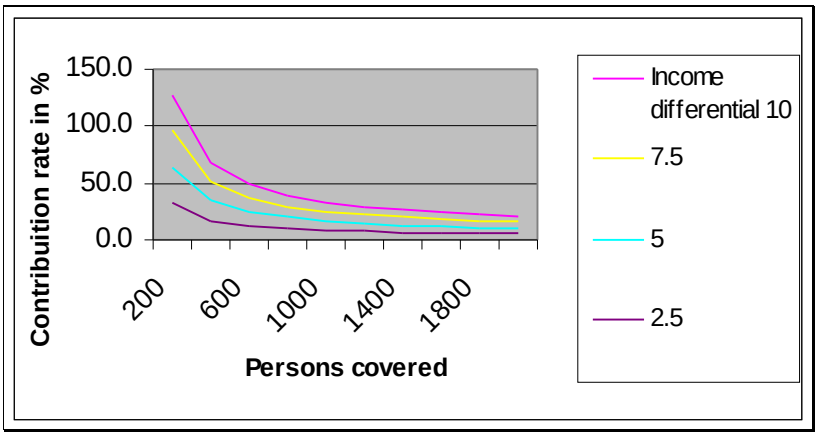
[6] This relationship reflects roughly the relationship observed in the statutory health funds in Japan in 1994, cf. Cichon et al: Modelling in Health Care Finance (ILO 1999), Table JPN 323. This is again an optimistic assumption as the referral rate in Japan seems to be less than 5% of all ambulatory visits, while the Health centre-based scheme in Kunaba and the Hospital-based scheme in Kisiisi faced referral rates of around 10%.

[7] Calculation:

CR =((1.25* 3 * AI *10 (am. cost)) + (1.25*3*AI*10) (hosp.cost) + AI*10 (Admin.cost)) / 400*AI=85/400=0.2125.

cash income of insured persons) for different levels of income differentials between health sector professionals and informal sector workers would look as follows:

Figure 1. Theoretical contribution rates in micro-insurance schemes by number of persons covered and provider/financier income distribution



Much more detailed country- and community-based studies would be necessary to confirm the above pattern. However, some systemic conclusions can be drawn from the example. The model calculations show that a cost-covering contribution rate for a provider/financier income differential of over 5 would never be lower than 10%, and could even be expected to be much higher, particularly for small schemes. This theoretical exercise clearly demonstrates that to cover the full cost of a comprehensive range of services, the contribution rates of small schemes will most certainly be prohibitive. Bigger schemes would require more staff (although the relationship is not linear) and the pattern of the above cost curves would most likely simply repeat itself for a higher bracket of covered persons.

Thus there appears to be little hope that community based insurance schemes in informal sector settings could ever achieve the full cost of recovery, i.e. in most schemes there would remain a *recovery gap* between the total cost and the total amount of contributions that can be recovered. They will always be dependent on external subsidies. The problem would be aggravated if, in addition to basic health service coverage, other crucial basic social protection benefits like invalidity cash benefits or basic relief of extreme poverty were added to the benefit package.

These three systemic problems lead us to conclude *that many micro-insurance schemes will never be able to operate as stand alone schemes independently from other financing systems.*

4. Elements of a solution

If one assumes that substantial increases in government social budgets (particularly including health) sufficient to permit the operation of an effective national health service are a rather remote possibility in most developing countries, then other systemic solutions have to be sought. These solutions should incorporate the following elements:

(1) National/international solidarity

The poor cannot take care of the poor alone. Thus, ways and means must be found to maintain or introduce a certain level of national or - in case all institutions of national governance fail - international subsidy for the poor.

(2) Community participation

The potential of community contribution has to be exploited. Being poor does not automatically imply the right to default on any self-responsibility. Thus, when it comes to social protection and health care financing, every able-bodied and -minded person of active age should contribute either in kind or in cash. In-kind contributions can, for example, take the form of voluntary community service.

(3) Potential full community coverage

Everybody in a community with a community-based health care financing scheme who wants to be covered should be covered. There should be no involuntary social exclusion at the community level.

(4) Acceptance of a certain degree of inequality

In societies with a disparate and very unequal income distribution, as is the case in most developing countries, the access and quality of health care cannot be equal for everybody. Inequality has to be managed to avoid it turning into gross social injustice, but a certain degree of inequality is unavoidable and has to be accepted. This runs counter to some long-held beliefs in National Health Service Schemes and Social Insurance schemes, but realism often does.

5. Satellite social insurance schemes - A solution?

One possible option - the one championed here - is to combine "macro-solidarity" with community involvement, and would be to organise community-based satellite insurance schemes linked to national social insurance schemes. The organisation, support and subsidisation of these satellites could eventually become new branches of national social insurance schemes (SI schemes). Instead of trying to reach out to the informal sector with a standard benefit package and standard contribution provisions, social insurance could play a role in the organisation and subsidisation of community based schemes. It could play the 'godfather', for example, acting as tutor, sponsor or even supervisor for community-based schemes.

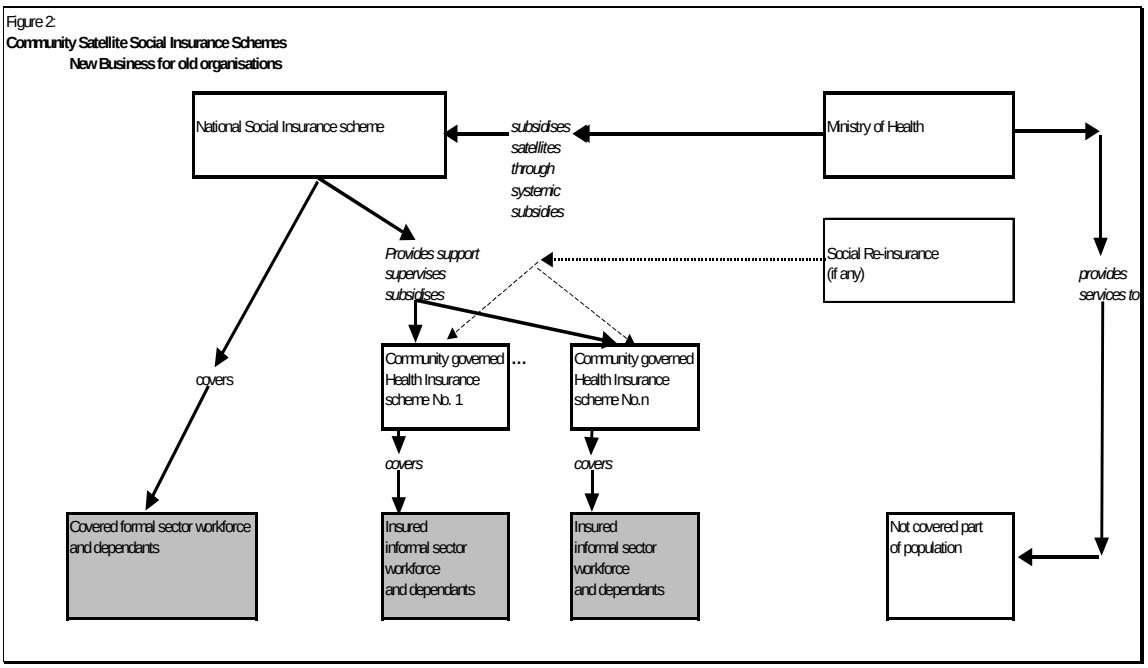
A contract could be concluded between community satellite insurance schemes (CSIS) and SIs that would envisage a certain degree of subsidisation of the CSIS through the SI. The contractual arrangements could contain a number of obligations for the CSIS, such as:

- maintaining an open enrolment policy,
- offering a minimum benefit package,
- maintaining a minimum set of accounting and statistical standards,
- employing standard administrative procedures,
- accepting regular auditing by the SHE, and
- being governed by a board elected by the local community.

The subsidy that the SI provides for the CSIS which thus becomes a social insurance **satellite**, could be re-financed in full by the government, or an international donor which could be conditional on achieving full (or nearly full) population coverage in a community. The

agreement could for example envisage that if the satellite financed all ambulatory health care, then co-payments in government and certain other hospitals would not be charged for insured persons. A prerequisite would be that the outpatient delivery units would exercise an effective triage function for the hospitals, and would not try to reduce their own costs by off-loading on to hospitals. These schemes could be an alternative to voluntary stand-alone micro-insurance schemes. Satellites could thus benefit from a systemic subsidy filling the recovery gap, and random variations in annual expenditure or benefit experience could be covered by a social re-insurance arrangement. Social Re-insurance would stabilise the contribution-financed part of total expenditure of the CSIS schemes and would also protect the government from assuming implicit contingent liabilities. Contingent liabilities for the government could arise if political pressure were to force the government or the intermediary SI to support the CSIS in "bad years" beyond the agreed amounts of systemic subsidies. Figure 2 depicts the potential role of satellite schemes in a SI and re-insurance context[8] in the health sector. For simplicity's sake the graph does not show that there might be co-existing voluntary private insurance schemes or non-satellite community based schemes.

Figure 2. Community Satellite Social Insurance Schemes : New business for old organisations



6. Potential obstacles and problems

Implementation of this scenario could encounter the following principal problems:

(1) The combination of community participation and supervision by SI might pose a governance problem. SI supervision should thus be restricted to technical and financial audits (as for example national insurance commissions or supervisory agencies provide for private insurance companies).

[8] The idea of social re-insurance in the environment of voluntary community-based health insurance schemes is presently being tested by an ILO/World Bank/University of Lyon team. That team won the World Bank Development market place competition for innovative ideas in development in 2000.

(2) The system can only function in the long run, if
   a) the quality of social protection including access to health care in the community is of a sufficient standard and actually improves, otherwise people will not be willing to contribute, and
   b) the consequence of a) is that there must be a net increase of resources going into the provision of social protection to insured persons, which - assuming that the amount of government inputs into the social protection system cannot be easily increased - can only be realised by a more efficient use of resources and an increased over-all resource mobilisation of the community, or a systemic sharing of the cost of the community-level satellite by the SI (or other sponsors). This may be justified since subsidising satellites may be a good investment for the long-term extension of 'classical' SHI coverage.

      In-depth studies are necessary, and should assess whether the total additional resource allocation makes the operation and satellites financially feasible and whether it could lead to effective improvements in the quality of care. Satellites would make no sense if the additional resources simply flowed straight into additional administrative expenditure.

(3) The introduction of another form of (partial) third party financing will inevitably have an influence on the behaviour of patients and providers. Careful cost monitoring would have to ensure that additional resources do not simply increase inefficiencies.

7. The way ahead: Piloting the model

A detailed and well-monitored pilot study is necessary to test the concept. A candidate country has to be found where:

a) a well governed social insurance scheme exists which operates at a minimum level of efficiency,
b) the scheme and the MOH are interested and willing to test a new form of extension in at least two or three locations.

As already said, the ILO is looking for volunteers.

Annex 2

NON-CONTRIBUTORY PENSIONS AND SOCIAL PROTECTION

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September 2002

1. Introduction

The issue of pensions for the poor is central to the extension of social protection in developing countries. The process of population ageing will accelerate in the developing world in the first half of this century, and the association existing between old age and poverty is as striking there as it was in advanced economies in the aftermath of their industrialisation. To date, most developing countries have given very low priority to population ageing and to old age poverty, seeking instead to focus anti-poverty programmes on prime age individuals and the young. Policy makers have commonly assumed that older people have little to contribute to the development process. The impact of the HIV/AIDS pandemic in the developing world provides a sharp refutation of these views. In countries affected by the pandemic, many traditional multigenerational households have become missing-generation ones, with the responsibility for sustaining the household falling squarely on older people. Rapid economic and social change in developing countries is having similar effects, and migration, unemployment, and globalisation, have further implications for intergenerational support. Pensions for the poor are therefore an urgent issue for developing countries.

There is an emerging consensus among multilateral institutions about the need for developing countries to strengthen and develop social protection policies and programmes in response to economic crisis and rising vulnerability (IADB 2000; Asian Development Bank 2001; ILO 2001; World Bank 2001).[9] Social protection has been defined as consisting of "public actions taken in response to levels of vulnerability, risk, and deprivation which are deemed socially unacceptable within a given policy or society" (Conway, de Haan et al. 2000). It covers a wider range of programmes, stakeholders, and instruments than alternatives such as, 'social security', 'social insurance', or 'safety nets'. The new consensus around social protection as the framework of social policy in developing countries is a consequence of globalisation trends which increase risk and vulnerability, and therefore the demand for social protection, while at the same time restricting the capacity of governments to respond (Rodrick 1997; Alesina 1999; Tanzi 2000). In this context, social protection can provide a more appropriate framework for addressing rising poverty and vulnerability in the context of current conditions prevailing in developing countries.

The distinctiveness of social protection lies in its emphasis of risks and vulnerability as the main factors behind poverty and deprivation. Social protection identifies the key risks affecting households in developing countries, and the policy interventions which could help households prevent, ameliorate, or cope with the materialization of these risks. Social protection therefore has a strong poverty focus. It places great importance upon the labour market as a major source of risk and insurance for poorer households. It includes a wide range of stakeholders and providers, including public providers, private providers, NGOs and other not-for-profit agencies, at both a national and international level. And it gives households an important role in the management of their assets to address their risks and vulnerabilities. Social protection recognises the central role of governments and public providers, but argues that this should be developed in partnership with the other institutions listed above.

Within social protection, pensions already play an important role, but to date the emphasis has been on contributory pensions. On paper, most multilateral agencies concur in the desirability of

[9] There are also important similarities between social protection approaches and the sustainable livelihoods approach of the UNDP and DFID.

establishing and developing multi-pillar pension systems in developing countries. However, in practice interest has centred on the second, contributory pillar, at the expense of much needed discussion about a first, tax-financed basic pension pillar.[10] Yet this first pillar is more likely to have an effect on growing poverty, risk and vulnerability, in developing countries. A useful first step in focussing attention on first pillar pension programmes is to review the evidence emerging from the handful of developing countries with established cash transfer programmes for the old. This paper aims to make a contribution in this respect.

Table 1 below provides basic information on non-contributory pensions in a handful of countries in Africa and Latin America.

Table 1. Old age non-contributory pensions in Africa and Latin America

Country	Type	Age of entitlement	Monthly benefit in US$	Number of Beneficiaries
Botswana	Universal	65	23	71,000
Mauritius	Universal	60	55	109,000
Namibia	Universal	60	26	82,000
South Africa	means tested	M65, W60	80	1,800,000
Costa Rica	means tested	65	30	41,620
Argentina	means tested	70	105	120,006
Chile	means tested	70	60	163,338
Brazil urban	means tested	67	108	1,963,160
Brazil rural	means tested	M60 W55	108	4,305,300
Uruguay	means tested	70	90	64.600
Bolivia[a]	universal but cohort restricted	65	20	NA

Data points are for 1999/2000.
[a]. Bolivia's programme was intended to provide an annuity payment to all aged 60 and over in 1995. It began operating in 1997 but was discontinued in 1998.
Sources: (Barrientos 1998; Fultz and Pieris 1999; Willmore 2001; Bertranou and Grushka 2002; Schleberger 2002; Werneck Vianna 2002).

The concept of non-contributory pensions would seem self-explanatory, but is in some ways misleading and ambiguous. It is inaccurate to refer to these pension schemes as non-contributory in the sense that most, if not all, beneficiaries make a contribution to their economies and societies. They are non-contributory in the very limited sense that payroll contributions usually constitute a pre-requisite for entitlement to social insurance schemes. This is itself problematic, where the contributory record required is in practice a simple, and sometimes meaningless, administrative hurdle.[11] Cash transfer programmes for the old is perhaps a more accurate term for the schemes considered here. Table 1 distinguishes between universal pension schemes covering all citizens regardless of their financial situation, and schemes including a means test.

[10] A full discussion of the reasons why this agenda has dominated pension debates is outside the scope of this paper, but see (Barrientos 1998; Mesa-Lago 1999; Muller 2000).
[11] In Brazil, for example, supporting letters from the local trade union or producer association, and in Uruguay, two affidavits from ex-colleagues or acquaintances, are required to establish contribution requirements.

In some countries, entitlement to pension benefits also requires an inactivity test, with important implications for the labour force participation of beneficiaries.

2. The evaluation of non-contributory pension schemes

The paper evaluates the impact, effectiveness and sustainability of these cash transfer programmes, and draws some conclusions about the feasibility and potential benefits of establishing these programmes more widely in developing countries. The evaluation of these programmes is complex because they address a variety of objectives and they have measurable impact on a variety of dimensions. The heterogeneity of conditions observed in developing countries adds a further layer of complexity to the evaluation. Cash transfer programmes for the old have important effects within three specific dimensions. Firstly, these programmes can have a strong impact on reducing poverty and vulnerability among older people as individuals. Second, they have effects upon aggregate poverty because of their considerable advantages as a demogrant: a benefit that targets the poor because of the strong association between old age and poverty, or more precisely, between poverty and households containing older people. It is important in this respect to determine the relative advantages of pension schemes over alternative social protection programmes. Third, cash transfer programmes for the old can work as an instrument of development policy, by encouraging and facilitating investment in physical, human, and social capital. As such, it is necessary to assess the secondary effects of pension provision on social and economic investment. A brief discussion of these three areas of evaluation follows.

The immediate objective of cash transfer programmes is to alleviate hardship among older populations. In most societies, vulnerability rises with age for numerous reasons: a decline in job opportunities (especially in formal employment), reduced pay for those in employment, increased vulnerability to health conditions, limited mobility, discrimination in access to credit and financial markets, restrictions in access to basic services, such as education or health, and changes in household composition and status. These justify focusing social protection programmes on the old, not just in order to compensate for declining opportunities, but also to facilitate older people's efforts to cope with their increased vulnerability. It is an issue, in this respect, that in most of the countries reviewed, benefit levels are set at a minimum income standard, be it the national poverty line or the minimum wage. In other countries, the benefit level is set at below the poverty line.[12] The vulnerability of older people also influences their status within their households and communities, and pension provision can have an impact on these. Cash transfer programmes to the old may empower older persons, and thus improve agency.

In developing countries most older people live in multigenerational households, and so their poverty and vulnerability, and the likely impact of pension benefits on these, is as much a household issue as an individual one. Pension provision has the potential to impact on poverty on a wider scale than just older groups. To the extent to which co-residence of older and younger people is more common in developing countries, and given the absence of comprehensive 'safety nets', pension benefits can have a wider role in poverty alleviation.

Households are both providers of support and economic units. The inability of poorer households to invest in the productive capacity of their members, especially the education and

[12] This is why the words 'alleviation' and 'hardship' are used above. In fact, a necessary step in extending cash transfer programmes to the old is to raise the level of benefits at least to the national poverty line.

health status of children, has implications for the persistence of poverty and deprivation. This also applies to the issue of physical investment, as in the seeds and tools needed for agricultural production, or the basic equipment for home production of garments. Cash transfer programmes to the old providing a steady, and reliable, source of income can have significant effects upon the capacity of households to invest in human and physical capital, and overcome the threat of long term, persistent poverty.

This paper examines these three dimensions of evaluation: the impact of pensions on poverty and the status of older persons, their impact upon aggregate poverty, and their impact upon the economic activity of the household. Chart 1 shows in summary form these key dimensions, as well as requisites for success and instruments for evaluation.

Chart 1. Evaluation of non-contributory pension schemes

Social Protection Dimension	Conditions for applicability	Design Issues	Impact Indicators
Poverty and vulnerability of older people	§ Correlation of old age and poverty § Political Support	§ Adequacy of benefits § Administration	§ Reduction in old age poverty § Improvement in status of older people
Aggregate poverty	§ co-residence of old and young § intergenerational support norms	§ Effectiveness of tagging in improving targeting and reducing costs	§ reduction in aggregate poverty and vulnerability
Household investment	§ Older people's influence on household expenditure § Intergenerational support norms	§ Regularity and certainty of benefit § absence of means test § absence of inactivity test	§ Improvement in school enrolments § Improvement in health status § increased economic activity § Reduction in chronic poverty

The main part of the paper draws on existing evidence to assess the impact of non-contributory pensions in these three dimensions. In addition, the paper considers the administration and financing of these programmes, and the feasibility and desirability of establishing them in low income countries. The paper will draw on the experiences of a number of countries in sub-Saharan Africa and Latin America. Particular attention will be paid to South Africa and Brazil, reflecting the scale of their programmes and the degree to which they have been studied. Box 1 provides some background on the programmes in these two countries.

Box 1. Key features of non-contributory old age pension schemes in South Africa and Brazil.

South Africa

A universal pension benefit paid to men aged 65 and over and women aged 60 and over has been in operation through the 1990s. The programme began as a means of providing a basic income in retirement for whites who lacked an occupational pension. Subsequently, the programme was extended to Coloureds and Africans, but with different conditions for entitlement and benefit levels. After the fall of apartheid, parity in the provision of the social pension was instituted, at a reduced level than that enjoyed by the whites. Africans are now the main beneficiaries. The scheme is funded through general taxation and pays relatively generous pensions (around US$3 a day). Benefit entitlements are means tested on the income of the individual beneficiary, and partner if married, but not on the income of other household members. They produce a significant redistribution of income in a country where, on average, the incomes of Whites remain ten times that of Africans.

Brazil

Limited provision of non-contributory pensions for workers in the rural sector dates back to 1963, but entitlements were restricted to the very old. The scheme was gradually up-graded during the 1970s, in response to mobilisations of rural workers and pressures for land reform. The 1988 Constitution recognised the right to social protection for workers in the rural sector, and especially for those in informal employment. This led to a range of reforms which were implemented in 1991. Firstly, the age of pension eligibility was reduced from 65 years of age to 60 for men and 55 for women. Entitlement to old age, disability and survivor pensions was extended to workers in subsistence activities in agriculture, fishing and mining, and to those in informal employment. Whereas prior to 1991 only heads of household were entitled to a pension, the reforms extended entitlement to all qualifying workers, thus expanding coverage to female rural workers who were not heads of household. The value of the pension benefits was raised from 50 to 100 percent of the minimum wage.

A key aspect of the programme is that access to pension entitlements does not require earnings or inactivity tests. Estimates of the coverage and cost of the programme for 1998 suggest that 4 million households include at least one beneficiary, at a cost of US$10 billion.

3. Cash transfers, poverty and deprivation

The available evidence from developing countries clearly demonstrates that cash transfer programmes have a significant impact on poverty among older people and their households. Precise measurement of the impact of specific programmes on poverty is a considerable challenge because of the difficulties involved in establishing the counterfactual as a benchmark. As a result, studies have focused on determining whether cash transfer programmes target the poor, and on comparing the adequacy of household income with and without the pension income component.

A study of South Africa's social pension by Case and Deaton used a US$1 per day poverty line to examine the impact of the pension programme on poverty. Using data for 1993, the authors estimate that the poverty headcount would have been 5 percentage points higher at 40 percent if "the pension incomes were removed and there was no offsetting charges in pre-pension incomes" (Case and Deaton 1998, p.1342). The gross impact of pension incomes is to reduce poverty by 12.5 percent. A recent study on Argentina relying on data from 1998 (i.e. before the current economic crisis) finds that headcount poverty rates among households with a non-contributory pension recipient aged 65 or over would be 5 percent higher if their pension income were left out (Bertranou and Grushka 2002).[13] Interestingly, extreme poverty would have been 16 percent higher in the absence of pension incomes.[14]

A study on the rural social pension in Brazil compares headcount poverty among households with a pension beneficiary and those households without one (Delgado and Cardoso 2000). Using a poverty line of half the minimum wage, it finds that headcount poverty is substantially higher among households without a pension beneficiary. In the Northeast region of Brazil, 51.5 percent of households without a pension beneficiary have per capita incomes below one half of a minimum wage, but the figure is only 38.1 for households with a pension beneficiary. In the South of Brazil, the figures are 18.9 and 14.3 respectively. The authors of the study conclude that rural pensions have therefore large effect on rural poverty in Brazil.

A key issue here is whether pension benefits are well targeted on the poor. In terms of the evaluation of the effectiveness of cash transfer programmes, this is of greater relevance for universal than for means tested ones. It is also important in countries like Argentina, where discretionary pension awards are made and administered under the same programme. Some commentators have argued that the link existing between old age and poverty in advanced economies and some middle income developing countries is weak (World Bank 1994; Whitehouse 2000). There is, unfortunately, only sparse information on old age poverty in low income countries, but the information that exists suggests a strong link between later life and poverty. In middle income countries, the evidence for this is mixed, but for most countries poverty rates among older people are similar to poverty rates for the population as a whole.

[13] The study focuses on all non-contributory programmes, but focusing on households with older persons is more likely to reflect the impact of old age pensions.

[14] Extreme poverty applies to households whose income is less than a basic basket of food (around US$ 2.3 a day for Buenos Aires in 1999). The poverty line is defined as the cost of a minimum basket of food and non-food goods and services.

Furthermore, conventional techniques for estimating poverty rates are likely to bias downwards poverty among the old (Barrientos, forthcoming). [15]

The discussion in this section has implications for the extension of cash transfer programmes in a universalistic direction, and as a core anti-poverty programme. To the extent that there is a close correlation existing between old age and poverty in developing countries, that pension income is fungible with other income sources within the households, that co-residence of young and old is common in developing countries, and in the absence of comprehensive safety net programmes, cash transfers to the old can provide effective social protection.

4. Non-contributory pensions and household dynamics

The experience of the West suggests that "development" is associated with an increasing proportion of older people living alone (Ruggles, 2000). A key part of this process has been the extension of pension provision, which has increased recipients' financial autonomy, thus facilitating residence away from younger relatives. However, the limited evidence from developing countries shows that rapid socio-economic change does not inevitably lead to comparable trends (Palloni, 2000). In most low and middle income countries the great majority of older people typically live with younger relatives, often in extended households, or in "skip generation" ones (i.e. with grandchildren but not children). For example, a 1993 South African survey found that 61 per cent of African pensioner households contained three generations, and a further 14 per cent were skip generation ones (Case and Deaton, 1996).

