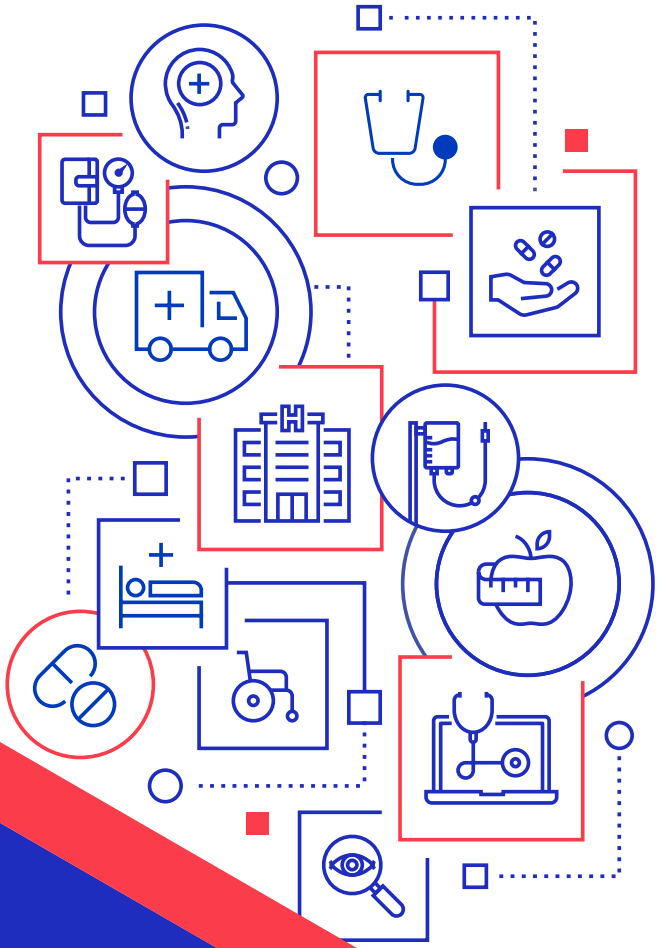
International Labour Organization

SHIF 1922–2022
One hundred years of mutual health insurance



One hundred years of mutual health insurance

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Foreword

Dear insured persons,

The year 2022 marks the centenary of the International Labour Office's (ILO) Staff Health Insurance Fund (SHIF), which was established in December 1922 – three years after the creation of the ILO and its social protection mandate but before the first international labour standard on "sickness insurance" was adopted. On this occasion, the SHIF Management Committee is pleased to present you with this booklet on the origin, history and salient features of the SHIF.

Over the 100 years of its existence, the SHIF has evolved from a health insurance scheme initially available only for serving officials at headquarters into coverage for all officials, in Geneva and in the field, former officials no matter where they live, as well as their families. Offering access to high-quality health care for staff in the field has been a particular area of priority for action for the SHIF, which has remained loyal to its founding principles: solidarity between insured persons in different situations no matter their income, health and age and joint governance through representatives of the Director-General and representatives of the insured persons.

After 100 years, the SHIF remains a financially sound and not-for-profit health insurance entity within the United Nations system. It provides worldwide health insurance coverage to 13,000 insured persons and is accessible online from anywhere and at any time.

We hope this booklet will delight current and future insured persons in its narrative on the very important role of the SHIF for insurance coverage of ILO staff, their families and former officials. The current context and socio-economic challenges make this role even more important. The engagement of all insured persons in the years to come will be essential to shape the future of the SHIF and to ensure its sustainability.

Tilmann Geckeler
Chairperson

On behalf of the SHIF
Management Committee

Acknowledgements

We would like to thank Dorothea Hoehtker, who has carried out the historical research and is the main author of this booklet. Pierre Sayour contributed thoughts on solidarity and health insurance and Luca Bormioli provided an overview of SHIF as well as the introductory and final remarks. Thank you also to Remo Becci and Jacques Rodriguez at the ILO archives, as well as to Heather Harris, Bojan Kochankovski, Corinne Michoud and Lan Xu for their kind support. Patrick Bollé, Karen Emmons, Elisabeth Fombuena and Patricia Pihen made sure that this booklet reads well in all three languages.

Florian Léger
SHIF Executive Secretary

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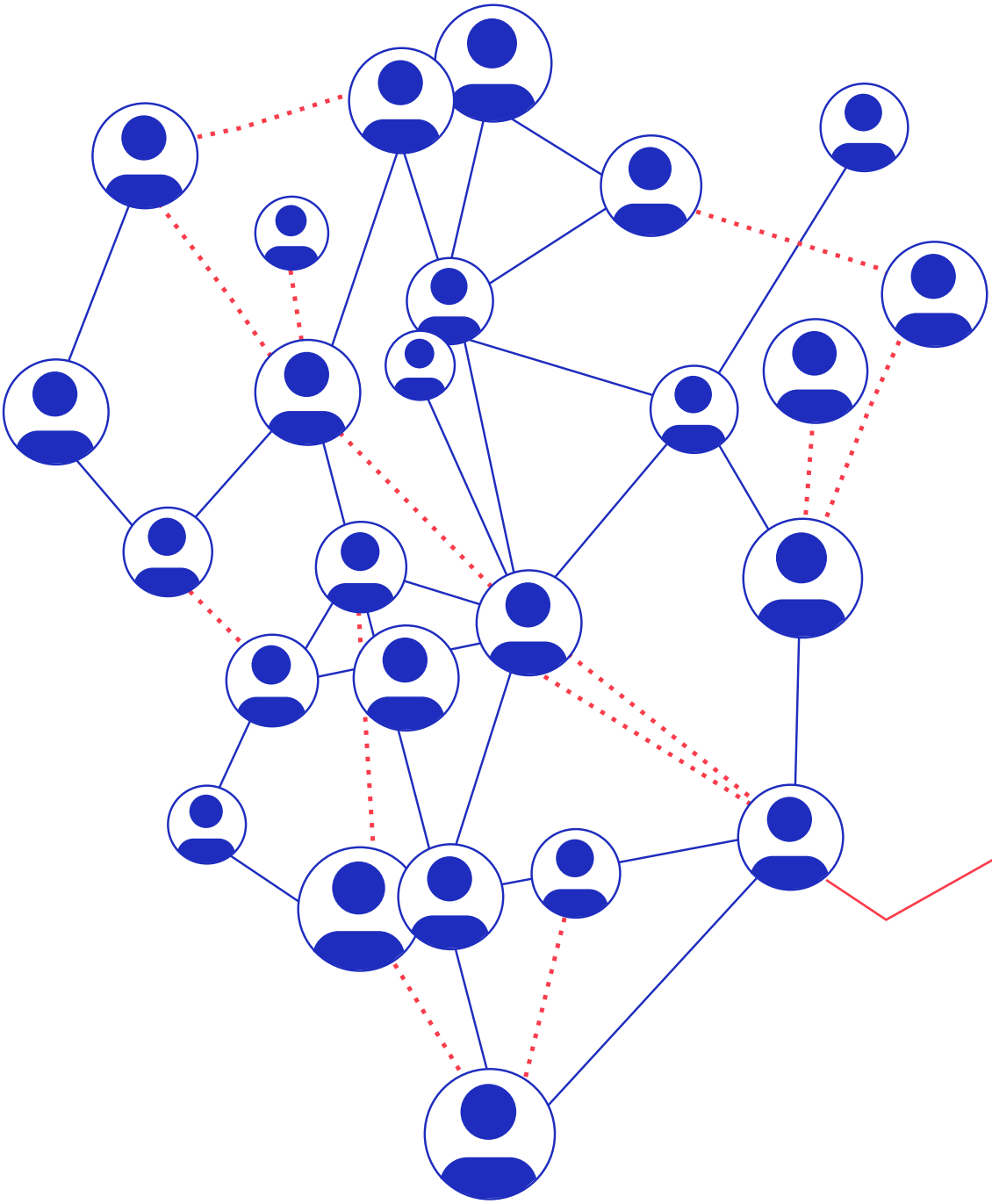