In some contexts, cash transfers may increase incentives for other family members to live with elders, and may create new possibilities for intergenerational reciprocity. This is likely to be particularly evident where sources of alternative income for younger generations are scarce. Edmonds et. al. (2001) studied the effect of the pension on black South African households. They found no increase in the propensity of older people to live alone. Instead, they observed a rise in the number of children living in pensioner households. Where the pensioner was female, the increase in children aged up to six was particularly marked. For Brazil, Camarano (2002) reports that in the years following the extension of pension entitlements there was an increase in co-residence with grandchildren for elder-headed households. This was particularly apparent in poor rural areas and where the head was female. As a result, by 1999 about 12 per cent of all children aged under 14 lived with an older person.

Access to cash transfers may increase the flexibility of household structures to respond to vulnerability and opportunity. This can be seen in a study of Namibia, which suggests that the pension increased levels of migration from rural areas (Adamchak, 1995). By providing a secure income, young adults were freer to leave households, while remaining members cared for children. This can give young adults a chance to take the risk of migrating without a definite job, or to extend the employment search process if they cannot send remittances back home.

Non-contributory pensions are usually pooled within households, and pooling has been found to be particularly important in contexts of poverty (Saad, 1999; Burman, 1996; Sagner and Mtati (1999). In contexts of very high unemployment, old age pensions frequently represent the only reliable source of income for entire households (Ardington and Lund, 1995). By 1999, Brazilian

[15] Further analysis is needed to identify any impact of pension receipt on consumption patterns. Case and Deaton investigate this issue in the context of South Africa and find no significant difference between expenditures financed from pension and non-pension income (1998).

elders were contributing more than half the total income of the households in which they lived, with the pension benefit accounting for a large share of this contribution (Camarano, 2002). There are indications that older women are particularly inclined to pool their pension income.

Across African societies, the central role of grandparents in caring for young children is well recognised (Moller, 1994; Bozalek, 1999; Mohatle and Agyarko, 1999). For example, in a survey of African women aged over 60, Burman (1996) found that 83 per cent provided significant childcare, which was almost always unremunerated. Given this role, it is likely that young children will derive large, direct benefits if their grandparents have access to a reliable flow of cash income. In South Africa, children with a low household per capita income are more likely to be living with a pensioner (Case and Deaton, 1996). Consequently, the country's pension disproportionately reaches impoverished children.

There is a small but growing body of evidence that access to non-contributory pensions can improve the health status of young children, by improving their nutrition and access to drugs and health care. One study from South Africa found that pensions received by women had a significant impact on the anthropometric status of girls (Duflo, 2000). Subsequent research found that for both African and coloured people, the presence of a pensioner was positively correlated with childrens´ height: the presence of one pensioner is associated with an additional 3 to 4 cm (Case, 2001). Similarly, it is thought that access to a non-contributory pension may also influence childrens' attendance at school and pre-school, by reducing the need for young children to work and by helping with school-related expenses. De Carvalho Filho (2000) found that Brazil's rural pension was significantly associated with increased school enrolment, particularly for girls aged 12 to 14. The effect was particularly strong when they were living with female pensioners. In South Africa, the relationship has been harder to isolate, due to numerous intervening effects. Since the country's pension was up-graded, school feeding programmes have been introduced and there have been renewed efforts to improve the educational infra-structure of poor areas (Moller and Devey, 2001).

There are good reasons to believe that access to pension benefits improves the status of older people within their households. At the very least, non-contributory pensions create an incentive for household members to extend the survival of the beneficiary, in order to guarantee the continuity of this cash stream. However, the effects on pensioners' status are likely to go beyond this basic consideration. Insights from gender studies suggest that access to an independent source of income is likely to increase the power and status of an individual within a household. This is likely to be especially significant for older women, who suffer the combined disadvantages of their gender and age. As frail older people become increasingly dependent on their families for instrumental as well as financial support, their access to a cash transfer may reduce power asymmetries in inter-generational relationships. This becomes especially important as their ability to make reciprocal household contributions, such as childcare, diminishes.

The abuse of older people within households is not well documented in developing countries, but there are indications that it is widespread and serious (Breslin et. al., 1997; Mohatle and de Graft Agyarko, 1999). Access to a pension does not guarantee that such abuse will not occur; indeed, there are anecdotal reports of older people surrendering their pensions to other relatives against their will. Burman (1996) recognises that the quality of elder care in South Africa is far from ideal, but adds: "the dependence of the family on their pensions at least ensured a roof over their heads, a modicum of food, and, for those with more dutiful children or in a better position to assert themselves, incorporation into a family structure and even some power within it." (p.591).

As well as increasing the *incentives* for households to care properly for elders, non-contributory pensions can strengthen their *capacity* to do so. Research from Ghana found that the worsening economic situation of younger generations was often the main reason for reduced support for elders (Aboderin, 2001). The expense of caring for frail older people, including medical care and opportunity costs, should not be under-estimated. In a context of extreme poverty and household vulnerability, it may prove impossible to reconcile cultural norms of reverence and support for elders with daily demands of care-giving.

Rather than promote household support, it is sometimes argued that formal pensions and other cash transfers may "crowd out" other forms of informal support for vulnerable groups (World Bank, 1994). However, empirical evidence for this is scant and inconclusive.[16] Jensen (1996) investigated the relationship between South African migrant remittances and the presence of a pension in the household which the migrant left to find work. He found that for each Rand of pension income, there was a 40 to 50 cent reduction in migrant remittances. He notes that the net effect is a transfer of income to urban areas, which is where most migrants reside. Subsequent research by Posel (2000) questions the directness of this relationship, noting that the scale of remittances is influenced more by the nature of the remitting household than by the pension status of recipients. If the remitting household contains children of school age, they are less likely to send money. This shows that, rather than the pensions, it is competing claims within the remitting household which crowds out transfers.

In low income countries very few people of pensionable age live alone. Consequently, non-contributory pensions should be understood in terms of a transfer to households, not to elderly individuals. There are clear signs that older people, particularly women, are inclined to allocate this income in ways which directly benefit more vulnerable household members, such as young children. For older people in good health, access to a dedicated cash transfer can strengthen their capacity to contribute to household welfare on a number of different fronts. This may cement their position of household heads, and enable them to hold families together in the face of crises associated with AIDS and extreme poverty. In the case of very old and frail individuals, access to a dedicated cash transfer may at least guarantee a basic level of care and status within households, and reduce the risk of abuse.

5. Cash transfers and coping with HIV/AIDS

Levels of HIV/AIDS infection among older age groups in developing countries have been significantly under-reported (UNAIDS, 2002). However, the principal impacts of the epidemic on older people are indirect: changes in household structure, loss of income, healthcare consumption needs, community breakdown and so forth. Increasing attention is being paid to the role of grandparents in caring for people with AIDS, as well as surviving relatives, such as grandchildren (Mupedziswa, 1997; Williams and Tumwekwase, 2001). To date, reliable empirical research about these issues in Africa remains scant. One exception is a series of four surveys in six districts of Uganda (Ntozi and Nakayiwa, 1999a and 1999b), which found that:

- Between 1992 and 1995, the number of households headed by over 61 year-olds rose from 23 to 27 per cent.

[16] The best-known study is by Cox and Jimenez (1992), which claims that informal transfers to older people in Peru would have been significantly larger if there were no social security scheme in operation there.

- In 1995, parents were the main group of prime carers for AIDS patients, accounting for 32 per cent of cases.
- In 1995, grandparents were the main group of prime carers for AIDS orphans, accounting for 34 per cent of cases.
- Over half of those surveyed reported that a lack of reliable funds was a major impediment for orphan care.

An on-going WHO study of 685 households affected by AIDS and containing older people in Zimbabwe found that in 84 per cent of cases, elders were the main care givers for orphans and children with AIDS. The survey stresses the financial problems faced by older carers, including the loss of remittances and other financial support, a lack of food and clothing, high cost of medical fees during illness, an inability to pay school fees for orphans, a loss of economic support and diminished livelihood opportunities (WHO 2002).

These findings highlight the importance of older people as carers for both orphans and children with AIDS in Africa. No completed studies are yet available to assess the effects of cash transfers on the capacity of households to perform these roles. However, there are numerous reasons to believe that such transfers could be of great importance. As seen above, pension income is usually pooled within households, and younger members have been demonstrated to benefit from it. The presence of a steady income stream is likely to help households with the costs of medication, meet funeral expenses, and compensate households for the illness and death of breadwinners. At first sight, non-contributory pensions may appear to be an unaffordable luxury in the context of high HIV/AIDS prevalence. However, they may actually represent a key tool for helping households and communities deal with the crisis.

6. Non-contributory pensions and beneficiary health status

The limited epidemiological evidence indicates that older people in regions such as sub-Saharan Africa are exposed to avoidable and unnecessary levels of morbidity and mortality (McIntyre, 2002). In part, this reflects a strong bias of existing health care services towards mothers, children and “people of working age” (Lloyd-Sherlock, 2000; Mohatle and de Graft Agyarko, 1999) . It also reflects a lack of access to cash income in households containing elders. Both of these problems are particularly severe in rural areas, which is where the majority of older people in sub-Saharan Africa continue to live. Survey data from Tanzania, the Ivory Coast and South Africa show that per capita spending on health services by people aged 50 or more was significantly higher than for other age groups (in South Africa it was 4.5 times higher). However, data for Tanzania and Ivory Coast (where pension schemes are weakly developed) found that significantly higher proportions of those aged over 50 did not seek treatment when ill than was the case for younger age groups (McIntyre, 2002). With the introduction of user fees in many developing countries from the early 1980s, the link between access to cash and access to health services became more direct (Russell, 1996). Relatively few countries have included older people in those groups exempt from paying user fees. Panel survey data from Kwazulu Natal in South Africa indicate that user fees had a particularly strong effect on the health service utilisation of people aged 50 and over (McIntyre, 2002).

As such, it would seem likely that access to a cash benefit will significantly improve the health status of beneficiaries. There is already some evidence to support this possibility. A recent study in South Africa found that older people in receipt of non-contributory state pensions had a significantly better health status than other household members, controlling for age, sex and

other factors, when the pensioner did not pool their resources with the rest of the household (Case, 2001). In households that pooled all their income, the health status of all members of pensioner households was significantly higher than in households which did not contain a pensioner. It has also been found that self-reported health status for South African women improves dramatically when they reach 60 years of age, which is when pension eligibility begins (Case and Wilson, 2000).

There are strong associations between poor health and household poverty. Sustaining the health of older people increases their capacity to continue in economic activity or to contribute to households in other ways. It also reduces the potential burden of care on other household members. The positive health effects found in South Africa suggest that the benefits of non-contributory pensions may off-set pressures on health provision, in which older people are becoming increasingly significant.

7. Potential impacts of cash transfers on the economic activity of older people and their households

Cash transfers for the old constitute a significant injection of income for poor communities, especially in rural areas. Evidence from countries with non-contributory pension schemes suggests that these benefits provide an important stimulus for economic activity in poorer communities. Delgado and Cardoso (2000) consider this in the context of rural regions in Brazil. Their analysis of household survey data shows that around one half of respondents use their pension benefits to finance rural economic activities, and that, against a background of the introduction of extensive liberalisation in the country's agricultural sector, benefits performed an important insurance function. The regularity, certainty, and liquidity of pension benefits meant that they played a key role in shifting households from subsistence to surplus agriculture. Similar observations have been made in South Africa, where pension benefits have been associated with the establishment and expansion of micro-enterprises, as well as other forms of household economic activity. In remote rural communities, the injection of liquidity can have a major impact, and pension payment days attract traders and create markets. In this way, pension benefits can have a large multiplier effect on local communities.

Evidence about the impact of pension provision on the labour supply of beneficiaries and their dependants is more mixed. Basic economic theory suggests that pension benefits will have an income effect on beneficiaries: an injection of income unrelated to employment may have the effect of reducing incentives for work. This income effect is exacerbated by any means tests which reduce incentives for earnings above allowable amounts, or by inactivity tests which require beneficiaries to stop working. In practice, it is difficult to disentangle these effects from what would have been the case in the absence of pension benefits. In Brazil, where no means or inactivity tests are applied as a requisite to accessing benefits, there is some evidence that this encourages continued activity by older people (Delgado and Cardoso, 2000). However, aggregate data from Brazil shows a decline in the activity rates of older people over time. Analysis is hampered by the difficulty in controlling for age-declines in job opportunities which have become more pronounced in the 1980s and 1990s in most Latin American and African countries. What can be said with some confidence on this issue is that means and inactivity tests associated with cash transfers to older people reduce incentives for work, and restrict their potential economic contribution.

8. The financing of cash transfer programmes

In most developing countries cash transfers for the old are mainly financed from general government revenues. It is in the nature of these programmes that no other source of finance has in the past been available. However, alternative sources of financing must be explored if programmes of this type are to be established in low income countries, as their tax base is slim. Also for middle income countries, new funding channels are needed to ameliorate the cyclical pattern of government spending. In Brazil sources of financing for non-contributory benefits include transfers from the social insurance programme (which in turn collects contributions from employers and employees in formal employment), revenues from excise duty, and taxes on large firms. For the rural pension programme, a tax is also levied on sales of agricultural produce, although the revenues from this cover only one tenth of benefits, and the majority of funding still comes from the urban social insurance scheme and government revenues (Schwarzer and Delgado 2002). Bolivia's (now indefinitely suspended) basic pension benefit was financed in part from a fund set up with the proceeds of privatisations.

For very low income countries, regardless of local political commitment, external sources of financing are likely be crucial to the establishment of such programmes. There are no signs that community sources of finance can make a significant impact, especially as micro-insurance and micro-finance normally exclude older people. Experience of community financing in other areas, notably the provision of health and water services includes some important successes in Africa and beyond (Precker et. al., 2002). However, there are no reported examples of community financing playing a major role in pension provision, and the prospects for this do not look strong.

Long-term external financial commitment to universal, non-contributory benefit schemes may seem, at first sight, quite unrealistic. However, it should be noted that the overall costs of such programmes are not very large. As expected, these are larger in countries with universal provision. In Namibia, the old age cash transfer programme requires just under 2 percent of GDP (Subbarao 1998; Schleberger 2002). In South Africa, estimates of the costs of the social pension estimate it at between 2 and 3 per cent of GDP (Barrientos 2002). In Brazil, the cost of the rural pension programme is around 1 per cent of GDP. In Argentina, the costs of the entire non-contributory benefit programme, of which old age pensions account for a fraction of expenditure, averaged 0.20 percent of GDP in the period 1994-2000 (Bertranou and Grushka 2002). Clearly, the amounts involved are important, but considerably smaller than other social sector programmes. Concerns about the rise of pension liabilities as a result of population ageing fail to take account of economic growth and rises in incomes following development, and of the impact of the pension programmes themselves. Ideally, these would enable such programmes to become less dependent on external support over time.

The scope for developing cash transfer programmes for the old may be strengthened by their integration into existing social insurance pension schemes. There are numerous examples of this in Latin America. In Uruguay a first tranch of pension contributions are directed to a fund to pay for basic first pillar pensions which includes a non-contributory component. This follows from the solidarity and redistribution objectives built into the pension scheme. The Colombian individual capitalisation pension scheme also includes some transfers from pension contributions to a fund used to integrate poorer, older heads of household into the pension plans. This is an avenue for financing which is worth exploring, but which has the effect of linking the financing of the non-contributory programmes to strongly cyclical and politically complex governance systems.

In sum, cash transfer programmes for older people are eminently affordable for many developing countries. Where they exist, these benefits are usually funded by government transfers. However, the contracting tax bases of developing countries associated with globalisation, and the cyclical pattern of government spending, makes it imperative to consider alternative sources of finance. In very low income countries, external financing is a possibility, while in middle income countries, integration of the cash transfer programmes with existing pension provision could provide another source of financing.

9. Administering cash transfers

There are two important issues regarding the administration of non-contributory pensions: the effectiveness and timeliness of the administrative procedures, and costs associated with programme administration. The expectation is that universal pension programmes will have lower costs and 'lighter' administrative procedures. An issue in developing countries is that the administrative and financial capacity to reach poorer communities, especially in remote rural areas, adds further complication. Namibia is a good example of these pressures. Schleberger (2002) finds that the administration costs of the programme accounted for around 15 percent of pension payments in 1996, and there were some difficulties in reaching rural areas. In 1996, the management of cash payments was out-sourced to private providers using 'mobile banks' to reach less accessible areas. Beneficiaries were provided with electronic cards to verify their identity. Administrative and payment services improved, but the costs of private providers take up around 9 percent of pension payments, in addition to the costs of public agencies. The same private providers operate in South Africa's rural areas, where the costs of provision have also risen. In Botswana and Mauritius the administrative costs of the pension programmes have been estimated at between 2 and 3 percent of benefit payments. In Argentina, the administrative costs of all non-contributory pensions (including old age cash transfer) has been estimated at 0.4 percent of the total budget, but problems with the administration and quality of service remain. In Brazil, a study by IPEA found high levels of satisfaction with the quality of service of public agencies, and with the promptness of payment (Delgado and Cardoso, 2000).

The effectiveness of cash transfer programmes in developing countries requires administrative and financial infrastructure, and simple but accurate routines to establish entitlements and process payments. The challenges of establishing such routines should not be under-estimated. Key concerns include:

1. the difficulty in collecting, processing, and accessing demographic and occupational information to establish entitlement;
2. the length of time and bureaucratic demands to process pension applications;
3. the certification process for payment of benefits;
4. the administrative and financial difficulties with the payment of pension benefits in countries where the banking or financial systems has poor coverage both geographically, and of the poor;
5. the capacity to deal with instances of corruption with efficiency and sensitivity.

Communities can play an important role in monitoring the administrative performance of pension programmes. The issue is whether these have the capacity to deliver on this. For example, Mohatle and de Graft Agyarko (1999) report that community institutions, such as churches, clubs and other informal voluntary associations were active in the South African locations they studied, and played a major part in the lives of many older people. However, they

comment that: “Many older persons felt that “ubuntu” is dying in the communities: “Ubuntu” signifies the presence of social capital, community support and the willingness to come to the aid of other community members.” (p.60). They add that this deterioration was particularly marked in urban areas, suggesting that the main cause of this was unemployment.

According to Ardington and Lund (1995), the voluntary sector should continue to play a role in improving take-up rates (already estimated at over 80%) by ensuring that people access benefits. They note that: “A number of organisations find that doing this helps them establish credibility in the communities in which they work: they are able to do something material for poorer communities as a preface to other development work. In this way public money underpins a more robust voluntary sector. Voluntary organisations could possibly become more systematic in their work, as the Legal Resource Centres have done. For example, they could shift the focus from “Why did Mr X not get his expected pension at Hlabisa last month?” to “Why did two hundred other pensioners also fall off at the same time?” (p.21).

Issues of administration are particularly important in the context of cash transfer programmes. The constituency of beneficiaries is a most vulnerable group, and even small administrative problems and delays can have devastating effects on them. In addition, instances of maladministration, inefficiency and corruption undermine political support for these programmes in ways that do not apply to social insurance and occupational pension programmes. There is considerable innovation to be observed in existing programmes, and there is much scope for partnerships between public, private, and not-for-profits agents in the monitoring and delivery of the benefits.

10. Alternatives to non-contributory old age pensions

The paper has already identified a number of potential advantages of non-contributory pensions over other forms of social protection. Elsewhere, it has been amply demonstrated that the scope for contributory pension schemes to reach poorer groups is very limited, and that such programmes sometimes have a regressive impact on income distribution (Barrientos, 1998; World Bank 1994). Experiences with targeted poverty programmes shows that they are administratively challenging, and that their capacity to reach those in real need is often limited (Graham, 1994).

The obvious alternative to a non-contributory pension would be a cash transfer programme aimed at young children. Such programmes are becoming more widespread in middle income countries, including a major scheme recently adopted in Brazil. In some ways, these would appear to share the advantages of an old age programme, including ease of beneficiary identification and potentially straightforward administration. They also include the possibility of making entitlement conditional on "good behaviour", such as regular attendance at school or a health clinic. In some contexts, there may be a closer association between household poverty and the presence of young children than with the presence of older people.
While there may be some role for child benefits, it is important to recognise that such programmes can have a number of drawbacks, particularly for low income countries. Firstly, they could possibly create an incentive to increase fertility, which remains high particularly in poorer communities. Second, given the youthful population structure of most low income countries, the perceived financial requirements of such schemes might well exceed the willingness to pay of governments or external supporters. Third, it is unlikely that the target individual (i.e. the child) would be personally empowered by the receipt of the benefit, since this

would be managed by a parent or other relative. As such, most of the potential impacts on the agency of the beneficiary would be lost.

Replacing an old-age transfer with a child benefit would do much more than simply shift resources between households. There are indications that many older people, especially women, are strongly inclined to spread pension income across households and to areas of particular benefit. This may not occur in the same way with a child benefit. There are also indications that non-contributory pensions support the contributions that many older people are already making to household welfare. Again, a child benefit is unlikely to have this effect. Finally, frail older people are arguably among the most vulnerable in any society, and this fact alone should justify their prioritisation in social protection programmes.

11. Conclusions

This paper examines non-contributory pension schemes found in a small number of countries, paying particular attention to the large cash transfer programmes in Brazil and South Africa. It evaluates the effectiveness of these programmes, and considers the feasibility of establishing similar schemes in other developing countries. This evaluation is complex both because non-contributory pensions programmes have multiple objectives, and because there is considerable diversity of socio-economic and cultural conditions across the developing world.

The paper identifies three main dimensions for evaluation. Firstly, cash transfer programmes for the old have as their primary aim the prevention of poverty and vulnerability among this age group. Second, given that the majority of older people in developing countries live in multigenerational households, cash transfers to the old can also be an instrument in reducing and preventing aggregate poverty. Cash transfers for the old have a number of advantages over alternative poverty policy instruments. Older people can be identified with relative ease, and therefore at lower cost. Potential disincentives to work or save resulting from cash transfers to the old are lower than for other groups. Also, cash transfers to older people promote their status and decision making powers within the household, with potential benefits in terms of the allocation of income. Thirdly, cash transfers to the old can facilitate investment which reduces the incidence of risks, and therefore of future poverty. Investment in physical, human, and social capital reduces the intergenerational transmission of poverty, and therefore the persistence of poverty over time. In so far as cash transfers reach the very poor, and given the restricted access of older people and their households to other sources of investment, cash transfer programmes can have a significant effect on economic activity and the development process.

The paper considers these three dimensions and concludes that cash transfer programmes do indeed have the potential to make a significant contribution to reducing poverty and vulnerability among the old and their households, as well as reducing the intergenerational transmission of poverty. Thus, the experience of the countries reviewed confirms that these programmes are able to deliver in all three dimensions, and with the right design and financing features, they could constitute the embryo for more embracing social protection systems in the developing world.

The available evidence from these cash transfer programmes shows they have a significant impact upon old age poverty, and on the status of older people. In terms of their impact upon aggregate poverty, this depends on the extent of co-residence, and on the cultural norms and practices regulating intra-household distribution of income. Cash transfers to the old may be a

less effective instrument in reducing aggregate poverty if, as is the case in transition economies or middle income countries in Latin America, a growing minority of older people start to live alone. However, there are no signs of this occurring on a significant scale in low income countries. Cash transfer programmes to the old also provide an important stimulus to economic activity, and can act as valuable insurance against risks to household consumption and investment. These programmes have the potential to make an important contribution to the development process.

It is important to be aware of potential conflicts between these different objectives. **While the design of cash transfer programmes should aim to combine and maximise these positive impacts, emphasis should be given to the primary objective of cash transfer programmes which is to reduce poverty among the old.** Pensions may be effective in enhancing the economic activity of households, but it would be a matter for concern if this were to happen at the expense of the well being of the current old. Similarly, co-residence of older people and children may enhance the impact of the programme on aggregate poverty, but it may also have the effect of bestowing unmanageable responsibility upon the old for the care of their grandchildren. The challenge is to 'tie ' these effects in, and to consider the impact of cash transfer programmes in the round. This is not an easy task, as determining the impact of pension provision on aggregate poverty and on the intergenerational transmission of poverty demands better research tools and data than those currently available. The extent to which cash transfers facilitate economic activity and development depends on the presence of means and inactivity tests. The paper found that the absence of such tests (as in Brazil's rural sector), or their limited application in practice (as with means tests in South Africa), strengthened the development impact of the cash transfers.

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Annex 3

Global Social Trust Fund

Feasibility Study On The Delivery Of Basic Health Benefits At The Community Level:

Lessons From Ghana

By Derek Osborne

NIB Bahamas

21 December 2001

Introduction and Summary of Findings

Community based health insurance schemes are not new to Ghana. The oldest and largest Mutual Health Organisation (MHO), as they are officially called, began operations in 1992, and is the model that almost all new schemes emulate. In recent years there has been significant growth in the number of new schemes, with 47 schemes counted in a study conducted in the 2nd quarter of 2001, of which 14 were described as "fully functional". While many of these schemes receive financial and technical support from external donors, the Government of Ghana encourages their formation and has in fact, itself initiated a few of them.

There is a general consensus among those directly involved with community based health insurance schemes that they have helped make medical care more accessible and affordable, thus the recent growth in the number of these schemes. There has been difficulty, however, in translating that perception into increased enrolment. Even the largest and oldest scheme has only been able to insure around 30% of its residents, while some of the newer schemes have much lower coverage rates. Common problems encountered by schemes are risks of adverse selection, moral hazard, fraud, underestimation of premiums, cost escalation and limited capacity to manage these schemes.

The author has little doubt that MHO's in Ghana, and elsewhere in the developing world, can play an important role in improving the health of populations, especially in rural areas. While the experience in Ghana is not extensive, there is sufficient evidence to show that, with support from governments and external donors, they can be relatively easily established and reasonably well managed.

Possibly the most important key to the successful implementation and operation of a community-based health scheme is its design, and the fact that it should be community initiated, community led and community run. To maximise its chances of success, the right community must be identified, an appropriate benefit package and premium structure established, the scheme must be properly marketed and its operations well managed. At the community level there will always be a need to enhance the capacities of leaders, scheme employees and managers. With assistance from one or more suitable local organisations a Global Social Trust Fund (GSTF) supported community health insurance scheme could make a significant difference in the lives of many people.

This report is based on the experiences of Ghana; it is divided into two sections. The main part deals with the practical aspects of identifying communities and establishing and supervising schemes for the best use of GSTF monies. While the experience gained is limited to Ghana, the suggestions and recommendations made are meant to be generic and thus applicable to all recipient countries. Of course, the structure and capacities of each community will dictate the specific design features of each scheme. Specific findings on health schemes in Ghana as documented by formal studies and local consultants hired specifically for this project, along with issues noted by the author during a 1-week visit in November 2001, may be found in the Appendix.

1. Community Health Insurance Schemes – An Overview

In generic terms, a community health insurance scheme (CHIS) is a not-for-profit organisation, based on solidarity between members, with the objective of:

- improving members' access to quality health care,
- improving the quality of health services
- improving efficiency in the allocation and use of available resources, and
- enabling more democratic participation in the health sector.

These are often risk sharing schemes structured upon financial contributions and democratic decision-making, and are owned and operated by the community.

In practical terms a typical community-based health scheme in Ghana has the following characteristics:

1. Annual premium – must be paid in full before coverage begins (may allow for payment in instalments prior to coverage starting). Coverage is likely to be based on all members of a family unit or household registering and coverage is not in place until premiums for all members are paid. The renewal premium may be slightly lower than the first year's premium, which often includes a registration fee (cost of card, picture, etc.)
2. Enrolment period – often restricted to only a few months during the year.
3. List of benefits – generally primary and secondary care – certain things may be excluded, such as normal delivery, and insured must usually meet expenses over a certain threshold for any single treatment. (A few also offer social services such as marriage grants, child allowance and funeral contributions.)
4. List of associated hospitals or clinics – where a particular service is not available from facilities operated by the scheme, these services are purchased, usually on a fee-for-service basis, from other nearby facilities.
5. Management structure – in some cases the care providers are also involved in managing the scheme while in others the two functions are separate.
6. Affiliation with a donor agency – donor may provide seed financing for equipment, meet deficits in the first few years, and provide ongoing training and conduct regular audits.

2. Identifying The Right Community

There is little doubt that community health insurance schemes (CHIS's) can be effective in almost any poor, rural or vulnerable community. However, not every community will exhibit many of the key characteristics that will increase the chances of successful implementation and continued operation of a health insurance scheme. Therefore, careful examination of the community, its people and leaders, their circumstances and their goals will be required.

Firstly, community leaders, tribal chiefs and residents should initiate the process of introducing a scheme to their district or community. Whether it is a community's desire to follow the example of a neighbouring community or simply to find some way of allowing the poor in their district to access quality health care, there should be a genuine interest generated from within the community first. Therefore, instead of the community seeing the Fund's involvement as setting up an insurance scheme, it should be the community who establishes the scheme with financial and technical assistance from the GSTF.

A past history of leaders who have successfully run organisations or cooperatives would be beneficial and useful. This would make it easier to introduce policies, procedures and guidelines easier and would bring a certain amount of respect and trust from residents. As the need for transparency, accountability and good governance is extremely important, the management of

such schemes should include a wide cross-section of district assemblies, tribal councils and opinion leaders.

It is unlikely that residents in many of the communities setting up CHIS's will already have the skills necessary to run the scheme themselves. Therefore, extensive training will be required, not only at the initial introductory stages, but on an ongoing basis as well. While finding the right people to operate the scheme is important, a community should not be denied support because it does not have qualified people to lead and run the scheme. Instead, the Fund should support efforts at enhancing the skills and capabilities of local persons so that the scheme can be established and that there can be an overall improvement in the competence of local leaders.

Residents should also see the need for improvements in the availability and affordability of health care as a priority. While most may view health as important, it may not be their most urgent need. During a recent visit to Ghana, for example, many people suggested that their top priorities were education, economic empowerment (jobs) and then health. In a study on the community in which the oldest and largest scheme in Ghana operates, health was listed as sixth in order of residents' expenditure. (Food, clothing, education, transport and energy were higher but for the few who actually incurred medical expenses, health may become the greatest single expense.) Therefore, where other concerns are greater, possibly food and shelter as well, joining a new health scheme may not be perceived as being critical. This may result in low participation rates.

Other community characteristics and considerations that could guide and influence the GSTF in its selection and choice of communities:

- The community must not be too vulnerable with regards health or other risks. For example, if there is high incidence of malaria, AIDS or some other disease, this could lead to the need for high premiums which may not be affordable by many and not acceptable to those in less at-risk groups.
- Strong sub-districts – where the community is made up of several smaller sub-districts, leaders in each of these sub-districts would be essential.
- Active village committees.
- Existence of nearby health facilities, community clinics and hospitals.
- Local banking system or organised susu schemes for example, where people are accustomed to saving and where there is likely to be greater appreciation of the idea of pooling funds – for use when most needed.
- Groups that are accustomed or are expected to be audited.

In some instances communities should be identified for immediate assistance. In others, commitments for future GSTF support may have to be given with the condition that specific things be put in place first. Once the GSTF is established, both types of communities should be identified. Depending on the issues that need to be dealt with prior to establishing the schemes, the Fund may provide assistance in helping the community meet these minimum qualifying conditions.

While the term "community" has thus far referred to a geographical area, it is possible that it may be extended to include organised groups of people, such as trade associations or even persons of a common ethnic or religious group. While the necessary prerequisites may be similar, the relatively small size of such groups over which risks will be shared may not allow for the economies of scale that would exist for a geographic area.

For the GSTF, assistance to specific ethnic or religious groups should be avoided. In the case of trade associations, the organisation and expertise of these groups may best be used to spearhead the set-up and early management of a health scheme, with the intention of having it evolve into a true community based and community run project.

3. Developing The Appropriate Design Features

Extensive planning and close cooperation with local community leaders will be required prior to establishing a CHIS. Therefore, developing relationships with organisations that have experience in working with health schemes is vital. This may reduce the time necessary for the set-up phase. As will be discussed in the next section, suitable local partners will have to be identified to supervise and assist community leaders in this venture.

This section covers practical issues that will have to be dealt with prior to establishing a scheme. Research conducted on MHO's in Ghana suggests that proper design features will greatly enhance scheme success. The ideas presented here have been formed after observing how several schemes in Ghana are designed and operated. While some of the suggestions have not been tried and tested, it is the author's view that they should enhance the overall effectiveness of a new scheme.

Insurance (benefits) package

The benefits covered should be consistent with the general needs of the community. Therefore, it will not be wise for the GSTF to establish a fixed list of benefits that will exist in all the schemes it supports in various countries. (Even within one country, different coverage may be warranted for different regions.) In Ghana, for example, since the main objective of these schemes is health, most offer only health-related benefits. However, there is some variety in what is actually covered. While most seem to offer drug, lab and x-ray services, medical consultations and hospitalisation, the Nkoranza (the oldest in Ghana) scheme does not cover normal deliveries or OPD bills for other than snake/dog bites. There is some difference, however, in the cover of maternal care as some feel that this will encourage women to have more children. (The author is of the view that all care related to pregnancy, delivery and antenatal care should be covered.) A few schemes in Ghana also provide marriage grants, child allowances and funeral contributions.

As the extensiveness of the benefits package will determine the level of the premium, consensus should be gathered from local leaders on how much residents are likely to be able to afford and therefore what can be covered. Thus, while it may be better to design the benefit package first and then set the premium, it may in fact be necessary to first agree on an acceptable premium and then establish the benefits that can be met by that premium.

Premium – Initial and Renewal

Like in any insurance scheme, premiums should be set so that projected income matches projected expenditure. Premiums should be expressed in annual rates per person, even though membership should be based on family registration.

Data on the frequency of residents accessing services and the average cost of each visit would be an important first step in estimating expenditure. As seen in Ghana, the cost of medical care will likely vary widely from district to district and so data from each region or district would be required. There should also be extra provision made for greater utilisation of services by insured persons.

While there might be a desire to set the first year's premium relatively low to get more members, the negative reaction to rate increases soon after inception may result in high dropout rates. This is true even if the GSTF commits to meeting deficits in early years. From the prospective insured person's perspective, the relationship between the cost of a single outpatient visit to a clinic, and the annual premium should be reasonable. In questions asked to residents in one district in Ghana on the reasonableness of a suggested premium, most tried to relate it to how much they spent in recent years on health care. This is likely to be the basis on which residents will decide whether the insurance package is attractive or not.

Premiums should also be set so that a small reserve fund can be held, so that bills may still be paid if expenses exceed current income. While the donor may commit to meeting deficits in the early years, the presence of a reserve fund is absolutely necessary for the scheme to sustain itself in the long run. An adequate reserve fund will also reduce the likelihood of having to increase premiums each year.

With large family sizes, annual premiums for a household may be beyond the reach of many residents. Therefore a system of collecting premiums throughout the year should be put in place, so that when the next insurance period comes around there is enough on hand to cover the renewal premium. This facility could either be managed by the scheme itself, or arranged with rural banks that may operate in the area. In all cases though, annual premiums, payable in advance, is the preferred policy.

While none of the schemes reviewed in Ghana use co-payments or deductibles, a survey in Nkoranza found mixed feelings on their introduction as a way of preventing the scheme from collapsing. While simplicity should be key in designing the payment method for insured's, the use of co-payments may make the annual premium slightly lower. However, even though the payment for an outpatient visit for example may be lower for an insured person, he/she may think they have paid twice.

Enrolment Period

In all of the CHIS's observed in Ghana the enrolment period is limited to two to three months. In some cases, this period does not coincide with the major harvesting season, the period during the year in which residents in many rural areas earn their highest incomes. The reasons given for a limited enrolment period are to avoid anti-selection (registering only when you require or expect to soon need health care services) and simplicity of administration.

With properly designed systems, year-round enrolment would greatly enhance the effectiveness and perception of CHIS's. To limit anti-selection, a waiting period of at least 1 month should be put in place. With computerised registration and record keeping, and the inclusion of the dates of the current insurance period on insurance cards, administration should be manageable by both care providers and the scheme.

Membership

CHIS's are advised to register families or households as a group. However, individuals who are genuinely not attached to a larger household should also be accepted. This will ensure that not only the sick or at-risk individuals in a household register for coverage. To limit under-registration of family members, inspectors or field workers will be required to verify that an entire family is registered prior to insurance coming into force. Picture identification cards should also be issued to each insured person. Children born during the year should be granted coverage free of charge for that insurance year.

Lower per-person premium rates for large family sizes could also be considered. If for example, the premium per person is 10 units, a premium of say 8 units could apply to all family members after the first five.

Marketing – Public Information

People tend to be skeptical of something new. Additionally, if in the first few years of operation there is no perceived value for those who join, or charges of abuse or fraud are levied, interest will decline. It is therefore very important that when CHIS's are being established, there is appropriate information provided on the objectives, benefits and the role community members can play in ensuring success of the scheme. It would also be best to select trusted and respected persons in the community to market the scheme.

Prior to joining residents should understand the concept of insurance and risk sharing. Without this, people who do not get ill and do not claim will feel cheated. This is a major challenge in Ghana and some schemes are trying to find ways of rewarding people who do not claim. CHIS's, therefore, have to be sold in a manner that can be understood and appreciated by all. References to phases such as "*today it's your turn, tomorrow may be mine*" or "*each of us is our brother's keeper*" may therefore be useful in promoting the benefits of annual premiums and year-round coverage. (Local sayings should as much as possible be used for this purpose.) Appropriate slogans and references will be especially necessary for attracting the illiterate for whom special radio or public address mechanisms may be designed.

Group enrolment with reduced premium rates should be encouraged. For example, premium rates should be lower for families who join as part of a group of tailors or hairdressers for example. The number of individuals that constitute a group will have to be determined based on the size of the community/district and the types of groups that exist. There are two main advantages to offering discounted group rates – increased numbers reduce per person fixed costs, and persons in trade associations and organised groups will likely have lower claims experience.

Paying commissions to field workers will also be a meaningful way of rewarding those in the community for increasing scheme membership. Management must be careful, however, that agents do not falsely advertise the scheme simply to earn a commission on new members who stay only for a year. The greater part of the commission, therefore, could be tied to the second year's renewal.

Service Afforded Insured Patients

Patients who are part of a health insurance scheme should never be made to feel that the level of service afforded them is worse than that provided to uninsured persons. Unfortunately, this seems to be the case in many schemes in Ghana, where the government instituted a "cash & carry" system of health care at public facilities in the late 1980's. Under this system, patients are not treated unless they pay. Therefore, attendants at clinics unaccustomed to the insurance concept often view insured patients as not having any money and thus not paying for the services being provided! With proper education of employees at care facilities, this could be eliminated.

At the same time, insured persons should not expect better treatment from care providers because they have "prepaid" for their treatment.

Moral Hazard

One characteristic of insurance schemes, community based or otherwise, is the tendency for providers to subscribe more services or drugs if the patient is insured. In a study conducted in Ghana, this is referred to as moral hazard, and is one of the challenges being faced by schemes there. Such oversubscribing could be reduced if treatment protocols were in place. Procedures should also be put in place so that doctors and other persons treating patients would not know whether or not patients have insurance.

Moral hazard from the user standpoint is also a concern in some schemes. For example, in a scheme where outpatient visits are not covered but hospitalisation is, some people fake serious injuries so that they can be admitted to hospital for at least 24 hours in which case the scheme pays their bills. It is clear from this that the benefit package must be well designed, and all possible methods of cheating the system be considered at the outset.

There also tends to be a practice of persons going directly to hospitals instead of first going to a primary care clinic, often incurring larger expenses. To reduce this a gatekeeper system may be adopted where referrals from primary care clinics are required prior to visiting participating hospitals.

Administration, Record Keeping and Auditing

While strict policies and guidelines need to be in place, the level of reporting and paperwork necessary to manage the affairs of these CHIS's should be kept to a minimum. There should also be simple procedures for affiliated providers seeking reimbursement for care provided to insured persons. In fact, the Fund may wish to assist care providers in improving or computerising their systems making it easier for all parties.

The benefits of greater controls have to be weighed against service as well as the capacities of employees. With too much "red-tape" there is a greater risk of workers circumventing procedures with the possibility of abuse or dishonest activities that may in turn increase costs.

From conversations with a few employees and those involved in health schemes there would appear to be no concern about the auditing process and the need to maintain proper records. For the type of schemes in which external donors are involved, it is expected that established procedures, proper reporting and auditing will be in place.

Incentives for Joining

In one particular clinic in Ghana, most visits to the clinic were malaria-related. Therefore, a useful incentive for this scheme would be the issuance of mosquito nets to households who register to help reduce malaria-related illnesses. Similar products or services could be given to new members depending on the needs of the district. The expenses of these incentives could be met by the Fund even after other financial support has ceased. While such continued assistance will not create a dependency on the Fund for ongoing scheme operations, there will be an ongoing relationship between the Fund and the scheme.

Other incentives that are both meaningful and inexpensive could be found. These could relate to aspects of life that are important to residents but which cannot be afforded, such as contributions towards school fees or school uniforms.

Appropriate incentives could also be found for persons who have not claimed for several years. Experience in Ghana suggests that many people do not renew membership if after a few years they feel that they have not benefited from the scheme.

Relationship With Providers

Several of the Ghanaian schemes also operate clinics and hospitals. There is, however, a move by the main umbrella organisation to remove itself from managing schemes and simply providing care in districts where there are no public facilities. For the GSTF, it would be advisable that only participatory, community-managed rather than facility-based and controlled CHIS's be supported. This will ensure that only covered persons are benefiting from the premiums they pay and that scheme funds are not used to subsidise hospitals.

With regards to reimbursement, monies should be paid to providers not to claimants. Therefore, patients should not have to pay when they visit participating facilities and efficient provider payment mechanisms should be established. With the volume of business that the scheme can bring health providers there should be negotiation of fees along with agreed reporting guidelines for reimbursement. Good relationships with the providers and their staff would also contribute positively to the development of CHIS's.

The payment system most often used in Ghana, and the one that is probably the most expensive but also the simplest, is fee-for-service. In the early years of a CHIS, therefore, this may be the preferred choice for reimbursing health care providers. To keep costs under control, procedures aimed at monitoring the practice of extra services being prescribed to insured persons should be put in place. As far as possible also, the scheme should ensure that members do not have to disclose their insurance status to the person who is prescribing treatment.

Scheme Management

Community participation in management and control over policy and decisions should be a hallmark of CHIS's supported by the GSTF. Key stakeholders and leaders from identifiable community groups should be involved in an influential way. This will enable the scheme to obtain wide acceptance which would likely lead to higher rates of participation.

While community management is preferred there should be close monitoring of those in authority as adverse behaviour by a few individuals could cause long-term damage to the scheme. Therefore, appropriate and timely training, oversight and audits would be essential.

A proper governance and management structure should be devised with different levels of authority. One suggested structure for schemes in Ghana is:

1. General Assembly
   - Ø the overall decision-making body for the scheme
   - Ø comprised of volunteer community leaders, especially those organisations that register their members as a group each year
   - Ø the role of this group would be more policy oriented than actually running it
2. Board of Directors
   - Ø maybe 8 or 9 persons, representing all relevant stakeholders in the community – the GSTF should be represented here and possibly an outside adviser who has experience in community health schemes
   - Ø main function is to ensure that the scheme is well run

3. Management
   - Ø would see to the day-to-day operations of the scheme
   - Ø provide timely reports to the Board

Each year there should be an annual general meeting at which the Board reports to the community on activities and results for the past year and the auditors present their report and findings. Representatives from communities, districts and villages, as well as leaders of community groups and associations should be eligible to attend.

To ensure high quality management it would be beneficial for the GSTF to develop, for the community schemes it will support, quality management standards, such as those found in ISO 9000. This particular standard is concerned with quality management and what the organisation does to ensure that its products or services conform to the customer's requirements. Having schemes follow an established quality management system should provide confidence in the conformity of these schemes to established or specified requirements. By following the founding principles of ISO 9000:2000 the overall management skills of scheme operators should be enhanced leading to overall improved governance and the better performance of these schemes.

Training

Having competent staff and managers, informed directors, honest and trustworthy leaders will be important for securing the success of any CHIS. In Ghana, the shortage of suitably skilled personnel to manage these types of schemes is another of the challenges now being faced.

In terms of skill improvements, the key areas of focus should be management, marketing, negotiating, accounting, computing and customer service. There should also be emphasis on community participatory methods. The need for training is so important that this may be the most costly aspect of supporting community based schemes in developing countries.

Unlike financial guarantees that may be short-term lasting for only 3 to 5 years, the GSTF could finance ongoing training programmes for schemes that it decides to support. This will likely increase the chances of long-term sustainability.

Registration With Authorities

Prior to setting up the first scheme in any country, the necessary procedures for registration and operating an insurance scheme must be identified. In Ghana, for example, it was suggested that a scheme be registered as both a legal entity and a non-governmental organisation.

As with any other venture, it would be necessary to modify structures and procedures as experience dictates. Again, country and region-specific environments will dictate the need for flexibility and adapting different approaches to different schemes.

To conclude this section, the following is a list of reasons given in a 1999 survey on why residents did not register with the oldest Ghanaian scheme located in Nkoranza. While some of the reasons may be relevant only to this scheme, the list has been included here as it provides insight into the possible concerns that residents in any poor, rural community, in which a scheme is being established, may have.[17]

[17] Source: An external evaluation of the Nkoranza Community Financing Health Insurance Scheme, Ghana, March 2000.

1. Financial – premium too high*
2. Registration period not good
3. No maternity cover
4. Large family
5. Better care for non-insured at hospital
6. No OPD (out-patient) cover
7. Staff attitudes to insured
8. Bad quality of care
9. Increasing coverage to all services
10. No cover for referrals out of St. Theresa's
11. Lack of incentives for health members
12. Distance from hospital
13. Lack of cover for other nearby facility
14. More education required on scheme

4. Identifying The Right Local Partner

It would not be practical or cost effective for the Fund to have a direct physical presence in each country in which its supported schemes are located. Instead a local agency will have to be depended upon to assist schemes in their implementation and ongoing operations. On behalf of the Fund, this agency will ensure that certain minimum standards are met, funds are properly managed, appropriate training is received, and that regular audits are conducted.

The main tasks of the local agency or partner would include:

- Assisting with the formation of an organisational structure, objectives, etc.
- Drafting an operational plan
- Coordinating activities with governments and donor
- Hiring and training management and staff
- Negotiating with hospitals and other clinics
- Reviewing the scheme's operations
- Conducting periodic audits

In some cases the partner need not be the agency actually performing these functions but may simply identify suitably qualified persons to do so.

Based on interviews and information gathered in Ghana the options that may exist in most countries for providing these services are the social security institution, the Ministry of Health, NGO's and international aid agencies. While each brings different strengths and weaknesses, the organisation with the most experience and best expertise should be the preferred choice. This would very likely result in different types of partners in different countries.

- The authors of the study note that even though the number one reason was "premium too high," it did not mean that it was unaffordable. Given that the number two answer was "wrong registration period" it is likely that the premium was too high at the moment it had to be paid.

(A detailed description of the Nkoranza scheme may be found in the Appendix to Annex 3.)

Social Security Institution

Using the national social security scheme - the Social Security and National Insurance Trust (SSNIT) - as supervising agency for the CHIS's may be an option if the SSNIT were prepared to give up its exclusive focus on the formal sector.

However, there is a government led institution whose mandate is directly related to improving health care affordability and provision in both the formal and informal sectors, and this organisation, the newly formed Ghana Healthcare Company (GHC), may also be a suitable candidate.

The GHC is a mutual health insurance company whose objectives include:

- Developing health insurance schemes in communities
- Developing and providing medical insurance schemes

As their global mission is to make health care more available and affordable they see themselves as being a natural link with the informal sector. While their involvement thus far in community schemes is very limited, they plan to work more closely with communities in establishing and managing these types of schemes, as well as supporting them in claims management. As of late 2001, GHC is still in the set-up stage and the role it will play nationally does not yet appear finalised. Up to now, the GHC has been supported financially by SSNIT.

NGO's

In Ghana there is extensive involvement in community based health schemes by an NGO called the *Christian Health Association of Ghana (CHAG)* and the newly formed *Ghana Coalition of NGO's In Health*. For years CHAG has acted as both a provider of health services and an administrator of health insurance schemes. Their officials demonstrate a strong passion and desire to see an improvement in health care as well as a genuine concern for the less fortunate. This same "passion" was absent in employees of private sector or quasi-public sector organisations where the attitude appeared to be rather more "what is in this for us?" This difference is doubtless consistent with NGO officials seeing their involvement as a "vocation" versus private and public sector employees who often see themselves as having a "job".

NGO's with religious affiliations may not be the best choice from amongst possible NGO's, but they should not be totally ignored if they are leaders in this area. Depending on the religious mix of the country and/or region, the fear of differential treatment may lead to lower participation rates among those of different faiths. The experience in the Nkoranza scheme in Ghana, which is run by the Catholic Church, suggests that at first there were some concerns by non-Catholics. However, once the provider and scheme were seen to be impartial, the proper education of residents can make all feel welcome.

Ministry of Health

In Ghana, the Ministry of Health (MoH) has made the environment conducive to Mutual Health Organisations. In fact, the Ministry has initiated a few community insurance schemes. The MoH has also recently established "earmarked accounts" into which donor funds may be placed and used only for specific purposes and projects. It is also understood that much of the usual government bureaucracy related to finances has been eliminated. The MoH was actually suggested by a leading NGO in health as the most appropriate financial intermediary for the GSTF.

If in other countries the Government is actively encouraging the formation of community based health insurance schemes and is working with other donor agencies, the relevant Ministry or department may be a viable option.

Other Donor Agencies

Where other donor agencies are actively involved in CHISs these could also be an option for assisting the GSTF in meeting its objectives on the ground. It would be unfortunate if the Fund and other agencies were to see their involvement as competing in any way; and partnerships could thus be formed to reduce administrative costs.

5. Role Of Governments

For these ventures, support from the government is critical. Governments should play a facilitating role and maintain an atmosphere conducive to the development of CHISs that are destined to be supported by external agencies. To this end they should establish a favourable legal, fiscal and institutional context, making the registration and statutory requirements for the setting up such insurance schemes simple and affordable.

Governments should also take measures aimed at improving the overall quality of care – both actual health care and customer service. From discussions with patients and providers in Ghana, there is an urgent need to improve the level of customer service afforded to patients. Governments should therefore create a system of accreditation of providers and their facilities, identifying specific standards that must be met. They should also regularly monitor performance. With such a system in place, CHIS's would then be able to negotiate with the highly accredited hospitals to provide care for its insureds.

The creation of official treatment protocols would also assist schemes in managing and controlling costs. Implementing health reforms that give autonomy to local health facilities could also serve to expand the coverage of CHISs.

6. Role Of The Global Social Trust Fund

The involvement of external support is critical to enhance the chances of early success for CHISs. The types of support afforded to schemes in Ghana are mainly logistic, cash and technical support. While it is not the intention of the GSTF to provide assistance indefinitely, financial support will be useful in the planning stages and during implementation. Provision should also be made for assistance that may be required after regular support has ceased but where genuine cash shortages could lead to the collapse of the scheme.

In general, the Fund's main role would be to reinforce the institutional, managerial and administrative capacities of CHISs. Specific uses of donor funds in Ghana include:

- Initial seed capital
- Securing physical structures
- Purchasing equipment
- Training scheme employees, management and overseer bodies
- Getting the process started – organise locality, developing rules etc.
- Marketing and communication
- Printing ID cards, equipment etc.