Chapter

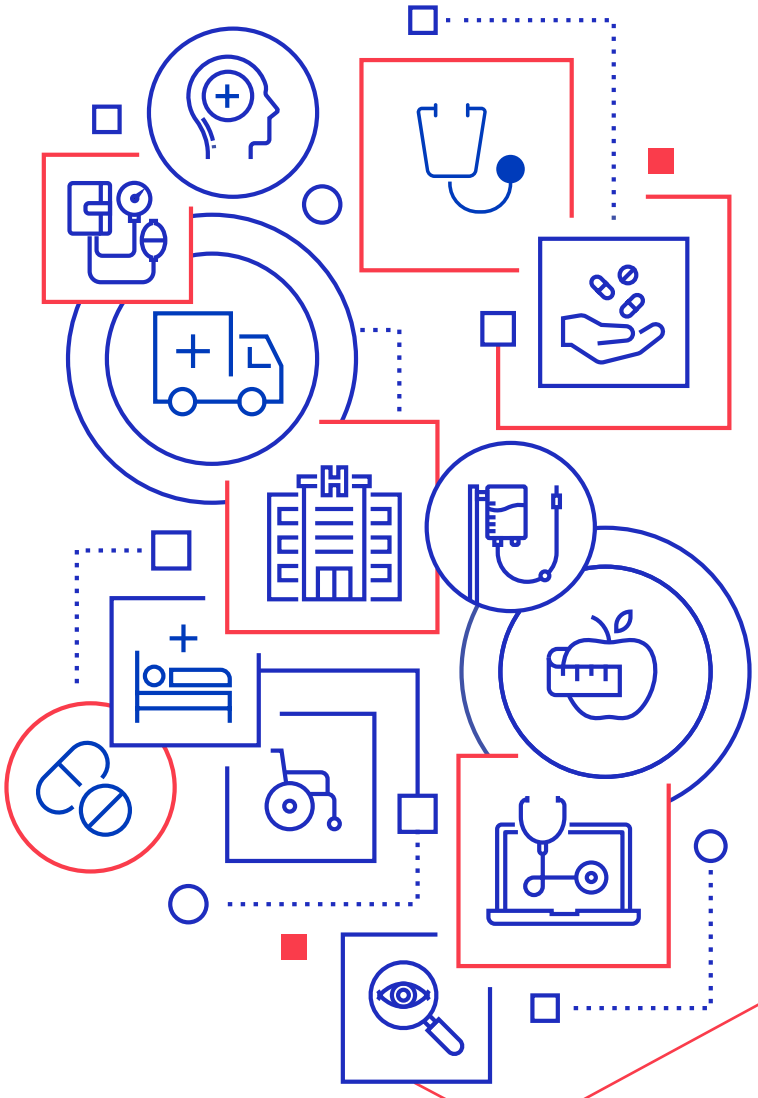
1

Introduction

This booklet describes salient prominent features of the International Labour Office (ILO) Staff Health Insurance Fund (SHIF), with a historical perspective reaching back to its inception. It explains the unique characteristics and distinctive advantages of the health insurance coverage available to ILO staff worldwide through a successful mutual scheme that has been in place for a hundred years.

The booklet reveals the previously untold history of the SHIF and how it adapted to a changing ILO and the evolving needs of its staff while remaining faithful to its solidarity principles, which are inspired by the values of the ILO. It describes how the SHIF adjusted its coverage policy to address changes in modern civil society and to deliver the health insurance needs of new family structures. It concludes with some numbers and graphs about membership, revenue and expenditure to illustrate some long-term trends.

In celebration of a century of operations, the booklet includes testimonials from three insured persons who share their recent experience with the SHIF. And in the spirit of looking ahead, it concludes with some thoughts about new challenges and opportunities for improvement.



Chapter

2

The SHIF in a nutshell

How does it work?

The SHIF provides health insurance for qualifying active and retired staff members of the ILO and their families. It is administered internally and financed by contributions deducted from the salary or pension that are matched by the ILO on an equal share basis for active staff and on a higher share basis for retired staff.

Today, the SHIF offers worldwide coverage of medical expenses incurred for health protection due to illness, accident, maternity and preventive care. Coverage is compulsory for staff members as well as eligible dependants. There is the possibility of voluntary coverage for non-dependant family members. Staff may elect to stay insured with the SHIF upon retirement, provided they meet eligibility conditions related to age and length of service.

Health insurance based on solidarity

The SHIF is a not-for-profit mutual insurance entity. Solidarity is the foundation of mutual health organizations. It means, first of all, solidarity, or shared conditions, between the better-off and the less well-off members. Contributions to the SHIF are proportional to each insured member's financial means (percentage of salary or pension), taking into account the family composition. Compulsory membership ensures that all qualifying ILO staff members have access to the same health care benefits, irrespective of their grade, functions or duty station.

Second, it represents solidarity between healthy and sick members. Accordingly, contributions do not depend on the risk incurred by any member, and the SHIF does not demand exclusions for pre-existing medical conditions. In practice, this results in a third form of solidarity, between the young