As mentioned in an earlier section, premiums should be set so that income may cover benefit and administrative expenditure. Since prospective insured's will relate the annual premium to the amount they may likely spend on health care in a year, premiums that cover set-up costs would make the scheme too expensive. The need for donor funds, therefore, will be greater at the start-up and developmental phases.

One important concern for the Fund is that its involvement should not be to replace funds that the government would have otherwise invested in health care. The significant number of new community health schemes in Ghana may be a direct response to reduced government involvement and increased lack of access to care, especially in rural areas.

Inadequate quality care at public facilities has been suggested as one of the factors constraining the growth of community schemes. Therefore, the Fund's involvement in community schemes should prompt government spending on improving health care facilities in nearby districts – both infrastructure and the overall quality of care. The inadequacy of facilities is one of the problems faced in rural areas. Thus, scheme establishment supported by a donor and facility improvement sponsored by the government would help both the scheme and the community.

Most of the donor's support is required in the set up stage and most of these activities will be similar regardless of the size of the new scheme or community. Therefore, costs are not likely to vary much between small and large schemes. The number of people enrolling in the early years, however, will have an impact on ongoing scheme finances: with fewer members, deficits may be higher and thus larger subsidies from the Fund would be required.

While the goal of the Fund is to develop and support schemes that become self-financing and sustainable after a few years, the Fund may wish to maintain a long-term relationship with schemes. This could be in the form of a reduced fixed level of support. Two suggestions for such support are providing an incentive for joining, e.g. mosquito nets as discussed in a previous section, or paying the annual audit fees. While not being critical to the sustainability of the scheme, such support may result in lower benefit costs and maintain credibility in the management of scheme finances, two key ingredients for the ongoing success of these schemes.

In addition to meeting genuine deficits in the early years of these schemes, the GSTF may also wish to commit to ensuring a minimum level of reserves prior to withdrawing its annual support guarantees. Financial assistance for activities that may indirectly support the scheme and promote its continued existence may also be considered; for example, the promotion of personal hygiene.

It may also be wise for the GSTF to co-ordinate its efforts in supporting community based health schemes with other donor agencies already working in a particular country. Duplication of manpower and other resources should be avoided. Moreover, these agencies would have experience in that country and thus could provide useful information and advice. (Donor agencies supporting schemes in Ghana include DANIDA, Partnership for Health Project under USAID, and Memesa of the Netherlands.)

The financial inputs made by donor agencies in new and existing MHO's in Ghana do not appear that significant. While the author was not able to obtain actual amounts contributed by donors, information on the newly formed Dangme-West Community Health Insurance Scheme indicates that it received almost US$150,000. (This scheme is purely provider-initiated and managed by the Ministry of Health.) Most of these funds were used for the in-service training of health

workers and management, supportive supervisory visits, preparation and implementation of the health solidarity associations and the insurance scheme, and the appointment of an expert consultant. (This community has about 100,000 residents, only 5,000 of which joined the scheme in the first year.)

From the limited data available, extremely rough estimates of donor financing necessary to support new and existing schemes are provided below.

Meeting Start-up Costs

Start-up costs are not likely to vary much by community size. If the US$150,000 provided by the donor for the Dangme-West Community Health Insurance Scheme is used to estimate necessary initial cash injections by the GSTF in similar communities, this translates to around US$1.50 per resident. Per-person costs would be smaller or larger in districts with more or fewer residents.

Meeting Annual deficits

The premium for the Dangme-West scheme was increased from c12,000 to c15,000 in 2001. While no official finances were available, if the per-insured deficit is assumed to be the c3,000 difference in the renewal and initial premiums, the total deficit is around c9 million or US$1,300. In the Nkoranza scheme, where there were 44,000 insured's in 2000, the deficit for the year was c18 million or US$2,600.

From these two examples, meeting annual deficits and ensuring a minimum reserves fund prior to suspending the guarantee of meeting annual deficits is not very costly. In the bigger and more established scheme the deficit per insured was US$0.06 compared to US$0.43 in the smaller and newer scheme.

Meeting Other Costs

The major ongoing costs would be training. Also, as suggested earlier, the Fund may wish to finance specific incentives for people who join or for those who remain insured with very low claims history. Special preventive and promotional activities may also be financed.

To reduce per-person costs, training programmes should be conducted in conjunction with other schemes, even those supported by other agencies. While it is not possible to estimate the magnitude of these costs, certain guidelines may be set. For example, the Fund may provide funds for incentives and preventive programmes in the order of 25% of the annual premium income. For training exercises and general improvements a fixed dollar amount may be established.

Conclusion

Assisting poor and rural communities establish their own health insurance schemes is a noble initiative. Experience in Ghana supports such an effort as these schemes have made health care more affordable and accessible to those who are covered. Many lessons can also be learned. Even though most schemes face many challenges and scheme enrolments have been disappointing – just over 30% in the oldest with lower coverage levels in almost all others, the outlook is positive. In fact, there are many new schemes now being formed. With appropriate modifications to the traditional model design, higher participation levels and greater satisfaction for the insured's should materialize.

Educating residents, especially the illiterate, on the concepts of insurance and pooling risks will be key to attracting members. A scheme with a relatively simple structure will also enhance its acceptance. Insured's and prospective insured's should be able to register at any time during the year and make premium payments in instalments. Covered contingencies should be consistent with the needs of the community and appropriate incentives for both those who join and those who get people to join should be in place. Community ownership and direct involvement at various levels is also likely to lead to greater support from sub-districts and villages that are being serviced by the scheme.

Training of both scheme operators and care providers will be important. The greatest threat to collapse is likely to be failure to manage scheme affairs and finances properly and transparently. Therefore, proper governance structures should be put in place, qualified people should be hired and trained and regular auditors conducted. Once a decision has been made to establish schemes in a particular country the people or organisations that have experience running these schemes, and who have the trust of the community, should be designated the local partners.

Most GSTF financial support of community based health insurance schemes will be at the start-up stage. Equipment and training will likely consume the largest share of Fund expenditure. Guarantees of meeting operating deficits in early years and ensuring that an adequate reserve fund is in place before guarantees are suspended should be the Fund's main financial contribution once the scheme is operational. One of the Fund's objectives should be for the scheme to be self-supporting after three to five years at which time Fund involvement may be more in kind than in cash.

Community based health insurance schemes have worked in Ghana, and with their experience as a guide, new schemes should be even more effective and could be judged successful after shorter periods. From the recent assessment made, none of the main characteristics important for successful set-up of a community health insurance scheme appear unique to Ghana. The author firmly believes, therefore, that with the practical experiences of each country, and those of Ghana if necessary, Global Social Trust Fund support in developing community based health insurance schemes could markedly change the lives of millions of people.

Appendix (Annex 3)

This Appendix contains a summary of three community health insurance schemes in Ghana together with the author's comments, and notes made as a result of discussions with various organisations and people involved in these schemes.

A. Dangme-West Community Health Insurance Scheme

- Ø The scheme began operation in 2000. It is a Government supported scheme and the participating clinics are all government facilities run by Government of Ghana staff.
- Ø Ghana has a "cash and carry" system where payment is required for treatment at public facilities (except for those under 5 or 70 and over)
- Ø During its first year it covered approximately 5,000 people, or about 5% of the district's population. (Only about 3,000 were registered in the 2nd year.) Two doctors and one anthropologist (PhD.) supervise the scheme.
- Ø In most cases complete households are registered as units, but individuals are also registered if not part of a larger household
- Ø The registration period is between September and November and the insurance year runs from October to September. The full year's premium for all household members is payable before coverage begins. (Instalment payments are accepted between September and November)
- Ø The premiums for the current year are c15000 (c12000 in the first year) per family member between ages 5 and 69. Children under 5 and persons 70 or over contribute c6000.
  - Fees for non-insured persons visiting clinics are c3000 for registration (c2000 for an outpatient visit and c1000 for consultation). The cost of prescribed drugs generally ranges from c3000 to c9000.
  - US$1 = c7100 at November 2001
- Ø Premiums were increased in the 2nd year as "prices have risen over the last year."
- Ø Benefits include:
  - Free treatment in any participating primary care clinic of patients choice
  - Treatment provided at participating hospitals outside the district on referral from any primary care clinic within the district
    - o While there are no co-payments, hospital bills will be covered up to c200,000 per referral - member must pay the excess
    - o Cost of transportation to hospital provided for acute emergencies only
    - o Babies born to insured mothers are automatically covered for the current insurance year
    - o There is presently no coverage for members who fall ill while outside the district
- Ø A donor, Danida, has agreed to cover any deficit in the first 4 years if the deficit is genuine and not a result of mismanagement. Danida recently audited the scheme and made a payment.

Concerns Noted

The following list of concerns has been compiled following discussion with the doctors in charge, nurses, insured and non-insured persons, as well as from general observation.

- Ø Restrictive registration period (not coincident with harvesting season – mainly fishing and agriculture conducted in district)
- Ø Large family sizes and the need to pay for all members during a limited period make premiums unaffordable for many

- Attitude of staff serving persons with insurance cards versus those with cash
  - Worse service to those "without cash"
- Expectation of insured's to be seen before non-insured
- Some see the c200,000 maximum as too low (a Caesarean-section procedure costs around c300,000)
- Initial issue of cards was not efficient so many people were disillusioned and are not renewing this year
- No feeling of ownership as the scheme is not community driven (government initiated)
- Administration and reimbursement for referrals – problems at affiliated hospitals and clinics, including lack of proper understanding of the scheme
- Attracting the illiterate
- Variety of drugs prescribed is limited – some patients have adverse reaction to certain drugs and no alternative available
- By far, most visits to the clinic are for malaria but no special preventive measures taken
- Need for improvement of facilities and equipment in order to improve quality of care
- If health care not accessed for a year or two, feeling among many that insurance coverage is a waste of money

Things learned and ideas for other schemes

1. Group registration and discounts for large groups could increase membership– many are part of trade associations (hair-dressers, tailors etc.) who have income and influence
2. Initial marketing and public information of the scheme is very important
3. Registrations through schools would help
4. Year-round registration – need a savings mechanism for building up contributions
5. Incentives for registering –mosquito nets for example, since malaria is number 1 reason for clinic visits
6. Staff treatment of insured persons needs to be improved
7. Free membership for a few years following death of the insured bread winner
8. Rewards for those not making a claim for several years
9. Introduction of incentives (rewards) for joining – e.g. school uniforms, mosquito nets, pay school fees

B. Nkoranza Health Insurance Scheme

- The scheme began operation in 1992 under the direction and control of the Catholic Church. It is the oldest and largest in Ghana and the model on which most new schemes are based.
- Initially it was a provider-initiated scheme, covering hospitalisations but is presently moving gradually to community co-ownership
- Scheme operates out of same offices as hospital
- Memesa, a Christian Charity NGO based in the Netherlands pledged financial support, the main one being to meet any deficits incurred during the first 3 years
- The main objectives of the scheme are to
  - Encourage the people of Nkoranza to pool their financial resources to cover hospital bills
  - To improve the district's economic accessibility to curative care by making health care more affordable and accessible.
- The major challenges being faced are:
  - Price instability
  - Close relationship with hospital
  - Low enrolment – 44,000 in 2000 or an estimated 33% of district population
  - Inappropriate registration period

- Adverse selection – all family members not paying
- Moral hazard
- Misconception about the scheme
- Skill level of scheme managers

Ø Renewal premium has increased from c2,100 in 1996 to c7,500 in 2000 and to c16,000 in 2001

Ø Summary of finances for year ended 31 January 2001 (in cedes):

Income:	433,532,672
Less: Direct Costs	347,660,050
Gross Profit	85,872,622
Less General & Administrative expenses	103,853,650
Loss during year	**17,981,028**

C. Christian Health Association of Ghana (CHAG)

Ø Involved in most of the MHO's in Ghana

Ø largest health care provider after the government with facilities mostly in rural areas where the government has no presence

Ø presently developing a policy framework and technical assistance for schemes

Ø suggests that environment is conducive for new MHO's (cash & carry)

Ø has begun to separate itself from direct involvement of the schemes as they also manage many of the hospitals

Ø for new schemes CHAG will perform both functions for a while and leave the management function to community

Ø new role will be to:
- serve as facilitator
- help set-up new schemes
- train personnel (recent 'train the trainer' course held) to manage and build resources

Suggestions made by CHAG personnel :

Ø giving insured's choice of hospitals will increase participation

Ø community must see the scheme as theirs

Ø education/marketing – we are our brother's keeper

Ø need to modify as you go

Ø Management structure - General Assembly, Board of directors (CHAG a member), Management

Ø Role of donor
- Initial seed capital as people wait and see if it works
- Equipment, training
- Government/Donor relationship and involvement
- Want a clean audit

Ghana Coalition Of NGO's in Health

Ø Network of local and international NGO's and civil society organisations involved in the provision of health services in Ghana (CHAG is a member)

Ø some of its members are involved in the assisting communities set up CHIS's or MHO's

Ø the Coalition actually suggested that any monies provided to support CHIS's be channelled through the Ministry of Health's Special Accounts for earmarked funds.

These accounts are meant for earmarked activities that the MoH and other donors have agreed to embark upon and have fewer bureaucratic hurdles.

The MoH is trying to help and get involved. There is now a private sector section that deals with rural banks and earmarked funds that have reduced "red-tape" attached to their operations.

D. Social Security & National Insurance Trust (SSNIT)

SSNIT is presently trying to expand coverage to the informal sector.
Suggest that their advantages in assisting the Fund would be:

- Already have people on the ground all over Ghana
- Manage money
- Have training department as well as internal auditors
- Have demonstrated a focus on the poor by building “places of convenience”, abattoir, student loans, etc.

Impressions of SSNIT, however, gathered from talking to different people in Ghana:

- Focus is on formal sector
- Seems to cater more for the wealthy, not for the poor
- Financial focus – who will pay
- Has a recently-built hospital but which is beyond the reach of the poor
- Investments make it appear to be catering for an elite

E. Ghana Healthcare Company

The CEO of the company, Mr. Kwamina Amoasi-Andoh, is a member of the ILO Governing Body, and so was aware of the purpose of my mission. While his company is new and still not certain of its mandate he was quite interested in being a partner.

- GHCC is a mutual health insurance company (owned by its members) and also tripartite in nature
- As their global mission is to make health care more available and affordable they see themselves as being a natural link with the informal sector
- In the area of community based schemes, they do not see their role as providing facilities or care (MOH will do that), but instead to help set-up and manage these schemes, especially in the areas of claims management and education
- They are involved in the scheme in Dodowa through their provision of computer software
- They also have seen recent interest from a few village councils
- Assist with the accreditation of providers (an A–B–C rating (for basic treatment); D or below does not qualify)

F. Elmina Fish Mongers Co-operative

- 20 members, most illiterate, older and led by a former Government employee
- not involved in any community-based health scheme
- have formed a co-operative
    - initial share purchase was c50,000
    - monthly dues are c1,000 per month
- susu scheme in place – minimum deposit of c1,000
- an executive committee (president, treasurer, secretary, etc.) is in place
- money invested in commercial bank
- have bought stalls in the market

- off-season is November to January
- cost of visits to clinic – c20,000 to c30,000 for fever/malaria; c70,000–c80,000 for a normal delivery, up to c150,000 if complications
- main hospital too far from where most people live/work
- average incomes – not clear
- issues most important to them
    - education – apparently cannot meet costs to send children to school
    - water

G. Central & Western Fishmongers Improvement Association of Ghana

- about 50 female members, led by a male secretary (former government employee)
- if an insurance scheme were put in place they would need to make payments by instalment
- average susu contribution is about c5,000 per week
- average family size is around 6 to 8

H. Christian Rural Aid Network (CRAN) Microcredits & Savings Bank, Elmina, Cape Coast

While not a community-based insurance scheme, I had a very interesting discussion with the two employees of this bank. They provided insight that members of the various associations did not.

Susu type arrangement in place

- People contribute as often as daily
- Minimum daily contribution of c1,000
- Sometimes up to c50,000 but average of about c30,000, lower in slow fishing months
- Receipts given to each contributor
- After 3 months contributors can get a loan of up to 2 times deposit
- They then are expected to make larger contributions over the next 6 months
- Field officers go around the market and collect – flat salary, no commission
- Book-keeping and computerised records kept at head office in Cape Coast
- No concerns about regular audits

References

Partners for Health Reform, An External Evaluation of the Nkoranza Community Financing Health Insurance Scheme, Ghana, March 2000

Partners for Health Reform, A Survey of Health Financing Schemes in Ghana, September 2001

Reports prepared by consultants hired to research community health schemes in Ghana.

Annex 4

Global Social Trust Fund [18]

Benefit Delivery in Recipient Countries:

Country Study Benin

by

Raymond Wagener
IGSS Luxembourg

December 2001

[18] The idea for a Global Social TRUST was originally launched as the Global Social Trust Fund; hence the reference to a 'Fund' in studies undertaken and documents dated prior to 2002.

Table of Contents

Executive Summary

The present report describes the conclusions of a mission by Raymond Wagener (IGSS Luxembourg) to Benin from 16 to 19 November to evaluate the possibilities of organising a pilot project in Benin for financial transfers and technical assistance as outlined in the GSTF proposal.

The Global Social Trust Fund (GSTF) proposal assumes that in the beneficiary countries there exist social security schemes and community schemes on which the fund could build satellite insurance schemes. Without specifically excluding other social benefits, the main emphasis would be on health care.

Formal social security in Benin covers less than 10% of the population. With the exception of civil servants, the wage earners of the formal sector are affiliated to the Office Béninois de Sécurité sociale (OBSS). Health insurance is not part of the social security system, but the employer has to pay up to 60% of the health care expenditure of his employees and the dependent members of their family.

Mutual health organisations (MHO) are rather new in Benin, in spite of the fact that the social security system has no health insurance branch and that since the eighties co-payments and cost recovery have increased dramatically.

The mutual schemes are small and their total number of beneficiaries is somewhere between 30 000 and 40 000 persons, of which some 15 500 beneficiaries belong to the CIDR network and some 6 000 to the "Caisses Villageoises de Mutualité Sociale Rurale" (CVMSR) of the ADMAB network.

With respect to benefit needs, it seems that the combination of old age insurance with health insurance, as proposed by the Ministry of Labour for the "mutuelles de sécurité sociale" corresponds to the needs of the urban informal sector.

In the rural areas there is a lack of access to health care services of good quality. Access to these services is restricted, not only because they are expensive for the population but also because often there are no local providers of these services.

For a pilot study at least, the support of GSTF should be limited to those local schemes which have progressed past the initial stages of scheme organisation and which have become reasonably stable. In the case of Benin, this condition seems to limit the participation of GSTF to the mutual schemes of the CIDR network and those supported by ADMAB.

At the national level the GSTF proposal seeks a supporting entity that would be in a position to distribute funds to the participating mutual schemes, to support these schemes through training and consultancy, and to supervise and audit them. OBSS has expressed its interest in the GSTF proposal. In order to fulfil the stated objectives, OBSS would have to establish a special unit in collaboration with an organization having a deep understanding of mutual health insurance schemes such as, for example, STEP and CIDR.

1. Introduction

The Global Social Trust Fund (GSTF) proposal assumes that in the beneficiary countries there exist social security schemes and community schemes on which the fund could build satellite insurance schemes. Consequently GSTF would not aim at fostering new community schemes from scratch. Through the fund, international and national solidarity would be linked to existing community schemes through financial transfers and technical assistance. Without specifically excluding other social benefits, the main emphasis would be on health care.

This report presents the conclusions of a mission undertaken by Raymond Wagener (IGSS Luxembourg) to Benin from 16 to 19 November to evaluate the possibilities of organising in Benin a pilot project of financial transfer and technical assistance as outlined in the GSTF proposal.

After a brief presentation of the country and population of Benin, as well as the health care and social protection system, chapter six describes the mutual health organizations presently existing in the country. Although these organizations have been created only over the last six years, some of them have nevertheless already accumulated enough experience to allow the development of a national pilot project of the GSTF in Benin. This pilot project proposal is presented in chapter 7.

Note: All amounts are in FCFA (Francs de la Communauté Financière Africaine).
The franc CFA has a fixed parity with the Euro:

- 1 Euro = 655.957 FCFA, or
- 1000 FCFA = 1.5245 Euro.

2. Benin: the Country

2.1 Geography and History

Benin is situated in West Africa between Togo and Nigeria. To the South it is bordered by the Atlantic Ocean and to the North by Burkina Faso and Niger. The surface area of Benin is 112 622 square kilometres and the population of the country is 6.3 million inhabitants, giving a population density of 56 inhabitants per square kilometres. Benin (called Dahomey until 1985) became independent from France in 1960. From 1975 until 1989 it was nominally a "Marxist-Leninist" one party regime under the leadership of President Kérékou who came to power in 1972 through a military coup. At the beginning of the nineties political and economic reforms were undertaken through which the one party was replaced by a multi-party regime; economic liberalization followed.

After being out of power from 1991 to 1996, Mr. Kérékou was re-elected president of Benin in 1996. In March 2001 he was re-elected again, although the elections were marred by irregularities. Between 1995 and 2000 the population grew at an annual rate of 2.7%. The average fertility rate during the same period was 6.1 and life expectancy 53.6 years, which is similar to other countries in the region, for example the neighbouring countries of Togo and Nigeria.

2.2 Population

Between 1995 and 2000 the population grew at a yearly rate of 2.7%. During the same period, the fertility rate was 6.1 and life expectancy 53.5 years, which is similar to other countries in the region, and comparable to its neighbours Togo and Nigeria. Benin is a mainly rural country with 59.5% of its population living in rural areas. Most people in Benin live in the southern part of

the country with the two main towns situated on the Atlantic coast: Cotonou, the economic capital with 850 000 inhabitants, and Porto Novo, the political capital with 195 000 inhabitants.

The population of Benin belongs to 60 ethnic groups, the most important of which is the Fon group in the South of the country. Seventy per cent of the population practice traditional African religions, 15% are Muslims and 15% Catholics. The literacy rate in 1995 was 39% for the whole population, 45% for men and 19% for women.

According to the UNDP Human Development Report 2001[19] Benin ranks 147th out of 162 countries in the human development index (HDI), after Togo and Nigeria. But one could also note that all the countries in the region are classified in the same group of "countries with low human development" with the exception of Ghana.

2.3 Economy

In 1999, the total GDP of Benin was 5.7 million USD (in Purchasing power parity dollars - PPP) and the GDP per inhabitant was 933 USD. From 1989 till 1999, GDP increased on average 4.6% per year and GDP per capita by 1.7%. By economic sector, agriculture produced 37.9% of GDP, industry 13.5% and services 48.6%. Whereas just over a third of GDP comes from agriculture, almost two thirds (63.5%) of the labour force is working in agriculture, 8% in industry and 28.4% in services.

Between 1975 and 1989 Benin adopted a centralised socialist development model and nationalised vital economic sectors, created public companies and extended considerably the public administration: the number of civil servants increased from 9236 in 1972 to 47,163 in 1986. From 1983, Benin entered a period of economic recession with an enormous drop in economic resources of around 10% of GDP. As private savings were low this deficit was financed by exterior credits. In 1989 Benin adopted structural adjustment programmes that succeeded in re-establishing economic growth. Public expenditure decreased significantly by reducing the number of civil servants, by de-nationalising public companies and by reducing social expenditure.

The 100% devaluation of the FCFA (Franc de la Communauté financière d'Afrique) decreed by France in January 1994 had both positive and negative consequences for Benin. GDP growth continued at 4% and cotton exports increased. On the other hand, however, public expenditure decreased drastically in real terms and social spending schemes were significantly reduced.

2.4 Health Indicators

According to the first national Demographic and Health Survey, conducted in 1996:

- The average woman in Benin gives birth to 6.3 children over the course of her childbearing years
- Only 3.4% of women in union use modern contraception
- Maternal mortality rates were estimated at more than 500 maternal deaths per 100,000 births
- 167 of every 1,000 children born in Benin die before the age of five
- Major causes of child morbidity and mortality are:
  - Malaria,
  - Diarrhoea and
  - Acute respiratory infections

[19] (United Nations Development Programme 2001.)

According to the Ministry of Health, the principal reasons for health facility visits in Benin are in general:

- Malaria (36%)
- Respiratory infections (15.4%)
- Gastro-intestinal problems (9.2%)
- Diarrhoea (6.5%) and
- Trauma.

For children under five, the principal reasons for health facility visits are:

- Malaria (38%)
- Respiratory infections (23%)
- Diarrhoea (9%)
- Gastro-intestinal problems (8%)
- Anaemia (6%) and
- Other (16%).

Statistics published in the Human Development Report 2001[20] show that life expectancy at birth is 53.5 years, the infant mortality rate is 99 per 1 000 live births, and that the under-five mortality rate is 156 per 1 000 live births.

3 The Informal Sector

There are several definitions of what is meant by the informal sector. The following is the definition given by the XVth Conference of Labour Statisticians:

"The informal sector comprises units in the household sector, as defined by the System of National Accounts (SNA), and which are unincorporated enterprises or do not hold a complete set of accounts, including:

- Units – registered or not – without permanent employees,
- Units with permanent employees and which are, alternatively or simultaneously
  - Unregistered units, or
  - Units which do register their permanent employees, or
  - Units that employ, on a continuous basis, less than a given number of persons, according to the legislative codes (fiscal or social) or to the practices of survey statisticians when they design the scope and coverage of enterprises surveys."

3.1 The Urban Informal Sector

With the help of UNDP and ILO the government established in 1995 a Study and Survey Program called PEESI (Programme d'Etude et d'Enquête sur le Secteur Informel). Through this program the Government intended to improve its knowledge about the informal sector so that a development policy could be designed which would be more adapted to the needs of this sector.

The following table gives the distribution of the business units of the informal sector by economic activity.

[20] (United Nations Development Programme 2001), p.168.

Table 1. Distribution of urban informal business units by sector of activity

Sectors of Activity	% of total
• **Production**	**28.2**
Textile	*13.7*
• **Construction**	**3.3**
• **Trade**	**19.3**
• **Services**	**49.3**
Catering	*19.9*
Transport	*15.6*
Repairs	*13.5*
	100.0

Two thirds of the heads of informal business units are women who are mainly concentrated in trade and catering units. Men are very dominant among the heads of the transport units of the informal sector where 2 out of three owners are men. Half the business heads are below the age of 30 years and 10% even are children below the age of 15 years. The managers of these informal units are lacking formal education: two out of three have at most three years of formal school education. Obviously they are severely hampered in acquiring the necessary skills for managing their businesses efficiently.

In 1998 an inter-ministerial committee undertook a preparatory study about the introduction of social security for the informal sector[21]. In fact, the study limited itself to studying only the urban informal sector in Benin, and surveys were undertaken in just two towns: Cotonou and Parakou. ILO supported the study, and as a direct result, the Ministry of Labour supported the creation of a mutual insurance scheme in Cotonou and a second in Parakou.

The study was based on a survey of 85 associations of craftsmen, taken from the list of those groups recognised by the Ministry of Interior Affairs, Security and Territorial Administration, and those known to the Ministry of Trade, Craftsmanship and Tourism. Fifty-four of these associations are based in Cotonou, the other 31 in Parakou. The survey showed that members of these associations were first and foremost interested in a social security system that gave them protection against the loss of income from old age or workplace accidents or for their families in the event of death. Health insurance was rated only after income insurance. Other types of benefits mentioned were job training in the case of craftsmen, and school insurance.

3.2 Rural Population

About two thirds of the population of Benin live in rural areas. Poverty is widespread, with significant differences between regions. The large majority of poor live in rural areas: of 1.5 million poor in 1995, 1.2 million were from rural areas.

Almost one in two inhabitants in the so-called Cotton Region of the South (beginning north of Abomey up to Parakou) is poor. In this region the cost of living is high because food production is mainly exported to the urban markets south of this region. Agriculture is not mechanised, so productivity is low. Income is not evenly distributed throughout the year and depends on the price of cotton and of other products. The same applies to expenditure on inputs for agricultural production. Furthermore there are sometimes problems for agricultural producers to sell their products on urban markets because the network of traders prevents them from selling directly and obliges them to trade through intermediaries.

[21] (Commission interministérielle 1998.)

The North of Benin is relatively better off than the southern cotton region, with about one out of three persons being poor. The South of the department of Borgou (just North of the town of Parakou) where food production is high is even better off than the rest of the north, with about one out of four persons qualified as poor in this region.[22]

Many of the existing mutual schemes in Benin have been created in the southern cotton region. Indeed cotton production has stimulated the development of village producers' groups and credit unions. Many of the villagers (peasants, craftsmen, women traders) are used to contributing regularly to traditional saving-credit systems, the so-called "tontines", or to the growing number of micro-credit institutions. Building on these community experiences that reinforce solidarity between community members, mutual schemes were created to give the villagers better access to health care, as is the case with the mutual schemes promoted by ADMAB.

4 Health Care Infrastructure

The Benin public health care system is structured in a pyramidal form with three levels structured around the administrative subdivisions of the country: central or national, intermediary or departmental and peripheral, broken down into sub-prefectures and municipalities. Benin currently has six functioning administrative regions (Atlantique, Mono, Ouémé, Zou, Atacora, and Borgou), 77 urban regions and sub-prefectures and 568 communes. The country's new decentralization law, currently being put into effect, has established a new administrative system consisting of 12 administrative regions, 74 communes and three autonomous urban areas (Cotonou, Porto-Novo and Parakou).

The Ministry of Health is in the process of reorganising its structure through the creation of public health zones or "*zones sanitaires*". These zones are designed to facilitate decentralised planning and management as well as the efficiency of resource allocation and the rehabilitation of referral units. Each zone covers a population of 100,000 to 150,000 inhabitants. The average sub-prefecture has a population of 50,000 to 60,000 inhabitants. Each of the 33 designated zones groups two to three sub-prefectures. Through this reorganization, the Ministry of Health aims to reinforce and reorient current services, and promote the effective decentralization of health services.

The Ministry of Public Health (Ministère de la Santé Publique - MSP) is responsible for the health system at the national level. It has offices at the departmental level which are responsible for managing health programs, allocating resources and providing support to the health facilities within the departments. At the sub-prefectoral level a chief medical officer supervises primary health care facilities, and at the community level a state midwife or nurse manages community-level primary care.

Within the three levels of the health care system the following institutions are providing health care:

- The national university hospital centre (Centre national hospitalier universitaire - CNHU) is at the top. This centre is responsible for tertiary care and offers specialised medical and surgical care. If the patient needs care which cannot be supplied by the CNHU, he may be evacuated to a hospital abroad. Training of physicians, midwives, nurses and technicians is also offered by the CNHU and some medical research is undertaken. The CNHU also serves as a primary health care and as a first referral health centre.

[22] (United Nations Development Programme 1997) p. 53 ss.

- The departmental hospitals (CHD) are at the intermediary level for the treatment of cases requiring medical specialists. The CHDs are also responsible for in-service training of regional clinical staff.
- The peripheral structures are:
  - Zone hospitals (HZ);
  - Health centres for urban districts (Centres de santé de circonscription urbaine – CSCU);
  - At the commune-level, there are 342 communal health centres (CCS), which generally contain a four-bed dispensary, a 12-bed maternity unit and an outlet for the sale of drugs. The CCS are typically staffed by just three persons: a nurse, a midwife and a nurses' aide. These centres serve as entry points into the health system and provide primary health care;
  - The only health structure at village level is the village health unit, of which the Ministry of Health listed 299 in 1999. A birth attendant and a first aid health worker usually constitute the staff of these units.

Essential drugs are provided by the *Centrale d'Achat des Medicaments Essentiels* (CAME) of the Ministry of Public Health, which buys generic drugs and sells them to health facilities at low cost. In consequence, many common drugs, such as chloroquine, are widely available. However, health centre staff are obliged to physically go to the CAME to collect drugs, whilst the private sector is not supplied through the CAME. In addition, a continuing problem identified in a 1996 UNICEF report is the uncontrolled circulation of low-priced drugs produced in Nigeria and sold in Benin. Many of these drugs of dubious quality are sold in open markets, unlabeled and undated.

Benin has approximately one doctor per 19,000 people and one doctor per 2400 beds. The real situation, however, is worse than indicated by these figures, for the University Hospital in Cotonou accounts for approximately one-third of all health staff (private sector included) in Benin.

At the end of 1999, there were 536 public health centres in Benin and 631 private centres. The public sector hospitals had approximately 3341 beds, and the private sector 3593 beds, making a total of 6934 hospital beds. According to Ministry of Health statistics for 1999, Benin has a total of 909 doctors, 2336 nurses and 885 nurse midwives. The majority of the country's health personnel are concentrated in the southern part of the country, especially in Cotonou and Porto-Novo.

For the people in rural areas it is sometimes extremely difficult to get to public health centres and often the services provided are of low quality. A study of the village of Agbogbomè, some 50 kilometres south of Savè, illustrates this situation[23]. The village is composed of 35 hamlets spread over a large region, so that the next CCS at the town of Paouignan is at a distance of between 18 km from nearest hamlet, and 40 km from the one farthest away (the hamlet of Agbogbomè). The next zone hospital is in the town of Dassa, 57 km from the hamlet of Agbogbomè. In the 35 hamlets, there are only 2 village health units - each with a staff of one first-aid worker, one village health unit with a birth attendant and a first-aid worker, and one private health practice with one nurse and two nursing auxiliaries. A health centre in Abomey has installed the private centre. Every fortnight a medical doctor comes from Abomey to give medical consultations. Medical treatment at the private centre is extremely expensive compared to treatments at the public health centre. For example a simple treatment of malaria costs 1 750 FCFA at the private centre and 375 at the CCS in Paouignan.

[23] (ADRAI 2000.)

Until 1990, public sector services did not require formal payment, as they were fully financed through the national budget. The percentage of Benin's national budget allocated to health has been up and down over the past several years, from 8.8% in 1987 to 3.2% in 1992, to 4.9% in 1996, 6.7% in 1998, and 5.1% in 1999.

As public funds became increasingly scarce in the early 1990s, the public health sector became increasingly reliant on both donor funding (largely for investments) and cost recovery (for non-personnel recurrent costs). According to a Ministry of Health annual statistics report for 1999 , donors supported 84% of the health sector's overall budget.

The health sector also suffers from systemic governance problems resulting in low absorptive capacity; only about 30% of total external funding is actually spent.

Besides the public institutions there are also a growing number of private health care institutions, pharmacies and self-employed professionals. Most of these private health care providers are situated in the urban centres. In addition, many religious institutions and some non-governmental organizations (NGOs) run hospitals or dispensaries, or provide training, health education, and other health services. It is estimated that the private/NGO/confessional sector actually provides at least 30% of health services in Benin. Overall, 19% of medical personnel work in the private sector, including approximately 37% of physicians, 16% of nurses and 14% of nurse midwives.

Traditional healers constitute an important element of Benin's health care system. As in many African countries, it is thought that in Benin too most people seek treatment from traditional healers before accessing modern or "western" treatment. Traditional birth attendants also exist at the community level.

At the municipality level, an elected committee called COGEC coordinates the health care program. This committee is responsible for managing essential drug stocks and proceeds from cost recovery and approves local non-wage expenditures financed through cost recovery receipts. The COGEC were initiated in 1989 as a means of stimulating the interest and involvement of Benin’s population in the health system.

5 Social Protection

5.1 Social Security

As in other developing countries, formal social security in Benin covers less than 10% of the population. With the exception of civil servants,formal-sector wage earners are affiliated to the Office Béninois de Sécurité sociale (OBSS), which covers six out of the nine social security branches of ILO Convention No. 102 concerning Minimum Standards of Social Security:

- Old-age benefit
- Employment injury benefit,
- Family benefit,
- Maternity benefit,
- Invalidity benefit, and
- Survivors’ benefit.

The branches missing are:

- Medical Care,
- Sickness benefits, and
- Unemployment benefit.

The OBSS is a public corporation with its own legal personality and is financially autonomous. It is placed under the administrative supervision of the Ministry of the Civil Service, Labour and Administrative Reform.

On 31 December 2000, 131,883 wage earners were affiliated to OBSS. The institution was paying 11,779 in invalidity, old age and survivors' pensions, and 1664 industrial injuries pensions. Its income was 23.1 billions FCFA, of which 12.3 billion were contributions. The expenditure of the year was 14.0 billions FCFA.

At the end of 2000, 322 persons were employed by OBSS at its central administration in Cotonou and its 6 local agencies throughout the country.

In 1991 OBSS began to implement a restructuring project to improve the collecting procedures of the contributions, to improve control of expenditure and to computerize the administrative procedures. In spite of some unresolved problems, the financial management of OBSS improved substantially during the nineties.

A new Code of Social Security was voted by the national parliament in 1998 and is being implemented. Civil servants have their own social security system which is managed by the Fonds National des Retraités du Bénin (FNRB). About 40 000 active civil servants are affiliated to this institution and about 25 000 pensioners get a pension from it. This fund is running huge deficits because of the reduction of the civil service during the nineties.

In summary a little bit more than 200 000 persons are either wage earners or pensioners of the social security system of Benin out of a total population in 1999 of about 6.1 million and a labour force of around 2.8 million persons.

The Ministry of Labour, together with OBSS, is promoting mutual insurance schemes for the urban informal sector covering health and old age risks. These schemes called "Mutuelles de sécurité sociale" have already started in Cotonou and Parakou.

5.2 Health Insurance

By law ("Code du Travail") the employer has to pay up to 60% of the health care expenditure of his employees and dependent members of their family. In addition, the employer has to organize a minimum medical service within his firm to provide his employees with first aid care in case of need. Some collective labour agreements stipulate that in case of hospitalisation the employer pays the total cost of the medical consultation and of pharmaceuticals. Unfortunately some of the employers do not comply with the law.

The State covers 80% of expenditure on medical care and hospitalisation for civil servants and members of their family in public health institutions, but they have to pay the full cost of the medical drugs they need. In the event of sick leave, a civil servant receives his full wage for a period of three months and then half pay during the next three months.

In a very limited way OBSS is also financing some of the expenditure on health care. First of all, in the case of a work accident OBSS pays the full amount of health care costs including pharmaceuticals, hospital care, rehabilitation and prosthesis. During his sickness leave and before being able to work again or getting an invalidity pension, the employee receives a sickness benefit equal to his wage.

After 6 months of employment covered by insurance employed women are entitled to maternity benefits corresponding to 100% of their earnings. The employer pays half of the maternity benefits and OBSS the other half. Maternity benefits are payable for up to 6 weeks before and 8 weeks after confinement. Maternity benefits paid by OBSS are financed by an employer contribution of 0.2% of the payroll.

Within their branch of Family Benefits, OBSS is financing a programme of health and social activities for the family members of employees affiliated to the social security system. This programme is financed out of the budget of the family allowances and has no autonomous budget. Through this programme family members may get medical consultations, preventive and curative care, and drugs, and pregnant women and mothers may get dietary advice.

Since the privatisation of the insurance sector at the beginning of the nineties, private insurance companies are trying to enter into the health insurance business. A mutual health insurance scheme called MUSANT ("Mutuelle de santé pour tous") is also offering insurance for primary health care for wage earners of the formal sector and self-employed people. MUSANT was founded in 1998 and covers about 1 600 persons. The average monthly contribution per person is 26 202 FCFA.

Around 50 mutual health insurance schemes have been organised during the nineties for the informal sector, most of them in rural areas. Several institutions are preparing to start more schemes in the near future. One could estimate that in 2001 between 30 000 and 40 000 persons were members of these mutual schemes. In chapter 6 the characteristics of mutual schemes will be discussed.

5.3 Social Assistance

The first social service in Dahomey, as Benin was formerly known, was founded in 1953 when it still was a French colony. The first social centre was opened in 1955 in Porto Novo and the same year the Service for Social Affairs was created within the Ministry of the Civil Service and Labour. Since 1998 the successor of this service, the Directorate of Social Development is part of the Ministry of Social Protection and Family. In spite of its denomination, it is not this ministry that supervises the social security system of Benin, but the Ministry of the Civil Service, Labour and Administrative Reform. The Directorate of Social Development manages a network of 78 Social Promotion Centres throughout the country at the "Sous-préfectures" and urban districts. Because of lack of financial resources 20 of these centres were not operational in 1999. The State budget for 1999 made provision for an amount of 383.7 million FCFA for the Ministry of Social Protection and Family, but at the end it received only 64.6 million FCFA, so that the activities of this ministry are seriously hampered by the lack of financial means.

The Ministry of Social Protection and Family may help people in desperate need by giving them a non-reimbursable benefit. But this is a totally discretionary faculty of that Ministry and people in need have no entitlement to this benefit and no possibility of appeal against the decision taken by the Ministry. And the financial possibilities of this Ministry today are very limited indeed.

5.4 National Committee for the Orientation of Social Welfare[24]

A National Committee for the Orientation of Social Welfare was created by a 1997 decree within the Ministry of the Civil Service, Labour and Administrative Reform with the following objectives:

- To formulate programmes for the orientation of social welfare;
- to discuss and work out proposals for the legal reform of social welfare bills:
- to participate in the elaboration of all national programmes having an impact on social welfare;
- to monitor the execution of such programmes.

The committee is composed in a tripartite way with representatives from different ministries, for example the ministries of labour, health, social affairs, rural development, with representatives of the employers and employees, farmers and craftsmen, of insurance companies and national NGOs working in the field of social protection. The committee entails also representatives of the federation of women's associations and of the elderly.

Up to now, the national committee does not appear to be playing an important role in the coordination and development of social welfare in Benin. Particularly with respect to the development of mutual health insurance schemes, it would be important to coordinate the initiatives taken by the state, bilateral cooperation and national and foreign NGOs. But it seems that even within the Government the executives in the concerned ministries are not always well aware of the programmes that their colleagues are developing in other departments.

The World Bank, with the help of the Ministry of Social Protection, published in 2000 a study on a future strategy of social welfare in Benin[25].

6 Mutual Health Insurance Schemes

In Western and Central Africa, the *mutuelles de santé* have existed only since the late eighties, and in Benin only since the second half of the nineties, as a means for the rural and urban poor to access better health care. Indeed, during the seventies and eighties, the quality of public health services deteriorated and access to public health care became more difficult. As a result of the economic crisis during this period, state subsidies to the health sector were reduced in an effort to cut deficit levels. Following the Bamako conference in 1987, African Health Ministries introduced cost recovery schemes through fees for medical services and drugs at public health centres, with the result that access to more expensive health services became unaffordable for the poorest.

6.1 Definition

As noted by Atim[26]:

> "*Attempts to translate the French term* mutuelle de santé *into English have always been dogged by the lack of any clearly recognizable equivalent, perhaps illustrating the fact that the reality of mutuals is different in the English-speaking countries. However, in the context of the study of mutual health schemes in the English-speaking parts of Africa, the term "Mutual Health Organizations" (MHO) has recently come to be used in the discourse*

[24] (Comité national d'Orientation de la Prévoyance sociale.)
[25] (Tovo; Bendokat; World Bank; Human Development Network, and Social Protection Team 2000)
[26] (Atim; International Labour Office; United States, and Agency for International Development 1998)

to describe these kinds of mutuelle and near-mutuelle organizations characteristic of such countries."

In this report the term "Mutual Health Organizations" (MHO) or mutual health insurance schemes will be used with Atim's definition:

"A voluntary, non-profit insurance scheme, formed on the basis of an ethic of mutual aid, solidarity and the collective pooling of health risks, in which the members participate effectively in its management and functioning"

All the organisations considered in this chapter cover the field of the previous definition, but some of them go beyond, either by including not only health but also old age pension, as in the case of the *mutualités de sécurité sociale* in Cotonou and Parakou, or by combining the mutual and solidarity principles with an individual health savings system, as may be found in the case of the "caisses villageoises" of the ADMAB network.

6.2 Mutual Health Organisations in Benin

Mutual health organisations (MHO) are rather new in Benin, in spite of the fact that the social security system has no health insurance branch and that from the eighties onwards co-payments and "cost recuperation" have increased dramatically.

There is no official inventory of the mutual health insurance schemes existing today in Benin. Nevertheless it is possible to understand the reality of these initiatives through a statistical survey undertaken for the Global Social Trust project[27] and through the report of Stéphane Vancutsem[28]. The statistical survey identified 28 MHOs, of which 18 belong to the CIDR network.

CIDR (*Centre International de Développement et de Recherche*) is a French NGO which started to work in Benin in 1994 and whose activities in the country are financed by the Swiss Development Cooperation. CIDR has announced that it plans to stop supporting the MHOs in Benin in 2006.

The mutual schemes are fairly young, with an average life of about three years. The oldest scheme was created eight years ago. Many schemes are still in their initial development phase or began only recently to finance health care services for their members. During the survey it appeared also that new mutual schemes are about to be created: for example, the Benin-German Project of Primary Health Care is about to organise two new mutual schemes in Banikoara and Kandi, near Parakou.

The mutual schemes are small and together their number of beneficiaries is somewhere between 30,000 and 40,000 persons, of which some 15,500 beneficiaries belong to the CIDR network and some 6000 to the *Caisses Villageoises de Mutualité Sociale Rurale* (CVMSR) of the ADMAB network.

ADMAB (*Association pour le Développement de la Mutualité Agricole au Bénin***)** was founded by the *Mutualité Sociale Agricole de France* together with some other NGOs (among them *Pharmaciens sans Frontière*). The president of ADMAB is a Benin national who has been

[27] (Moustapha 2001)
[28] (Vancutsem 2001.)

working for 35 years in the rural mutual movement in France. ADMAB has been financed by French national and regional development funds.

Table 2 gives some results of the statistical survey established for the Global Social Trust Fund Study.

Table 2.
Main characteristics of mutual health schemes

Name	Location	Network	Year of creation	Beneficiaries 2001	H.C. Benefits	Other Benefits	Financing	Monthly Contributions per beneficiary (in FCFA)	% of expenditure covered by contributions and entry fees
UCGM Nikki	Nikki	CIDR	1996	646	Child delivery, small surgery, hospital care			1311	
UCGM Biro	Nikki		1996	603				1204	64.6
UCGM Kilibo	Ouesse		1998	788				1236	91.7
UCGM Guinagourou	Perere		1996	1015				1043	101.6
UCGM Gbanlin	Ouesse		2000	344				1368	73.7
UCGM Ouesse	Ouesse		1999	325				1548	70.2
UCGM Sirarou	N'Dali		1995	2073				1095	95.5
UCGM Saka-Bansi	Nikki		1995	401				1107	72.3
UCGM Bori	N'Dali		1998	452				1074	104.6
UCGM Kalale	Kalale		1998	904				954	82.2
UCGM Ouenou	N'Dali		1998	493				1064	95.3
UCGM Tasso	Nikki		1998	778				1396	80.4
UCGM Suya	Nikki		1995	198				856	
UCGM Laminou	Ouesse		2001	408				1164	
UCGM N'Dali	N'Dali		2001	455				1189	
UCGM Toui	Ouesse		1998	1183				1182	82.6
UCGM Challa-Ogoi	Ouesse		2001	220				1157	
UCGM Kemon	Ouesse		1998	223				*1502*	72.2
Hwengan-Abomey			1998	1729	Primary health care			*292*	128.7
Mutuelle La			1993	*2640*	Primary			*1212*	94.6

Famille					health care				
Alafia			2000	115	Primary health care			3000	
Mutuelle de sécurité sociale Parakou	Parakou		2001	686	Primary health care	Old age pension		179	
Mutuelle de sécurité sociale Cotonou	Cotonou		2000	510				1751	20.0
Fifonsi de Atchegou	Dassa	CREDESA	2001	87	Primary health care			193	
Mutuelle Mededjro Agbogbome	Dassa		2001	297	Primary health care			364	
CVMSR Assrossa	Bonou	ADMAB	1996	*1035*	Primary health care, hospital care		Health savings accounts (for primary health care), else contributions	*1064*	356.0
CVMSR Biguina	Bassilia		1996	792				*1292*	407.0

In italics: figures relating to 2000

Table 2 is certainly not complete. Indeed, only two of the mutual schemes of the ADMAB network, and none of the Børnefonden (see below), have sent in their answers to the survey questionnaire. Other MHOs have not been included in the survey, as can be seen by comparing the list of the survey with the report by Mr. Vancutsem.

Many institutions and groups are in fact taking initiatives in this field and preparing new MHOs, so that the situation is evolving from month to month. On the other hand, and above all because so many of the schemes have been created only recently, some are still very weak and fragile. There have been failures even within the most experienced networks, as for example the mutual scheme of Sanson in the CIDR network, or the CVMSR of Gbowiné of the ADMAB.

The figures concerning the number of beneficiaries, and amounts of expenditure and receipts must be interpreted very cautiously. Indeed the available statistical information on MHOs is very weak and unreliable, because the situation is changing so rapidly and because statistical reporting is very underdeveloped.

6.3 Membership Criteria

Mutual health insurance schemes in Benin may be classified into three categories:

- Mutual schemes for the population of a region (village, municipality): most of the schemes are of this type.
- Mutual schemes for specific professional categories, as for example:
  - OPT, the mutual scheme of the postmen;
  - ALAFIA of Unacotamo which is essentially a mutual scheme of the taxi bike drivers, although other professionals are admitted;
  - The *mutuelles de sécurité sociale* in Cotonou and Parakou where the members have to belong to member associations of craftsmen, peasants or traders.
- Mutual schemes for the customers of a given health institution. The Ministry of Public Health is promoting such a project to support the hospital of Comé (department of Mono); this project is financed by the Belgian cooperation fund.

The divide between these categories is not always clear. As an example, the mutual schemes of ADMAB, the *caisses villageoises de mutuelle sociale rurale* (CVMSR) are schemes designed for village populations. Nevertheless they are also organised around a health centre that has been newly built or renovated by the corresponding CVMSR. As the CVMSRs are managing their health centres, it would seem more appropriate to classify them as belonging to the first group rather than to the third[29].

Besides these three categories, the Danish NGO Børnefonden is supporting an unusual type of mutual health insurance scheme. Børnefonden started as a supporting scheme for poor children. Today it is supporting poor families over a three-year period. The families may choose to continue to belong to the mutual scheme, but once the support of Børnefonden stops, they will have to pay a doubled contribution amount.

6.4 Organisation of Mutual Insurance Schemes

Typically the mutual scheme has four organs:

- The general assembly (*Assemblée générale* – AG): The AG meets once or twice a year and takes all the relevant decisions concerning the scheme, for example, electing the other organs

[29] (Loko 2001.)

of the scheme, voting the statutes or fixing the contribution rates. In general only the members of the schemes have the right to vote at the AG; not all family members are covered. In rural areas (for example in the schemes of ADMAB and CIDR) this means that only a small number of women have the right to vote at the AG.

- The board of directors (*Conseil d'administration* - CA) composed of members elected by the AG. In some mutual schemes the CA also includes, besides these elected members, directors delegated by exterior institutions; thus, at the mutuelle de sécurité sociale in Cotonou, one of the members of the CA is a delegate of the Ministry of Labour.
- The executive committee (*comité exécutif* – CE), elected either by the AG or the CA. Often the CE is composed of some of the members of the CA. Sometimes there is no division between CA and CE, as in the case of the schemes of the CIDR network or of the "mutuelles de sécurité sociale" in Parakou and Cotonou. But these schemes have a professional manager who is appointed by the board of directors.
- The supervising committee (*conseil de surveillance* – CS), elected by the AG. Again sometimes exterior delegates of the supporting institutions are members of the CS, as for example in the case of the *mutuelle de sécurité sociale* in Cotonou.

Not all the mutual schemes have a legally recognised statute. The CVMSR are registered at the Directorate for rural promotion and legislation, because they need to be recognised so that their health centres might get drugs from the *Centrale d'Achat* of the Ministry of Public Health. On the other hand, the UCGMs of the CIDR network are only de facto associations without any legal recognition and according to Vancutsem[30] they seem to lack internal formalization (statutes, internal regulation, contracts with external organizations).

The network of the CIDR mutual schemes is organised as a federation with three levels (four levels up until quite recently, the fourth being schemes within the same village):

- On the lowest level, the village mutual scheme
- On the intermediary level, the municipal union of mutual schemes, and
- On the highest level, the associations of mutual schemes that encompass the municipal unions of one public health zone or those using the same hospital. The association supervises the mutual schemes that belong to it and it is the privileged negotiator of the schemes in their relations with the CSSPs and the hospitals.

6.5 Contribution Systems

In the case of some mutual schemes, new members must first pay a registration fee, which may vary between 500 and 1000 FCFA. In terms of contributions, one may classify the schemes into different categories:

- Systems with the same contribution for each family member;
- Systems where the same contribution is paid by every member, independently of the number of family members;
- Schemes with contribution rates depending on the number of family members covered. For example, for a family of 5 persons or more, the basic monthly contribution of 2000 FCFA for the *mutuelle de sécurité sociale* in Cotonou increases by 500 FCFA for each person after the fifth family member.
- Schemes with contribution rates depending on the health care services covered by the scheme. For example, the standard contribution to the CVMSR of the ADMAB network is

[30] (Vancutsem 2001), p. 110.

15,000 FCFA per family, or 25,000 FCFA if free transport to the specialised health care institution is included.

6.6 Contribution Capacity

In recent years, several studies have analysed the capacity of the target population of mutual schemes to pay the contributions of those schemes. With respect to the rural population, in 1999 and 2000 ADRAI and CREDESA conducted a feasibility study of a mutual scheme in the municipality of Agbogbomé, 50 kilometres south of Savè in the southern cotton region[31]. The mean income per year in this region is about 253,400 FCFA, which is relatively high compared to the average income of the Zou department. The economic situation of the municipality will probably improve further due to the construction of a new bridge that will link Agbogbomé to the main road from Abomey to Parakou.

The people of this municipality produce enough food for their own needs throughout the year, so that they spend relatively little on food. According to the study, the peasants of Agbogbomé declared that they were prepared to pay 291.6 FCFA in contributions per person per month for a mutual health care scheme. A preliminary awareness campaign for promoting a mutual scheme showed that the families interested in joining the scheme had on average 9 members besides the head of the family (2 wives, 6 children, 1 other person) per head of family, so that the monthly contributions per family would be 2916 FCFA. The mutual scheme would start with a lower monthly rate of contribution of 150 FCFA per person, about half of the amount indicated in the study.

6.7 Services offered by mutual schemes

Most of the mutual schemes have a probation period during which the new member pays contributions but is not yet able to obtain services from the scheme. Typically the length of such a period is six months, but it may be less or more. In the case of the mutual schemes of ADMAB, there is no observation period, so that a new member is entitled to benefits immediately.

There are two types of health care packages:

- Most of the mutual health insurance schemes cover both primary health care services, i.e. medical consultations, nursing care, generic drugs, light hospitalisation, and child delivery, and preventive care, or pre- and postnatal consultations. In general specialised care, dental care and special drugs are not taken care of by the mutual schemes.
- However, not all mutual schemes offer primary care services. The PAZS/MONO project offers essentially specialised hospital care and obstetrics at Comé hospital. The CIDR mutual schemes do not pay for primary care but only for major health risks such as hospitalisation.

The *caisses villageoises* (CVMSR) of ADMAB are organised in an unusual way, as they group together two different systems for financing health care. Indeed, 80% of their contributions are put into individual accounts of a health credit and saving system. The owners may use the amount accumulated in their health accounts to pay for primary health care services given at the health centre of the *caisse* for themselves or family members. There is no risk sharing between members of the CVMSR for these 80% of contributions and for primary care. The other 20% of contributions are put into a real mutual solidarity fund to cover expenses at specialised institutions with which the MHO has signed an agreement. Another peculiarity of the CVMSR is that by contributing 25,000 FCFA per family per year instead of 15,000 FCFA, the mutual scheme guarantees, in case of need, free transport to the specialised health care institution.

[31] (ADRAI 2000.)

The mutual schemes of the CIDR network offer a supplementary advantage to their members: they have the right to use all the health institutions belonging to other mutual schemes or with which those schemes have signed an agreement.

Besides health care benefits (with or without risk sharing) some mutual insurance schemes also offer other social services. In this respect the *mutuelles de sécurité sociale* in Cotonou and Parakou are interesting, because as well as health care, they include pension insurance for their target population of small craftsmen and traders. Apparently the members of these schemes are more interested in the pension insurance part than in the health care insurance. This seems to confirm the findings of the preparatory study about the introduction of a social security for the informal sector[32].

There is no statistical report on the number and cost of health care services financed by the MHOs. In general the statistical monitoring of the activities of the mutual schemes seems to be rather weak, with one notable exception. CIDR has organised a statistical reporting system that enables the monitoring, for each MHO, of the number of member families and covered persons, the number and average cost of health care services both by type of service, and for health care centres and hospital,

The following table gives an example of the information available through the statistics established by CIDR. It shows the evolution of the utilization rates and average cost of health care services for the mutual scheme of Sirarou, one of the oldest MHOs of the CIDR network.

Table 3. Utilization Rates and Average cost of health care services[33], UCGM Sirarou

Category	Utilization Rate (in ‰)			Average Cost per Intervention (FCFA)		
	1995-96	**1996-97**	**1997-98**	**1995-96**	**1996-97**	**1997-98**
Community Health Centre:						
Child delivery	7.5	23.7	18.1	7 863	2 872	3 375
Minor Intervention	3.8	10.2	21.9	1 090	1 860	1 969
All Interventions	**11.3**	**33.9**	**40.0**	**5 605**	**2 566**	**2 605**
Reference Hospital:						
Child delivery		8.7	8.7		9 532	7 112
Minor Intervention		1.6	2.4		3 000	5 000
Hospitalisation	52.6	54.4	58.8	6 557	8 990	9 051
All Interventions	**52.6**	**64.6**	**70.0**	**6 557**	**8 916**	**8 669**
Total Interventions, Community Health Centre and Reference Hospital	**63.9**	**98.5**	**110.0**	**6 389**	**6 732**	**6 462**
Average number of beneficiaries	266	1 268	2 872			

6.8 Co-payments

Some mutual schemes have a system of co-payment where the beneficiary must pay between 10% and 50% of the cost of health care. For example, the *mutuelle de sécurité sociale* in Cotonou covers 90% of the cost of medical consultation and 70% of other medical expenses. Members of the Børnefonden mutual schemes pay a co-payment amount that varies with the

[32] (Commission interministérielle 1998.)
[33] Taken from Table 13 in (Atim and others 1998.)

total amount of the medical bill: for a total expenses of less than 50,000 FCFA the co-payment is 80%, between 50,000 and 75,000 it is 50%, and for an amount higher than 75,000 FCFA the co payment is 25%. The mutual schemes of the CIDR network and the CVMSR do not have any co-payment for the health care services they pay for.

Members of the mutual scheme in Agbogbomé, which began granting health care benefits in November 2001, pay 30% of the cost of the treatment, and the mutual scheme pays the remaining 70%. This mutual scheme pays for a maximum of 2 health care consultations per year per person, but these consultations may be redistributed among the members of the family.

6.9 Relations with Health Providers

Some MHOs manage one or several health care units; others have only reached agreements with some health care providers.

The CVMSR of ADMAB are organised around a medical centre, which they have renovated and reequipped. Such a centre is composed of a polyclinic, a maternity unit, and pharmacy. The managing board of the centre is composed of members of the board of the CVMSR, members of the CVMSR and representatives of the staff of the centre.

The CVMSR have negotiated agreements with other health centre for treatments that cannot be given at their own health centres.

Health treatments may be paid for in different ways. For example, in the case of the convention between the CIDR network and the CSSP of Ouèssè, the hospital is paid through a system of fixed amounts per type of treatment:

- Simple child delivery: 3 000 FCFA
- Child delivery with complications: 6 500
- Minor surgical intervention: 2 000
- Minor complicated surgical intervention: 6 000
- Hospital care without surgery: 8 000
- Hospital care with surgery: 25 000
- Patient referred to the hospital in Papanè: 6 000.

In the case of specific illnesses, for example meningitis, the agreement with the CSSP of Ouèssè stipulates that 100% of the real cost of the treatment is paid by the MHO.

In its agreement with the private St. Luc Hospital, the *mutuelle de sécurité sociale* in Cotonou applies yet another system: capitation. It pays 2000 FCFA per month for each person entitled to services paid by the *mutuelle*.

6.10 Financial Management

The following table gives the evolution of two financial indicators for mutual schemes of the CIDR and ADMAB networks. As already indicated, these data are not very reliable, and should be interpreted very cautiously. According to the data, contributions do not cover the expenses of the MHOs of the CIDR network, whilstin the case of the *caisses villageoises* of the ADMAB network, contributions seem to be largely sufficient to finance the expenditure of the scheme. Probably these figures correspond to the aggregated operations of both the health savings and the health mutual insurance system, so that the high ratio comes from the savings scheme. To

understand the financial management of the *caisses villageoises* it would be necessary to obtain the figures separately for the health savings schemes and the health mutual insurance schemes.

Some of the schemes indicated in table 4 seem to spend a high percentage of their income on expenses other than benefits.

Table 4. Financial indicators for some mutual schemes

	Ratio Contributions/Total Expenditure			Ratio Administrative Costs/ Total Receipts		
	1998	1999	2000	1998	1999	2000
Biro (CIDR)	97.6	76.7	64.6	22.4	33.3	32.5
Kilibo (CIDR)	72.2	95.7	90.2	40.5	18.5	19.7
Guinagourou (CIDR)	114.6	109.1	93.1	31.7	30.3	21.5
Sirarou (CIDR)	99.9	97.2	91.3	16.5	18.0	13.0
Saka-Bansi (CIDR)	111.1	106.8	72.3	23.1	15.5	10.9
CVMSR Assrossa (CIDR)	144.2	119.6	152.0	17.6	14.6	39.6
CVMSR Biguina (CIDR)	82.9	340.1	401.4		6.3	21.9

6.11 Intervention of supporting organisations

The supporting organisations of the mutual schemes have different intervention strategies, which explain differences in the participation forms of the members, autonomy of the schemes from the supporting organisations and governance profiles. In general one may distinguish among three sectors of intervention:

- *Technical and organisational support*, which often takes the form of training responsible persons of the schemes, as well as counselling by experts on organisational techniques, accounting and financial management and on organising promotional campaigns. All the supporting organizations give this kind of support to the mutual schemes that they are promoting, above all in the initial phase of establishing the scheme
- *Financial support.* This type of help varies according to the supporting organization. Some organizations, for example the Ministry of Labour in the case of the ***mutuelles de sécurité sociale*** in Cotonou and Parakou, pay the benefits and running costs during the initial phases. Other organizations do not want to subsidize the schemes so directly, as it may make it more difficult for the schemes to become sustainable in the long run. Nevertheless most of these organizations are subsidising the mutual schemes more indirectly, above all in the initial phase. For example, CIDR subsidises a fund of their federation of mutual schemes to promote this type of scheme. ADMAB has financed in the past some part of the wages of the health care personnel of the health centres of their CVMSRs as well as some equipment of the centres.
- *Follow-up and evaluation.* Most of the supporting organizations have monitoring procedures. CIDR has in fact organised a rather strong monitoring of the MHOs in its network: it audits the accounting and financial documents of its network of mutual schemes on a regular basis, and has organised a statistical reporting system. On the basis of these data CIDR evaluates the activities of the individual schemes and formulates proposals to improve their administrative and financial management.

6.12 Relations with Government Departments

The Ministry of Labour is fostering mutual insurance schemes for the urban informal sector and is planning to establish such *mutualités* in all major towns of the country. The Ministry of Health is planning to work together with ADMAB to organise mutual insurance schemes centred at health centres and zone hospitals. The Ministry of Family, Social Protection and National Solidarity is preparing an action plan to organise MHOs linked to their social assistance centres throughout the country. This action plan will be based on a World Bank study. The Ministry of Family plans to start pilot projects in the next year.

At the Government level there is an obvious lack of exchange of information and coordination concerning the activities of different Ministries in the field of rural and urban health insurance. Moreover, the ministerial departments do not seem to have a complete overall understanding of the way MHOs work in Benin.

6.13 Strengths and Weaknesses of Mutual Schemes

The Benin Ministries of Labour, Health and Family are aware of the importance of promoting health insurance for the informal sector. Trade unions and employers' organizations also feel that the development of health insurance for the informal sector would be a positive step. Many MHOs have been organised in the last couple of years with the help of national and international NGOs and with financial resources from the bilateral cooperation of France, Switzerland and Belgium.

Apparently the concepts of insurance and solidarity, especially with respect to health care insurance, are not well understood and appreciated by the population of Benin. Whereas the importance of individual saving for future needs seems to be well understood, this is not the case with respect to social insurance, a system where many people contribute to a common solidarity fund to finance benefits for supporting a comparatively small number of individual catastrophic. Micro-credit projects have been developed successfully based on traditional forms of saving (e.g. the *tontines*). Some of these projects have also incorporated health savings, where members can save some money that can be drawn to pay for health care. There are also examples of a mix of a small health insurance scheme coupled with a health saving scheme. Such is the case of the mutual schemes promoted by ADMAB: 80% of the contribution is in fact put into an individual savings account and 20% is used as a contribution to the mutual health insurance scheme. Indeed the CVMSRs of the ADMAB work together with local micro-credit organisations called *Caisses rurales d'Epargne et de Prêt* (CREP).

However, due to negative experiences in the past, it would seem that the population - at least in some areas - is rather sceptical concerning such initiatives, and is wary about the members of the boards of mutual schemes.

NGOs active in the health care sector are promoting very different approaches. There are some exchanges and common seminars or conferences organised, for example in Cotonou in June 2001. STEP is helping to promote these exchanges.

The following table summarizes the strengths and weaknesses of some of the mutual health insurance schemes in Benin.

Table 5. Strengths and Weaknesses of mutual schemes[34]

	Strengths	Weaknesses
CIDR	Strong participation of the members of the MHO Good collaboration with the health centre, Improves health situation of the population Initiatives taken by members Strong cohesion of me with social events (theatre, traditional dances,)	Does not cover primary health care Lack and seasonality of resources of peasant members Lack of control of benefits' cost Problems of human resources and of voluntary work
CVMSR promoted by ADMAB	Solidarity among members of CREP (Caisse Rurale d'Epargne et de Prêt), main promoter of CVMSR	Lack and seasonality of resources of peasant members Lack of quality in available health care services
Mutuelle MEDEDJRO de Agbogbome (CREDESA)	Ethnically homogeneous Grouping of women around income generating activities	Low educational level of member of executive committee Low income sources Health centre at a distance of 40 km, almost no health infrastructure nearby Lack of trust because of bad experiences in the past
Mutuelle de Sécurité Sociale pour le Secteur Informel de Parakou (MSSP)		Difficulties to recruit members Insufficient material and financial resources
Mutuelle de la Famille	Supported by organisational base of health centres	Low income of members Absence of a culture of foresight and solidarity among the population

7 Proposal for a Pilot Project in Benin

The aim of this study is to assess whether and how benefits sponsored by the Global Social Trust Fund (GSTF) could be delivered effectively and efficiently in Benin to satellite systems. Benin is one of the poorest countries on earth and there is a need for social welfare benefits, although the priorities are probably not the same in urban and rural areas. In recent years a significant number of mutual health organisations have been started up in Benin and these could be candidates for satellite systems of the Global Social Trust Fund. On the national level there is a national social security system managed by the OBSS. Although this system does not entail health insurance, OBSS is interested in being in charge of the national responsibility for distributing benefits of the Global Social Trust Fund in Benin and supervising the use of them.

7.1 Benefit needs

On a global level one should probably distinguish between the needs of the informal urban sector and those of the population in rural areas.

Concerning the informal urban sector, the preparatory study on the introduction of social security for the informal sector[35] shows that the people of this sector are above all interested in income protection programmes and only afterwards in health insurance. Indeed, contrary to the population in rural traditional areas, the urban craftsmen and traders cannot count so much on the solidarity of their family or their community to guarantee sufficient revenues for themselves or for their spouses or children when they are no longer able to work. Therefore it seems that the combination of old age insurance with health insurance, as proposed by the Ministry of Labour for the *mutuelles de sécurité sociale*, correspond to the needs of the urban informal sector.

[34] From (Moustapha 2001) and (Vancutsem 2001).
[35] (Commission interministérielle 1998).

In the case of the rural areas poverty is widespread, not necessarily a consequence of old age or accident but rather of the general lack of income in these regions. To remedy this situation income generating activities and economic development are needed, accompanied of course with social programmes. Such a comprehensive development programme goes beyond the objectives of the Global Social Trust Fund.

One of the main problems in rural areas is the poor health status of the population, as shown for example by studies done by CREDESA since 1989 in the region of Agbogbomé. As pointed out in chapter 6, there are several mutual health organisations that are financing benefits in the health field, and these benefits are financed to a large part by contributions of the local members of these schemes. Thus one might conclude that benefits financed by the Global Trust Fund could be delivered to the local population through mutual health organisations.

The mutual health organisations aim to provide access to quality health care services to their covered families, but this is only possible if providers of health services are available to the local population and if the services provided are of an acceptable quality. In the rural areas of Benin this is not always the case, as shown by the Agbogbomé study[36]. The ADMAB network demonstrates an interesting approach to improve the availability and quality of health services available to the population of villages where they have organised *caisses villageoises:* as well as the health savings scheme for primary health care and the mutual insurance scheme for hospital care, such an MHO manages the local health centre which it has built or rehabilitated and equipped.

To improve the health situation of the rural populations it is also important to focus on health promotion, education and prevention activities, which could again be organised through the mutual health organisations.

Studies in rural areas show that the schooling ratios in rural areas are very low and it is well known that low educational levels are linked to poor health status. Although no mutual scheme has developed activities in this field, it would be possible for mutual insurance schemes to develop activities to improve the educational situation of their members and families.

7.2 Satellite Systems

Potential candidates for the satellite systems do exist in Benin. These mutual organizations have been created only recently and are in general rather small and not yet particularly robust. Nevertheless one should note that three networks of rural MHOs do exist in Benin and that the oldest MHOs of these networks have been active for at least five years. The three networks are those of CIDR, ADMAB and Børnefonden. Unfortunately almost no information is available on how the Børnefonden mutual schemes are managed. In urban areas a network of mutual health and old age pension organizations is emerging through the *mutualités de sécurité sociale* promoted by the Ministry of Labour for members of associations of craftsmen and small traders. These schemes for the informal urban sector are still in the preliminary stages; indeed, the *mutuelle* in Cotonou only began granting benefits in September 2001.

For a pilot study, one should limit the support of GSTF to those local schemes that have passed the initial organisational stages of operation and which are reasonably stable. In the case of

[36] (ADRAI 2000.)

Benin this condition seems to limit the participation of GSTF to the mutual schemes of the CIDR network and those supported by ADMAB.

The support given by GSTF to the mutual schemes should be sustainable in the medium and long run and help to promote solidarity and social insurance. Therefore it is not recommended to directly subsidise contributions of scheme members, which would blur the link between the contributions of the members and the benefits that may be financed with these contributions.

Taking into account the condition that the external support should help mutual schemes to become sustainable, possible support of GSTF could be used for:

- Financing health promotion and health education programs, to help members understand the importance of preventive health, health care and health insurance;
- Organising and financing training of the schemes' staff;
- Financing programs to improve the quality of health care available to members;
- Financing supplementary benefits on top of those financed by contributions: especially in this case close attention should be given to the sustainability of financing these benefits.

7.3 National Social Transfer System

Unfortunately the Benin social security scheme does not include health insurance, with the result that OBSS has only very limited experience in the field of health insurance coming from its industrial injuries branch. Nevertheless one should note that OBSS has expressed its interest in the GSTF proposal.

At the national level the GSTF proposal requires a supporting entity in order to distribute funds to the participating mutual schemes, to support these schemes through training and consultancy, and to supervise and audit them. To be able to fulfil these objectives, OBSS would have to establish a special unit in collaboration with an organisation having a deep understanding of the field of mutual insurance schemes, and especially mutual health insurance schemes. Two possible partners for organising this MHO unit could be:

- STEP, which has a local office in Benin with a highly competent staff and good contacts with mutual health insurance schemes;
- CIDR, whose network is organised in a similar way to the scheme envisaged by the Global Social Trust Fund, and which has established a regular auditing system of the accounting and financial documents of the schemes in its network, as well as a statistical reporting system.

The MHO unit would be accountable to the Global Social Trust Fund for the use of the funds that it receives and distributes to participating MHOs.

Building on the experience of CIDR and with the help of STEP[37] the MHO unit would:

- Negotiate contracts with MHOs to finance benefits through the GSTF;
- Define procedures for distributing funds to the participating MHOs;
- Define accounting procedures for registering the use of the GSTF funds;
- Define procedures for auditing accounting and financial documents concerning the use of funds coming from the GSTF;
- Define a regular statistical reporting system on the activities of the MHOs.

[37] As well as perhaps other organisations, as for example the "Alliance Nationale des Mutualités Chrétiennes de Belgique", which is present in Benin in the health sector.

It is clear that a main obstacle to the development of the MHOs in Benin is that the managers and staff of these schemes often lack the skills needed to manage such health insurance schemes. The MHO unit of OBSS should offer the staff of the participating MHOs systematic training sessions on themes such as: Building on the experience of CIDR and with the help of STEP[38] the MHO unit would:

- Setting contribution rates;
- Determining benefit packages;
- Marketing and communication;
- Choosing and negotiating provider payment mechanisms;
- Assessing the appropriateness of care provided;
- Accounting;
- Statistical reporting.

The MHO unit should also promote an exchange of experiences amongst the mutual insurance schemes, as well as contacts between the mutual schemes and the national Ministries. To help the development of the mutual health insurance schemes the MHO unit, in collaboration with the participating schemes, could also work out proposals for a legal framework adapted to the activities of the mutual health insurance sector.

[38] As well as perhaps other organisations, as for example the "Alliance Nationale des Mutualités Chrétiennes de Belgique", which is present in Benin in the health sector.

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Annex 5

Contributions to a Global Social Trust Fund [18]

Feasibility Study

including a special survey in Germany

Globaler Sozialer Partnerschafts-Fonds, GSPF

Report prepared by

Peter Rosenberg, Bonn

18 December 2001

English summary of

Machbarkeitsstudie zu Möglichkeiten der Beschaffung von Finanzmitteln für einen Global Social Trust Fund (Globaler Sozialer Partnerschafts-Fonds, GSPF),

German original is available on request

Executive summary

In the globalization of the economy, the spirit of a truly global citizenship has not yet taken root. To establish a global social partnership, we must seek to enable pragmatic and successful social transfers. To address these issues, the ILO has conceptualized a *Global Social Trust Fund* through which citizens of the wealthier countries could help poor countries to develop social security institutions, in particular by providing voluntary financial support for self-help initiatives of community-based health care schemes.

The purpose of the present study is to examine the feasibility of procuring financial resources, notably to know more about the attitudes of political leaders and the public at large, taking Germany as an example. Two studies, carried out in parallel, explore minimal social security needed in selected developing countries and the overall issues of managing a Global Fund using existing administrative structures without creating long-term dependency.

Interviews were carried out with leading officials of Ministries, parliamentary delegates of major political parties, top managers from industry and the federations of employers and trade unions, banking, insurance (including health insurance), and religious groupings. Decision makers' opinions were positive regarding the idea of helping developing countries build appropriate health care schemes. However, government experts expressed certain reservations:

- the objectives of the Global Social Trust Fund, i.e. its "product", need to be well defined;
- some among them conceived it as yet another competitor collecting donations;
- no commitment for financial support was made, but several persons offered to collaborate as regards publicity (e.g. the Gerling insurance company and the AOK health care scheme).

According to the Ministry for Economic Cooperation and Development (BMZ), donations of EUR 500 million (about USD 450 million) flow annually into development aid, of which larger organizations handle EUR 50-100 million. It may be possible to achieve the same order of magnitude for a Global Social Trust Fund; this corresponds to 0.1 per cent of the net wages of 20 per cent of the working population.

A survey about *attitudes in the population* towards voluntary contributions for social transfers was carried out by the Infratest polling institute: 28 per cent said that they would be willing to pay EUR 5 (about USD 4.5) per month during 2-3 years. Assuming that 20 per cent of the working population contribute EUR 60 per year, a total volume would amount to EUR 400 million – which does not appear to be feasible in light of competing organizations.

From the interviews and survey, it was concluded that the project should be carried out in two phases: first, to develop concrete, convincing examples of fund objectives, with financing through public funds, extra-budgetary resources of the ILO, and donations by bigger enterprises; second, and only when concrete conditions of the goals and use of transfers can be shown, voluntary contributions form individuals and donations or sponsoring from undertakings can be solicited.

The explored technical aspects regarding the implementation of a Global Social Trust Fund included the following:

German *tax laws* are fairly advantageous for non-profit organizations (they must have their headquarters in the country). Funds can be transferred to an international organization and evidence of development aid rendered must be provided.

As to possible *collection channels*, social security institutions cannot be called upon to collect, administer and transfer funds for legal and other reasons. But they may offer *publicity* support through their printed materials and via the Internet. On the other hand, banks offer special conditions for non-profit organizations, whilst, in Germany, the use of credit card institutions does not appear viable. A national fund-handling institution would have to deal with all administrative aspects: record keeping, auditing, public relations, and donor care. The study recommends using expert advice concerning legal issues, the organization of the various contributions and donor care (including "ambassadors"), making publicity, and building up professional management.

The Global Social Trust Fund project should have a persuasive image, i.e. convey its objectives and the way it works, the "product" and projects carried out, issue progress reports and publicity on a regular basis, and underline the policy aspects of a sustainable social infrastructure. With this strategic argumentation, indifferent or sceptical persons can surely be convinced to help support the endeavour.

Contents

1. ILO's concept of basic social protection

Recent reflections within the International Labour Organization have resulted in a concept of how to assist highly impoverished countries in developing basic social security, especially relating to health care. Through the elaboration of a global social partnership, citizens of wealthier countries could help poor countries in building up and developing social institutions: a *Global Social Trust Fund*[39] would manage the donations made by individuals and perhaps enterprises and would distribute these funds to poor countries (in particular, their social institutions) according to defined and controllable conditions. The funds are exclusively to be used for the co-financing of national or communal financial means as well as to complement the contributions made by the population itself. The Global Social Trust Fund would close the gap between the cost of a reasonably comprehensive benefit package and the contributions available for community-based health care schemes.

To assess the feasibility of this concept, three studies are being undertaken:
A. Feasibility of contribution collection, the example of Germany. [This study]
B. Feasibility of the delivery of basic health and anti-poverty benefits in one or two receiving countries.
C. Governance and management of a Global Social Trust Fund.

The willingness to contribute to the Fund will depend decisively on
– the very goal of the donations, i.e. the Fund's "product";
– that donors can be sure that the resources are used effectively and economically, and that potential donors do not get the impression of uncoordinated financing from several sources;
– that administrative expenditures, financed through donations, will be maintained within reasonable limits.

The numerous interviews carried out have shown that people are willing to contribute whenever the goal appears convincing or plausible. For this very reason, donations are made readily following moving TV reports on natural disasters. Likewise, donations can only be solicited when illustrative examples of the needs and use of the funds are given.

Hence, the project should be carried out in two phases:

- In a *first phase*, a concrete, convincing example of using funds is to be developed, the financing of which, however, cannotbe achieved via donations from individuals. In other words, this is not a pilot project for the feasibility testing, but rather a "product" with which financial resources are solicited. (But a successful pilot application project may well be used as a showcase in the implementation phase.) Financing will be via public funds, extra-budgetary resources of the ILO, and donations from bigger enterprises.
Seeking to obtain voluntary contributions from individuals and possibly donations or sponsoring from undertakings can only be done in the *second phase*, the actual implementation phase. The interviews with officials from institutions have shown that a definitive attitude towards the project, its acceptance and possible support depend on the concrete conditions of the objectives and use of donations.

[39] In Germany, the working title "Globaler Sozialer Partnerschafts-Fonds" [Global Social Partnership Fund] was used; the final designation will be determined following market research.

The present study[40] of *procurement of financial resources*, commissioned on 17 September 2001, explores in particular the following issues:
– possibilities of collecting funds;
– acceptance by and support through social groups;
– legal conditions, limitations, obstacles;
– organizing financial procurement.

Our study is based on the following input:
– an *ad hoc* study of German language literature on donations, sponsoring, and fund raising;
– interviews and other contacts with institutions, including trade unions, employers' organizations, federal ministries, political parties, social security institutions, banks, church, etc., exploring the political and social acceptance of the project, the willingness to provide support in publicity, financing, and organization. (In some cases, the tight deadline made it difficult to obtain interviews; for example, it was not possible to schedule a meeting with the political opposition.)
– a survey of the population's willingness to donate and an estimation of the potential fund volume, carried out by the Infratest polling institute in Munich, under the heading "Would Germans make financial commitments for a Global Social Trust Fund?"[41]

2. Whither a Global Social Trust Fund

2.1 Features of a GSTF

Our literature survey and interviews revealed that the willingness to make and maintain donations depend decisively on:
– the acceptance of the goal (the "product"),
– the trustworthiness of the organization,
– how well product and organization are known,
– customer care, i.e. informing donors and tying them in.

Acceptance

The above-mentioned Infratest survey revealed that 28 per cent of the population would be willing to pay EUR 5 (about USD 4.5) per month during 2-3 years.

Our conversations with decision makers from various groups[42] had a positive echo throughout. However, interviewees considered a complete justification was essential in view of other similar endeavours (e.g. under the topic of "development aid for health care" alone, the German Foundation for International Development[43] lists 81 institutions). They wondered why the ILO was involved in the project, and feared counterproductive effects when yet another organization would enter the scene. Private and religious bodies suggested that they could act locally in a much more flexible manner without being subjected to longwinded coordination processes.

[40] The version in hand is an English language summary of the German language consultant report commissioned on 17 September 2001 (for other details, see title page).
[41] Original title of the survey: *Würden die Deutschen sich finanziell für einen Global Social Trust Fund engagieren?*
[42] Institutions contacted: Federal Ministries for Economic Cooperation and Development, Economics and Technology, Finance, Health, Labour and Social Order; Members of Parliament of Bündnis 90/Die Grünen, SPD; German Employers Association, German Industry Association, Federation of German Trade Unions; Federation of the AOK health insurance fund; Thrift Industry Association, Gerling Insurance Company; and German Bishops Cconference.
[43] Deutsche Stiftung für internationale Entwicklung, DSE.

Some interviewees queried why such a global project in health care was not undertaken by the WHO, since the ILO's role was to combat child labour and to improve working conditions. Development politicians felt that the coordination or targeted public-private partnership initiatives appeared most promising.

Trustworthiness of the organization

A willingness to donate would depend upon a continuously positive image of the organization regarding impeccable administration of the funds and their effective use – even minor irregularities could result in a drastic reduction of donations. The German Central Institute for Social Questions[44] awards a "donor label" to humanitarian-charitable organizations under the following conditions:

– true, clear and objective publicity,
– verifiable, low-cost and statute-defined use of the resources, respecting the tax laws,
– clear and controllable rendering of accounts,
– annual auditing report to be submitted to the DZI,
– internal auditing of management by an independent supervisory board,
– as a matter of principle, no premiums, commissions or payments by result.

An official from the Ministry for Economic Cooperation and Development pointed out that the verification of funds is very complex and time-consuming; this has resulted in an outspoken aversion towards them, and no financial or other support from the ministries could be expected. The parliamentary delegates said that no new funds were necessary but rather better implementation conditions in the developing countries and a better coordination of the numerous donation initiatives.

Reputation of product and organization

Interviewees contended that institutions like the Red Cross, UNESCO, churches and the like are very familiar to potential donors, whereas the ILO was known mostly to people involved in labour issues. They said that the UN (whose reputation, however, cannot be considered unconditionally positive at times or in certain countries) might be better placed as the coordinating organization.

Decisive for the success of a Global Social Trust Fund would be extensive (but costly) publicity.

Donor care

As in customer care, donors require appropriate information to acknowledge their contribution or to encourage continuous payment, no matter how high the amount. To this end, salient data about donations are to be kept on record whilst scrupulously respecting data protection legislation.

A soliciting letter should also include detailed information about the project's goals, use of the funds, and any other further information available (e.g. via an Internet homepage).

2.2 Pros and cons of the concept

The persons interviewed contended that there was indeed a need for improvement of health care, including its administration, although less so for survivors benefits and other social security coverage.

[44] Deutsches Zentralinstitut für soziale Fragen, DZI: *sozialinfo@dzi.de*

As mentioned above, *government* experts showed strong reservations at the present stage of the project.

Of the *religious groups*, contacts could be established only with the Catholic Church. Their activities of the mid-1990s regarding fostering financial control of social security are somewhat similar to the ILO proposals. However, the ILO project was also viewed as an undesirable competitor regarding access to public financing and local coordination.

As for *economic institutions*, the existence of an additional fund and the role of the ILO were questioned. The utility of a donor label was considered less promising than a public-private partnership (PPP) such as the Daimler-Chrysler's anti-AIDS campaign in South Africa aimed at industrial workers and their families. Local PPP, i.e. at the enterprise level, was thought to be more concrete and successful than trying to counteract an economic globalisation by a "social globalisation".

A member of the management board of the Gerling insurance group approved the idea of a global social responsibility – this in light of the World Trade Center catastrophe and of "Global Compact", the sustainability debate promoted by UN Secretary-General Kofi Annan. He thought that it made sense to support the ILO initiative for strengthening the social infrastructure in developing countries and that donation emblems or labels could be appealing to undertakings.

A representative of the Federation of German Trade Unions considered the ILO project a very useful meansof supporting the self-help process in development
and promised the Federation's help in publicity, whilst excluding financial contributions.

The member of the AOK health insurance federation (which has experience in developing social security in developing countries) also approved the idea of the project and promised support in publicity actions; he too excluded financial help.

It can be concluded that, in order not to endanger the project, targeted actions must be undertaken in the initial phase in order to convince opinion leaders of their roles.

3. Legal aspects and collection channels

The questions specific to Germany, are: What are the tax laws concerning donations? Can social security institutions function as a donation channel?

3.1 German tax laws

Charity can take the form of collections, donations, sponsoring, foundations, or disposition by will. *Donations* are tax deductible upon submission of a valid receipt (not only for development aid rendered, but also for consultancies carried out) and when they constitute voluntary, cost-neutral expenses for tax-privileged purposes of tax-privileged institutions. *Sponsoring*, in contrast to donations, implies a concrete return service; this requires approval by the German revenue office competent for the sponsoring enterprise. (A *GSTF Donor Label* alone will not suffice.) *Foundations* are not of interest here as the collected resources will be used promptly for GSTF actions, rather than being absorbed into the foundation's assets; however, foundations may act, in the initial phase, as donor for a specific purpose.

Tax deduction for charity is limited to 5 per cent of total revenues or 2 per mille of turnover (or wages paid during a calendar year). As donations are deductible from gross income, income tax can be reduced by up to nearly 50 per cent, for individuals by some 25 per cent of their contributions made.

German tax laws require the establishment of a corporate body before collecting donations. Donations in kind are also tax deductible but can prove themselves cumbersome due to customs laws in the receiving countries.

3.2 Collection channels

For the collection of contributions and donations, social security institutions, banks, and credit card organizations can be considered. Synergistic effects may result when these institutions show a particular interest in fostering the potential donors.

Among the *social security institutions*, those engaged in annuity business have a wide geographical distribution. However, coverage of persons with higher incomes is relatively low; also, collections are normally handled by employers, thus impeding a direct contact with the insured persons. In addition, pension funds cannot engage in activities other than those legally attributed to them. The same holds for health insurance companies, who are better placed for publicity actions through their newsletters and branch offices.

Banks are known to have promoted various charity actions through free money transfers. (Registry of donors, issuing receipts for contributions above EUR 100, publicity and reporting on the use of the funds collected etc. is usually taken care of by the organizing institution.) Telebanking and banks' publicity potential would be an asset for a GSTF.

Credit card institutions were not examined as in Germany credit cards are not used extensively and because there are numerous competitors; also, trends in European countries indicate that bank cards are more popular.

4. Organizing the procurement of financial resources

This will be done at three levels:
– the national organization for procuring resources and donations;
– the Global Fund that manages the resources and decides about their use;
– national organizations in the receiving countries who are concerned with the use of funds –
– received (the subject of another study).

Here, the requirements of organizing fund collecting and the establishment of an institution handling the funds in the implementation phase are considered.

4.1 Willingness to make donations

The total volume of donations in Germany is not evaluated statistically. According to M. Haibach's *Handbuch Fundraising* this amount is in the range of EUR 2000-7000 million; according to the Ministry of Finance it is more likely to be the lower value (probably based on tax declarations), whilst the Ministry for Economic Cooperation and Development states a development aid volume of EUR 500 million. [IN USD, roughly 10 per cent less.]

For 2000, the values of EUR 500 and 2000 correspond to a GDP of 0.25 and 1 per mille, respectively, or 0.4 and 1.7 per mille of consumer expenditure by private households.

Cited by the *Handbuch*, the German Fundraising Association says that "leading" major donations amount to EUR 50-100 million, e.g. about EUR 90 million by the Hermann-Gmeiner-Fonds (SOS-Kinderdörfer), Miserior EUR 65 million, the Catholic missionary work and Brot für die Welt EUR 60 million each, and the German Unicef committee EUR 35 million. A new organization, like GSTF, would have to "share the cake" with these well-established competitors.

4.2 Institutional organization

Name and legal form

The fund's name should be easily understandable in German – this does not exclude foreign language designations such as Miserior or Greenpeace. It is to be determined whether the goal "health care" should be in the foreground, or the organization itself. "Mnemonic access" via the Internet should also be considered.

The common *legal form* of such an institution is that of a registered association (e.V. = eingetragener Verein). Legal advice should be solicited in this regard.

Call for donations

Potential donors should be determined at the outset:
- individuals and/or undertakings?
- ILO specific groups like workers and/or self-employed, civil servants, retirees?
- activation of donors on a once-off or long-term basis?

Addressing "solidarity appeals" at rather homogenous groups like the workers does not necessarily appear to be successful, since such a group may be quite heterogeneous after all; also, the notion of solidarity seems to lose momentum.

Donations should be voluntary and spontaneous. The establishment of a faithful clientele appears cumbersome and time-consuming and may require expert advice.

Role of the institution

A national institution will be in charge of fund raising, requiring appropriate public relations and customer care regarding donors and others. It will also deal with tax aspects, organizing the collections, their administration and transfer, auditing, issuing progress reports, etc. The establishment of professional management is essential. Expert advice should be sought at an early stage.

Publicity may be via health insurance institutions for example and, in the second phase when clear goals are set and examples are available, via TV.

A trustworthy image of the institution can be developed with the help of a suitable patronage and "ambassadors".

A donor label can be awarded to those who commit themselves to a social responsibility. This can be used as a publicity tool. A global logo appears of interest, although some interviewees expressed interest in company specific actions.

Publicity actions for the general public should address concrete needs in the receiving countries, perhaps using a certain "emotionalization", less so the rather abstract idea of global partnership and solidarity. As to enterprises and politics, a more rational argumentation will be preferred, e.g. the ILO project as it relates to a global sustainable development. Government officials said in this context that social policy aspects often encounter difficulties in politics. However, the ILO appears to be well placed in offering the build-up of a well-functioning social infrastructure, i.e. its administrative and institutional frameworks, whilst fostering an implementation of social minimum standards. Progress reports about the institution and the various projects will convey a feeling of identification of donors with the GSTF project

Thus, in a *first phase*, the national institution will be created and contacts with potential donors established; to this end, support by public leaders in politics and the economy will be essential. In the *second phase*, the actual implementation of the project, the handling of donations is to be dealt with, i.e. publicity work, negotiations with financial institutions on transfers, costs and the like.

5 Conclusions

In the interviews with ministries, political parties, religious bodies and others, extremely positive attitudes towards the goals of a Global Social Trust Fund were expressed, i.e. support for the strengthening of health care in developing countries both through financial aid and the development of governance and good management. The Infratest survey has revealed positive attitudes as well in the population.

Whenever certain doubts were expressed, concern was directed towards organizational issues rather than the Fund's objectives itself. These organizational obstacles appear surmountable.

There will be high administrative costs for the national institution, in addition to the tasks carried out centrally by the Global Fund – costs that can be reduced through negotiations with financial institutions, associations and others.

Judging from the results of this study, the project appears feasible. Financial contributions from individuals appear certain, whilst those from undertakings can be activated.

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Deutscher Sparkassen- und Giroverband	Matthias Hönisch
Gerling - Versicherungs-Beteiligungs-AG	Mitglied des Vorstandes Dr. Uwe-Volker Bilitza Joachim Ganse

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Appendix **(Annex 5)**

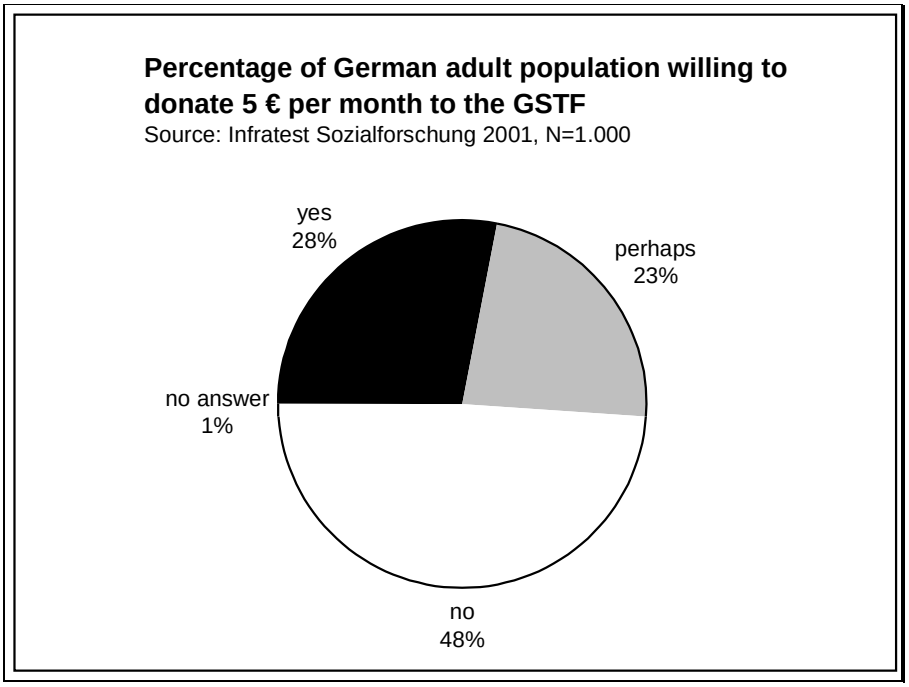
Summary of a study by Infratest Sozialforschung München
Dr. Thomas Gensicke
Would people in Germany contribute to a voluntary Global Social Trust Fund?

1. Summary of the November 2001 survey

The International Labour Office (ILO) in Geneva, a specialised agency of the United Nations, intends to establish a "Global Social Trust Fund" (GSTF) to provide minimum health and social protection for needy people in poor countries. People in developed countries like Germany should make a monthly donation to the GSTF of 5 €. If only 20% of the workforce of the developed countries would do so, basic medical and social support could be provided for 100 million people in poor countries.

At the request of the ILO, Infratest Sozialforschung Munich conducted a representative telephone survey in Germany in order to investigate people's willingness to support the GSTF by 5 € per month for up to three years. As a result 28% of the adult population said they would definitely donate to GSTF, 23% would "maybe" do so and 48% showed definitely no interest in financial contributions (1% with no opinion). Accordingly a considerable percentage of the German population share a positive opinion about "global partnership" between citizens of rich and poor countries. Which meets an important requirement of the ILO's idea with respect to the intended GSTF.

Table 1. Willingness to Contribute to GSTF



The highest percentage of people willing to donate to a GSTF can be found at an age of between 35 and 59 years. About 35% say that they are definitely ready to make a donation. This is an important result since most of these people should belong to the (active) workforce and therefore to the ILO's most wanted target group of possible donors. A very high percentage of definitely ready supporters of a Global Social Trust Fund can be found in another important target group - people with high incomes (46%). Furthermore the idea of global partnership is more supported by women (30%) than by men (26%), especially by higher educated women (46%). Women can be seen as experts in terms of charity. In most families they decide whether and where to give contributions for charity. This is another important link for ILO.

Infratest Sozialforschung also calculated the propensity to transform this positive ***attitude*** of the German population towards the GSTF into ***reality***. The growing volume of the German voluntary charity market is nowadays 4 to 5 Million €. A monthly donation of 5 € from 20% of the German workforce to the Global Social Trust Fund would mean an extra volume of €420 million and a high potential market share of 8% to 10%. This extra contribution for a Global Social Trust Fund has to be realised in a market situation of tough competition between large charity organisations. The market in general is expanding but not to the benefit of large organisations.

Moreover, charity recently has tended more to the so-called "home charity contributions" rather than to international donations. Seventy-five per cent of the charity market volume belongs to the first category. It has also been recognized that charity donors nowadays are more concerned about the effective use of their money to help the needy people. They fear money is wasted for administrative purposes or is getting lost because of corruption in the poor countries. Therefore it does not seem to be easy for the ILO to establish the GSTF project in the intended extension.

Nevertheless, there are also favourable facts to the GSTF project. Experts in the charity market speak of a new generation of charity donors with better income whose charity priority is not anymore "ad hoc help against misery" but "sustainability of change". This new mentality converges with the ILO's idea to introduce a regularly and sustainable contribution by private supporters of the GSTF in contrast to the traditional annual "Christmas" charity. On the other hand, ILO as part of the UN family can benefit from the good image of the latter in respect to its publicity strategy.

As a result of the reported tendencies on the German charity market, Infratest Sozialforschung recommends that ILO adopt a publicity strategy that is primarily based on a "rational" charity concept and less on traditional demanding for charity feelings. The German charity market is already highly penetrated by large charity organisations through traditional emotion-based publicity strategies. The rational strategy should refer to aspects of functionality and long term change on the one hand and on favourable consequences for the developed countries on the other hand (less immigration of the poorest and millions of potential consumers of goods).

Important prerequisites of successful fundraising for a Global Social Trust Fund are to introduce a culture of transparency and effectiveness in all aspects of the Funds work and, as intended, to realise the link to the existing small and local structures of social security in poor countries. Potential charity donors prefer television and newspapers as channels for information about charity projects. They like to be informed about the success of charity projects in the poor countries, as well as about occurring problems and how these problems can be solved.

2. Summary of the July 2002 Survey

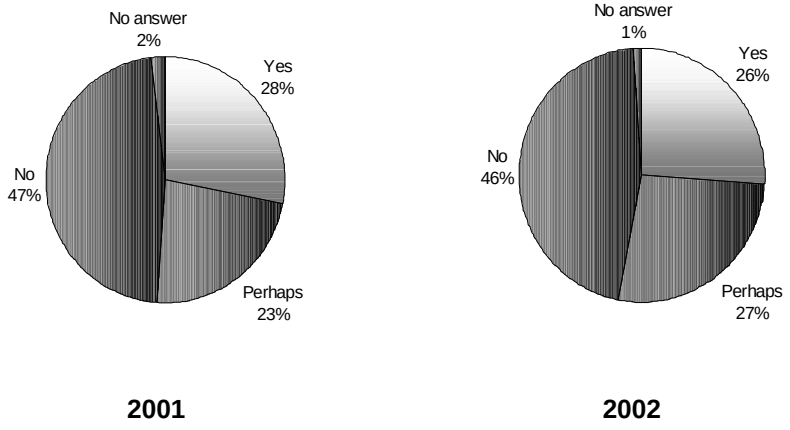
In 2001 28% of the adult population in Germany were explicitly willing to help the Global Social Trust with 5 € per month over 2 to 3 years. In July 2002, the ILO assigned Infratest Sozialforschung to re-examine the stability of this propensity to contribute. In addition, the ILO requested to test the effects of a change of the benefits focus from health to basic old age benefits in poor countries.

In two separate representative telephone surveys with 1000 participants each, these questions were clarified. Compared to November 2001, the financial willingness to engage was steady (see figure 1): In Juli 2002, 26% of the Germans were explicitly willing to help the Global Social Trust Fonds with 5 € per month. The differences between the two results (28% vs., 26%) lie in the random area of normal variation (in reference to the unchanged questionnaire).

The willingness of Germans to contribute to a Global Social Trust with a focus on olds age pensions tends to be lower compared to the willingness to contribute to a Trust with a health care focus. 24% of the Germans were explicitly willing to contribute 5 € per month to the Global Social Trust (see figure 2). Nevertheless, the differences over the whole German population are not important. Despite those small differences in general, it should be taken into account that an important target group of the ILO, the workforce, reacted less favourable to an old age purpose of advantageous regarding retirement care, i.e. those aged 46 to 65 years.

However, the overall stability of the results, especially of the readiness of the financially stronger population group in West Germany to contribute to the Trust, supports a positive assessment of the potential ability of the Trust to enlist s sufficient number of contributors.

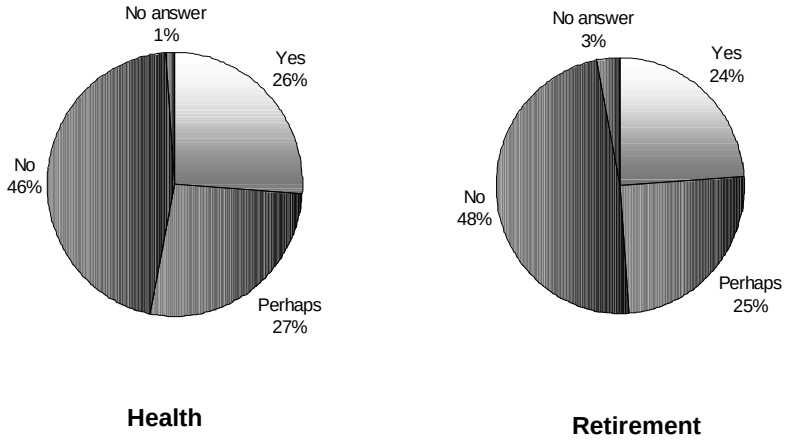
Figure 2
Willingness to contribute to a GST-Fonds/Health Care (2001 und 2002)
Grown up Population (in %)



Contribution to a GSTF, ILO Geneva
Infratest Sozialforschung 2002

Infratest

Figure 2
Willingness to contribute to a GST-Fonds/Health or Retirement
Grown up Population (in %)



Contribution to a GSTF
Infratest Sozialforschung 2002

Infratest

Annex 6

Survey of Expert Opinions

Following a meeting of international consultants and ILO staff in Geneva in September 2001, the proposal and draft concept paper on an ILO initiative for a Global Social Trust Fund[18] was circulated to a wider expert community - to prominent social policy and social security experts around the globe.

On the following pages is a synopsis of the comments and feedback received in response to that mailing. The feasibility study team has endeavoured to include all comments and viewpoints and hopes to have accurately reflected the thoughts and opinions expressed.

Valuable input and contributions were received from:

Malcolm Bryant, MSH, Boston
Monica Burns, Independent Health Care Consultant, Ireland
Théopiste Butare, International Social Security Association (ISSA), Geneva
Guy Carrin, World Health Organization, Geneva
Karl Heinz Cless, Procter and Gamble, Geneva
Carola Donner-Reichle, Ministry for Economic Cooperation and Development, Bonn
Dharam Ghai, Consultant Economist, Geneva
Neil Gilbert, Professor of Social Welfare, UC Berkeley, California
Robert Gillingham, Sanjeev Gupta, International Monetary Fund
Wouter van Ginneken, ILO Geneva
Ursula Engelen-Kefer, Burkhard von Seggern, Deutscher Gewerkschaftsbund, Berlin
Klaus Dieter Klein, formerly Hewlett Packard, Geneva
John Langmore, UN New York (now ILO)
Garth Manning, Royal College of General Practitioners, UK
Bill Mansfield, Australian Council of Trade Unions
William McGreevey, Futures Group International
Carmelo Mesa-Lago, professor emeritus, University of Pittsburgh (US)
David Parker, UNICEF China
Hernando Perez Montás, Consulting actuary, Dominican Republic
Alec Preker, World Bank
Aviva Ron, World Health Organization, Philippines
Xenia Scheil-Adlung, International Social Security Association, Geneva
Karl-Hermann Schlettwein, Ministry of Labour, Windhoek, Namibia
Ole Settergren, Riksförsekeringsverket, Stockhom, Sweden
David Stanton, and Mathew Gray, Australian Institute of Family Studies, Melbourne
Mr Subrahmanya, Secretary-General, Indian Social Security Institution
Professor Noriyasu Watanabe, Japan
Axel Weber, International Social Security Consultant, Cologne

We are very grateful to everyone who took the time to read, think about and comment on the paper we circulated: it was generous of you to share your thoughts and ideas whether skeptical, positive, detailed or brief. All inputs have helped us to advance and the resulting document is richer in consequence.

A document containing the complete collection of original comments received can be obtained on request to actnet@ilo.org.

The idea, the concept

The idea, complimented for its scope and ambitiousness, was positively and enthusiastically received, with many subscribing to the concept of a global social trust fund and its underlying principles, and applauding the globalisation of social solidarity, citizenship and partnership - albeit voicing concern about successfully translating the concept into reality. It was welcomed as any additional north-south transfer that, effectively used, could help counter the negative social effects of globalisation on the world's developing countries responding especially to their poverty and health problems. It was recognised that developing countries had neither the means nor manpower to develop their own systems and the idea of inter-country social solidarity, and providing assistance on a people-to-people basis, was appealing and exciting. Making individuals or groups responsible for the social needs of other children or families was a concept that had been successfully employed by various NGOs for many years. Making funds and resources available to poorer sections of the population that are currently limited in access to health care and services was welcomed. One commenter rightly pointed out that transfers alone would only cure the symptoms of poverty, not help to root out its causes; and clearly the latter was not the purpose of the GST. It was felt that the proposal rightly recognised the importance of contributions collection, service delivery and support, and fund governance and management; and indeed that the feasibility and sustainance of the GST were contingent on the success of contributions collection - given an appropriate mobilisation, promotion, and support effort, and on effective fund governance. Especially applauded were the emphases on matching grants, on supplementing other sources and on self-help to provide incentive, on the use of existing administrative structures, the focus on community-based health and capacity enhancement, and a governance structure designed to promote public trust.

More measured were the remarks from some respondents who commented on the multiplicity of overlapping aid ideas, programmes and funds, who cautioned about the difficulties and the mechanics of implementing, managing and monitoring a fund of this order, adding scepticism about raising adequate funds, and who stressed the ever-present problems of local corruption and misuse of funds. With respect to the fundraising ethos on which the concept depends, several respondents critically queried whether the resources raised by the fund would be "new" money or simply money redirected from other charities. For even if it raises substantial resources, the benefits of the fund would be severely limited if it simply provided a more attractive destination for giving; diluting the resources of other agencies and imposing another level of coordination would be counterproductive. The essence of these remarks is that **a case has to be made for why people will give *more* if the fund is established than they would otherwise do**.

Others warned of the fierce competition to be found in the fundraising arena with a number of very professional competitors all basically chasing and competing for the same money – $1/10^{th}$ of one percent of average wage from 10 percent of the population - albeit with different products. Whether the scheme could actually be financed by individual contributions was queried, with the suggestion that rather than trying to collect a few dollars from millions of people – a costly undertaking – perhaps the initial focus should be on raising larger sums from fewer sources.

More precision, focus and clarification in the document was encouraged by many discussants, on the one hand with respect to different aspects of the workings of the Fund – requesting more specificity on the practicalities and mechanisms, but also to improve the readability of the text itself. It was particularly felt for example that a fuller explanation of poverty and deprivation was called for, with reference to the historical context, and the underdevelopment of human and

institutional capabilities, and that there could be more substantial mention of the international constraints on developing countries that cause poverty growth, for example, financial crises, recession in developed economies, debt, declining ODA, restricted market access, all of which impose external constraints on developing countries. The impression that the 'relatively poor' in developed regions subsidise the 'very poor' in the developing world should be avoided.

Support was given to the idea of **conditionalities** to governments - the linking of these important new funds for social development to governments' own commitment to develop and implement, for example, social legislation; conditions were also suggested for some form of time-binding of benefits, although it was admitted that this would be more difficult – cancelling benefits once they have been provided is not easy, especially where basic needs are concerned. It was clear that effective accountability and conditionality mechanisms would be essential. And if cost sharing is to be conditional on a "proper financial and fiscal diagnosis of the (host country's) social transfer system" details of what this entails should be more explicit.

Bearing in mind the acknowledged competition in the fundraising arena, it was clearly essential for donors that the product be both **easy to understand** and **attractive**; success, therefore, could be said to depend to a certain extent on the clarity and communicability of both the aims as well as the means to approach those aims.

Equally critical was the question of competency, which could well be raised by potential contributors and which should be clearly elucidated: why is this Fund, heavily concentrated on health care schemes, being organized by the ILO rather than the WHO? Several respondents inevitably drew a parallel with the Global AIDS Fund (or 'Global Fund on AIDS, Tuberculosis and Malaria' (GFATM), a global public/private partnership initiative of the UN Secretary-General, intended as an innovative, autonomous new fund to tackle HIV/AIDS, tuberculosis and malaria and to strengthen associated health systems). It was felt that the GFATM had raised issues that were certainly pertinent also for the GST, and that lessons could be learned from its experiences to date.

Thus some queried whether there was enough room for a new, parallel initiative bearing in mind the glut of existing programmes on AIDS and health generally, and the global AIDS fund in particular, but also other health sector reform projects targeting local communities and stressing local participation and cost sharing. Noting specifically that the proposed focus of the Fund was on health benefits and health care schemes, concern was voiced in many quarters about overlapping with and duplicating the action of the many other developmental organizations, donors, international agencies – World Bank, UNDP, WHO, bilateral, NGOs, etc. operating in these same fields. The possible effects on the funding and objectives of the AIDS fund of an additional fund in an overlapping area was again raised. Some warned of the difficulties that had besieged the AIDS Fund, particularly on management issues with wrangling between different interest groups, whilst others felt that the experiences of the one fund could actually benefit the other, and that lessons learned should be noted and heeded. How the two funds –or any similar and overlapping action programmes - might co-exist and relate to each other was also queried. Some questioned whether it might not be possible to use an existing fund rather than set up a new one; another suggestion was made that the Funds complement each other in their activities and functioning – or join forces - thus minimizing for example administration and promotive efforts, also for improved efficiency, but particularly to avoid the irony of two new socially oriented international funds competing for the same dollar, euro or yen.

It was clear therefore that there was real concern about overlapping areas of expertise and responsibility and a certain duplication of action, and that these questions needed to be carefully addressed and the issues clarified. It was suggested, for example, that the proposal provide details on how it perceives its comparative advantage in pursuing action in this field, advancing arguments and evidence on what is wrong with current assistance processes and, more important, **why this fund would be in the best position to address and correct these problems**.

It was felt that the pilot and feasibility studies would be crucial for addressing many of these specific issues.

Benefits

Very many queries and questions were raised with respect to the **focus** of the Fund, the exact **benefits** envisaged, and the criteria for the granting of support from the Trust for specific projects, and the discussions fostered many ideas and suggestions.

The general idea that funds and resources would be made available to the poorer sections of the population – populations that currently are very limited in access - to improve that access to health care and services, was applauded. That funds and resources and support would be made available to HIV/AIDS sufferers, their families and survivors, was positively received as was the prospect of an increased range of services such as hospitalisation or chronic care being made available. It was hoped that it might also be possible to envisage access to more expensive private providers in the community. Improving access, however, to health care would be more difficult to address where the problem was geographical and this unfortunately would concern a good proportion of the rural poor. And, as already evoked, a query was raised about the core focus being health care benefits which could be seen as an area more appropriately catered to by other more specialist agencies with experience in such operations.

More specifically, though, questions were raised as to the choice of countries and institutions to be supported, and the 'selection' criteria to be used. Likewise, identifying the target group, defining the 'poor' and ascertaining who fitted the definition would be a key issue. What categories of 'poor' would benefit? Would the Trust Fund really reach the very poor or in its focus on community-based schemes would it only reach those who can still afford to pay some contributions and hence are not the very poor? And how could the fund ensure that health care benefits were correctly and regularly delivered to those targeted? Was priority indeed to be accorded to the poor, or to particularly high or particularly low HIV/AIDS incidence areas; and how to ensure that disfavoured groups - migrants/ women/children etc. within those target groups benefited? Would transfer payments be earmarked for particular benefits, for example, a basic care package, or only HIV/AIDS treatments, etc. How to ensure a judicial disbursement of resources? How would spending on administrative costs would be controlled, and the proportion of costs to reach patients and the poor monitored?

An important point was raised concerning the Fund's responsibility with respect to the quality of care, and its role in ensuring that - with increased funding for community access to more and newer services – that those services be of an acceptable quality, provided by appropriately trained and credentialed personnel. Yet another challenge would be the pressures to raise salaries and the pay of health workers, for unnecessary prescriptions and other charges when new funds become available. It would be essential for the Fund to be able to manage and maintain an acceptable equilibrium between spending on health care, related administrative costs, and an appropriate quality of service.

Was it intended that the fund provide direct support to governments? Was the Fund designed to target only countries with established social protection schemes? – the general lack of national social security schemes, for example, in sub-Sahara Africa was pointed out. And would the efficiency of existing schemes be a factor? Was it intended that the Fund work with existing community-based health schemes only? Or would it also be involved in setting up such schemes in areas or countries where they do not presently exist?

Was it intended that the Global Social Trust Fund address all social security components, including pensions, unemployment compensation, health, workmen's compensation, or would it concentrate on 'priorities' (cash for families of persons with AIDS, community based health insurance)?

It was suggested that the **initial focus** should be on somewhat better-off developing countries -- those with functioning social insurance and/or social protection schemes that could be built up and piggy-backed upon for the operation of the GST-funded elements, for developing or supporting such systems - as would be required in the poorest countires - would be a longer-term task. It was acknowledged that even in the better-off developing countries, there would still be enormous challenges for effective targeting and for ensuring an adequate standard of service quality for the poor.

Concrete suggestions were made that the Fund be targeted particularly to the informal sector, or to specific vulnerable groups such as the elderly that have no retirement benefits; or alternatively as providing staged subsidies to members joining a social insurance scheme at the district, area, or association level, to be phased out over a fixed period; or again, as a micro-finance scheme providing seed money for training, administrative costs, etc.; or perhaps to subsidize participation in social insurance schemes in conjunction with other parallel finance programmes, for example, informal sector workers looking for micro-credit.

Another suggestion was that the Global Social Trust Fund should be utilised primarily for providing succour to people affected by natural calamities, major accidents, epidemics, riots and other civil disturbances, including rehabilitation of persons displaced from their homes as a result of the execution of major projects, and it was felt that the benefits to be provided by the satellite insurance schemes should be primarily concerned with disaster relief, famine or drought relief rehabilitation of displaced persons and other such programmes.

Finally, it was wondered whose role it would be to oversee the activites under ‘community-based transfer payments’ - for example, the needs assessments activities, the build-up of a contingency reserve, and whether this would fall to the national social security/protection scheme; and who – the Trust and/or ILO? - would be responsible for financing assistance to improve management and financial governance.

Benefit delivery

On **benefit delivery** an official link-up between the various community-based organizations and the national system was supported, not only with respect to the receipt and distribution of funds which it was felt could result in more stewardship from above, but perhaps by creating incentives for initiatives from the bottom up to address specific social protection goals.

The following are comments regarding the **service delivery** dimension, stemming from lessons learned in a similar exercise, which could be relevant to the Social Trust Fund:

- the necessity for a country-specific approach, with resources adapted to individual country situations and requirements;
- a need for adequate technical and management support for any efforts to strengthen health service management, community-based activities and health policy reform;
- the subjecting of any substantial additional funding to political dynamics and pressures in the recipient country;
- the difficulty to support and interconnect on a country-wide basis with community-based health services/financing schemes within countries, including donor-supported ones, because of their diversity;
- the even greater challenge for harmonization with national policy frameworks and with (often internationally supported) health reform initiatives.

Others too agreed that it was appropriate for a national authority to be set up or designated in each country for mobilising funds and for the disbursement of benefits to ensure their accountability. They suggested that the actual delivery of benefits could be routed through people's movements or organizations, which could be set up or designated to operate for the Fund as National Social Trust Funds.

Associating the term 'satellite social insurance' with 'micro insurance', it was pointed out that many micro-insurance schemes were already operating in India and that furthermore central and state governments were actively promoting Self-Help Groups which could be developed into satellite insurance agencies.

The possibility of linking the proposed activities of this Fund with other on-going ILO programmes such as IPEC, STEP, HIV/AIDS, Social-Re was raised. And on a technical note, it was wondered whether there might be possible difficulties delivering basic health and anti-poverty benefits – typically the responsibility of the Ministries of Health or Planning, whilst ILO's official counterpart is the Ministry of Labour.

Financing

On the resourcing of a global solidarity fund, a first word of caution was advised with respect to being overly optimistic about the volume of funds to be counted on, citing as example the GFATM where only one-sixth of the estimated budget had so far been collected or pledged.

Warnings were also offered with respect to financial controls, both at the international and national levels, noting in particular collection mechanisms, communications to donors, and auditing of accounts as areas and issues which needed to be clearly addressed. Addressing these issues will help establish and maintain confidence in and the integrity of the Fund, remembering that the feasibility and sustainability of the GST are contingent upon the success of contribution collection and fund governance.

Various remarks were offered on different aspects of the funding mechanisms by different respondants. For example, it was suggested that governments and larger funding agencies may be reluctant to make large contributions, feeling that in so doing would free the country's government of its own responsibility, allow it to spend its money elsewhere rather than attend to the wellbeing of its population. Submitting governments to a financial and fiscal diagnosis of their social transfer systems was queried on the grounds that international agencies do not habitually issue such conditions or pre-qualifications on poverty projects. One commenter remarked that the financing envisaged could increase labour costs in some of the already not-very competitive OECD countries. The point about 'small' contributions and the 'rich' countries

was questioned, with the suggestion that rich enterprises in LDCs could equally well contribute, encouraged with tax exemptions on contributions. Matching funds from enterprises should be solicited, it was felt; and support was given to the idea of contributing firms publicising their membership and participation in the fund, in their advertising and publicity materials. Another suggestion proposed that the unions make block payments on behalf of their members as a solidarity gesture. On the individuals vs. collectivities aspect of resourcing, it was felt that the people-to-people idea created a powerful image that would appeal to the public imagination; including national governments as donors would doubtless reduce the impact of this personal ownership concept.

More particularly, however, it was felt that the options and processes proposed on **fund raising** in general, and the mechanisms to be used for the **collection of contributions** warranted clarification - but also serious reflection, given the fundamental differences between a system of voluntary contributions on the one hand and credit card deductions/ surcharge (or tax) on consumables on the other.

According to the proposal, for example, the fund would "use existing national social insurance schemes, private health and life insurance companies, and credit card organizations in Europe and OECD countries as collecting agencies," although there is no indication as to how practically these collections would be effected. The basic question is whether choices would be made individually or collectively, and whether public entities would be allowed to act as agents of the Fund: if, for example, the proposal is for the establishment of "affinity" credit cards—particular accounts that *individuals* choose from private providers similar to those for colleges and universities—in which case it is relatively benign. Or whether the idea is to make a collective choice to increase credit card costs to raise funds; as it was pointed out, this would then become a tax which would be inconsistent with the "people to people" motto.

Also on the issue of individuals vs. collectivities, it was suggested that the collection scheme could put public entities in an awkward position. On agreeing to become conduits for completely voluntary, individual contributions, they broaden their activities in a way that could be potentially dangerous: what, for example, would prevent other charitable organizations from demanding the same services, whereupon public agencies would become collection agencies for a variety of non-profit organizations, diluting both their primary missions and the support available to any particular organization. Worse would be a mandatory contributory (*i.e.*, tax) scheme implemented through public entities. Finally it was warned that even a scheme that left the choice to individuals would have to carefully structure default options to avoid a *de facto* mandate or excessive moral suasion.
It was felt that the work of the feasibility study would be crucial on these issues and their findings and assumptions should be very carefully assessed.

Potential impact

It was remarked under this section that the figure of 18 million greatly understates the number of people in the world without any protection; this figure, and the 100 million referred to should be clearly specified and defined to avoid misunderstandings and confusion as to the groups actually targeted.

Governance, management

Most respondents were unanimous in stressing the importance of efficient and effective management of the Fund, in establishing and maintaining the integrity of and confidence in the

Fund, and were equally unanimous in linking sound and effective governance to the Fund's feasibility, its sustenance and ultimately its success.

It was clear that many aspects of the mechanics of management and governance needed to be established and detailed, and the following points were raised in this respect. It was noted that the proposed fund would be an independent body, governed by a board that would include representatives from the donor community as well as the recipient community, businesses and civil society, and that the ILO would serve as its technical secretariat. With this structure, it would be important to justify why such an organization needed to be affiliated with the ILO. Would the ILO have any control over or role in how the funds were used or how assistance was delivered? Would the fund reimburse the ILO for the full cost of any services provided and, if so, how would this cost be calculated (noting that a marginal cost calculation would imply a substantial subsidy from ILO). And would the fund trade on the ILO's credibility and, if so, on what basis should this imprimatur be granted? A transparent and accountable structure was thus paramount.

Recalling the enormous challenges for the Fund in the delivery context, to conciliate effective targeting with an adequate standard of service quality for the poor, whilst at the same time containing administrative costs, expenditure and charges – restraining tendancies to over-prescribe medication, or over-spend on salary increases, for example, confirms and underlines the need for effective recipient-country-level GST **governance** mechanisms; careful attention should be paid to ensuring that national auditing and accounting services, as correctly proposed, have the capability to perform this task.

Likewise, with respect to the accountability and conditionality mechanisms written into the GST, and cautioning that monitoring the enforcement of conditionalities is no easy task – particularly where basic needs are concerned, experience showed the importance for such conditionalities to be appropriately designed and implemented so as to be administratively, technically and politically effective.

Other comments stated it was imperative that overheads and administration costs be contained and controlled and not allowed to eat up the budget; collection mechanisms, communications to donors, auditing of accounts and decision-making processes were singled out as areas and issues which would need to be clearly addressed. It was clear that, from a donor's point of view, this section should be stronger - that it was not sufficient to say that management would be highly efficient and effective without indicating how this might be attained and maintained.

Whilst acknowledging that efficient and effective management was essential, whether government was the most appropriate agency for this role was queried, as was the viability of and confidence in governing and existing national institutions. For, despite all the good will and good management in the world, skeptics warned of the true reality of administrational experience, the corruption and misuse of funds by government officials and community elders, and expressed reservations about being able to sufficiently integrate effective mechanisms to prevent this.

Promotion

It was recalled that the feasibility and sustainance of the GST was equally dependent on an appropriate and successful mobilization, promotion and support effort, and a variety of remarks and comments and constructive suggestions on **promotion strategy** were offered.
Primarily though, because of the fierce competition in the fundraising arena, it is essential that the product be both (i) **easy to understand** and (ii) **attractive for donors** : donors must know what their money will be used for – and like its use. Thus success depends, to a certain extent, on the clarity and communicability of both the aims as well as the means to approach those aims, and it is important that the project description meets these criteria.

It was recognized that the Global Trust Fund would only be able to operate if **financial resources** were sufficient, and that to generate financial resources on a continuing basis would require an ongoing professional **promotion campaign** (e.g. as used by UNICEF, WWF etc.). Aware that such promotion activities can be expensive, the question was raised as to how these costs would be covered, and whether donors would accept that their contributions be used for promotion rather than direct support.

It would be essential to report early and promptly on achievements from the use of the GST funds and to document the real impact on families (underlining the 'people to people' perspective), and to credibly identify gains that are due to GST inputs - yet in the context of an ongoing and sustained national health service/financing system.

There will also surely be a need to balance additional technical and managerial resources to support accountability requirements, against the virtually universal reluctance of donors (governments, individuals, corporations) to fund 'overhead' expenses. In this respect, it is suggested that the decisions and messages of the international board will be critical input to the public awareness campaign.

On incentives and encouragement to donors, it was remarked that whilst enterprises may be happy with ‘social labels’ as proposed in the note, perhaps an equivalent should also be found for private donors, with the suggestion made of tax reductions, or certificates; or perhaps access to special products of the FUND?

Support was given to having firms contribute and using membership of the fund in their publicity material; in the same way unions could also be persuaded to make block payments on behalf of their members out of solidarity. The personal concept of making individuals or groups responsible for the social needs of other children or familes projects a very powerful image – and can be compared to that used for several years by various NGOs; but it was essential to develop the marketing and PR aspect of the appeal, using the sort of simple language used under "potential impact" that people can relate to.

On marketing and public relations, it was pointed out that there is a widespread misperception about the present extent of foreign aid. It was argued that whilst the average US citizen would probably imagine their government spends 20 per cent of the federal budget on aid, it spends in reality less than 1 per cent; this could be spelt out. The scheme and its benefits could surely be more strongly argued.

Reference to the ‘perceived inefficiencies of UN agencies’ is perhaps not too judicial a remark, and caution was also given against the use of empty marketing gimmickries; ILO was

encouraged to present better and surer evidence of how and why it can succeed, to stimulate confidence and thus help to generate the trust it depends upon.

Finally, the stated **goal** of providing basic social security to 100 million people in the next ten years is perhaps over ambitious, if not frightening for potential donors.

Implementation

It was generally felt that the pilot studies would be crucial for addressing specific issues and this has been emphasised in the discussion on the individual chapters.

It was agreed that the **proposed initial focus** would be on better-off developing countries -- those with functioning social insurance and/or social protection schemes that can be built and piggy-backed on for the operation of the GST-funded elements. Developing or supporting such systems, as would be required in the poorest countries, is a longer-term task. But even in the better-off developing countries, it was warned, there would be enormous challenges for effective targeting and for ensuring an adequate standard of service quality for the poor.

Tanzania, which has a recently piloted and now scaled-up Community Health Fund raising contributions from patients with matching funds from national government, was proposed as a serious and viable candidate. This Fund, for example, caters for basic, ambulatory primary health care, but in poor rural areas cannot cover hospitalization and in-patient costs at private, mission-run hospitals – emphasising an earlier point made about the responsibility for increased quality. Geographical access to services is not a significant problem but Tanzania is looking more especially at improvements in the quality of services through mechanisms of accreditation and the community monitoring of rural private practitioners. A government representative and specialist from Namibia declared interest in fielding one of the first pilot projects. Another expert pointed out that the term community could equally well be interpreted as an occupational group of course; he proposed a group of diamond cutters in India for a pilot project. In supporting a feasibility study of the three major elements of the proposal, another offer was made to carry out a pilot study, with ILO support, on satellite social insurance schemes in India, in association with other organisations working at the grass roots level such as SEWA (Self Employed Women's Association).

It was hoped that feasibility studies in Ghana and Benin would highlight (i) the possible involvement of Employers and Workers Organizations, and (ii) possible linkages between specific on-going ILO programmes (IPEC, STEP, etc) and the Social Trust Fund, both of which would enhance its worth and appeal.

By others, the need at all for **pilots** and pilot areas was queried, if the concept and the operation of the social trust was sufficiently thought through; it was argued that successful implementation in one area does not by any means guarantee success in another; and furthermore, that pilots are not necessarily transferable or replicable.

It was felt that the aim of the feasibility study concerning the 'strengthening of governance structures' (p.1) would be to enable national social transfer systems to function 'self-sufficiently' or 'sustainably' in the longer-term (rather than 'independently').

Finally, quoting one respondent in the aftermath of September 11, it is clearer than ever that the whole world is threatened and insecure as long as there is such poverty and powerlessness that fanaticism seems the only escape.

Annex 7

List of participants to the Interregional meeting on exploring the feasibility of financing social protection benefits in low-income countries through international transfers

(Bossey/Geneva, 14-16 May 2002)

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Secretary General
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India

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Employers Federation of India

South Africa

Mr. Barry Shipman,
Legal Counsellor Specialist in Employee Benefits,
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Mr. Kurt Feller,
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Pictet & Co., Bankers

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Mrs. Phyllis C. Borzi,
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National Union of Namibian Workers

Thailand

Mr. Sripo Wayuphak,
Vice-President,
Labour Congress of Thailand

(Observer)

Mr. Bill Mansfield,
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International Organization of Employers

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Mr. Dalmer Hoskins,
Secretary-General,
International Social Security Association

Mr. Derek Osborne,
Actuarial Officer,
The National Insurance Board
Bahamas

Mr. Peter Rosenberg,
Social security economist and former Director General of Planning
in the Ministry of Labour and Social Affairs
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Mr. Frank Lisk (ILO/AIDS)
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Mr. Rolf van de Hoeven (IPG – World Commission)
Ms. Susan Hayter (IPG – World Commission)
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