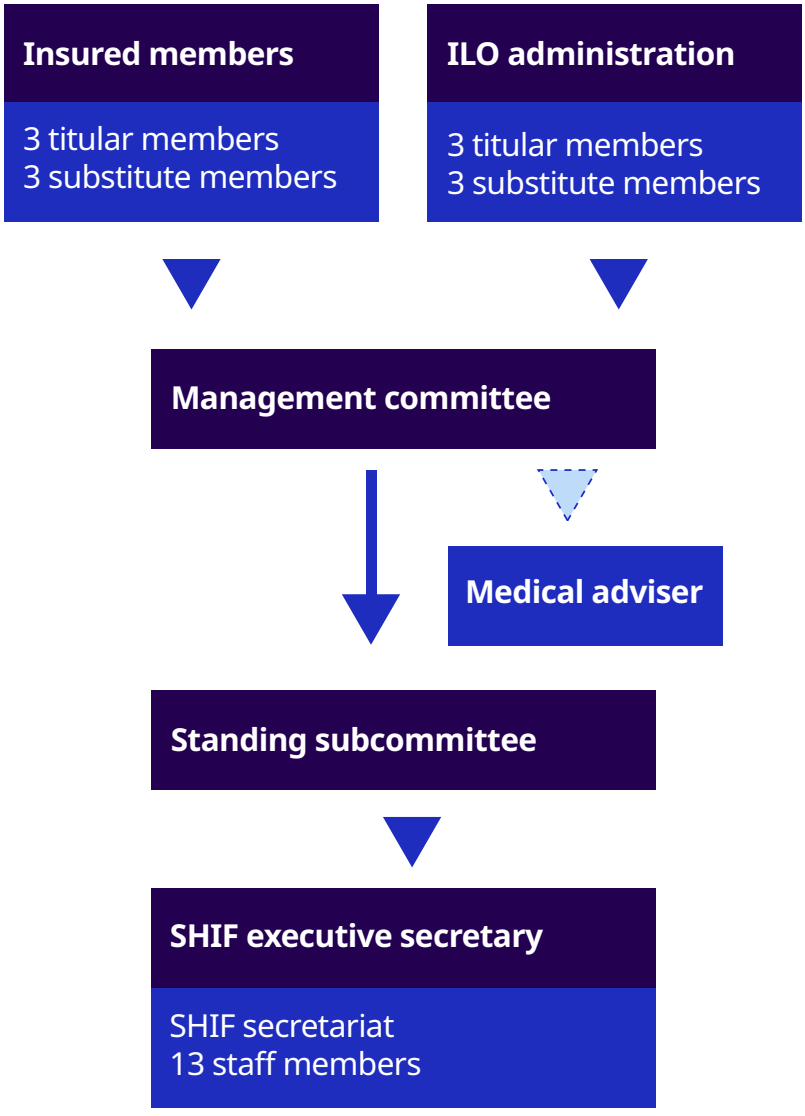
and the old members, as risk of illness increases with age. The SHIF has a multi million Guarantee Fund that ensures that the insurance has sufficient assets to cover mid-term liabilities. Its investment portfolio is managed by external financial experts engaged under the supervision of the ILO.

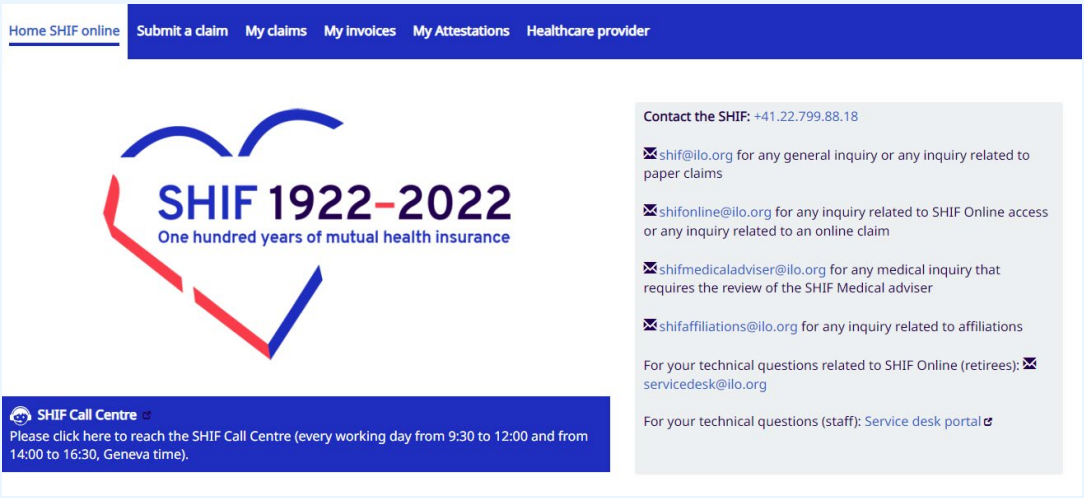
Free choice of medical providers worldwide

SHIF-insured members are free to choose any suitable medical provider and claim reimbursement of medical expenses based on the applicable schedule of benefits. Although the SHIF has specific agreements with a selected range of medical providers worldwide, there is no obligation for insured members to use a specific provider. The SHIF has a dedicated Medical Adviser designated by its Management Committee to ensure that the conditions provided under the approved schedule of benefits are duly applied. This function is performed by an external qualified medical practitioner who is totally independent from the ILO Medical Adviser.

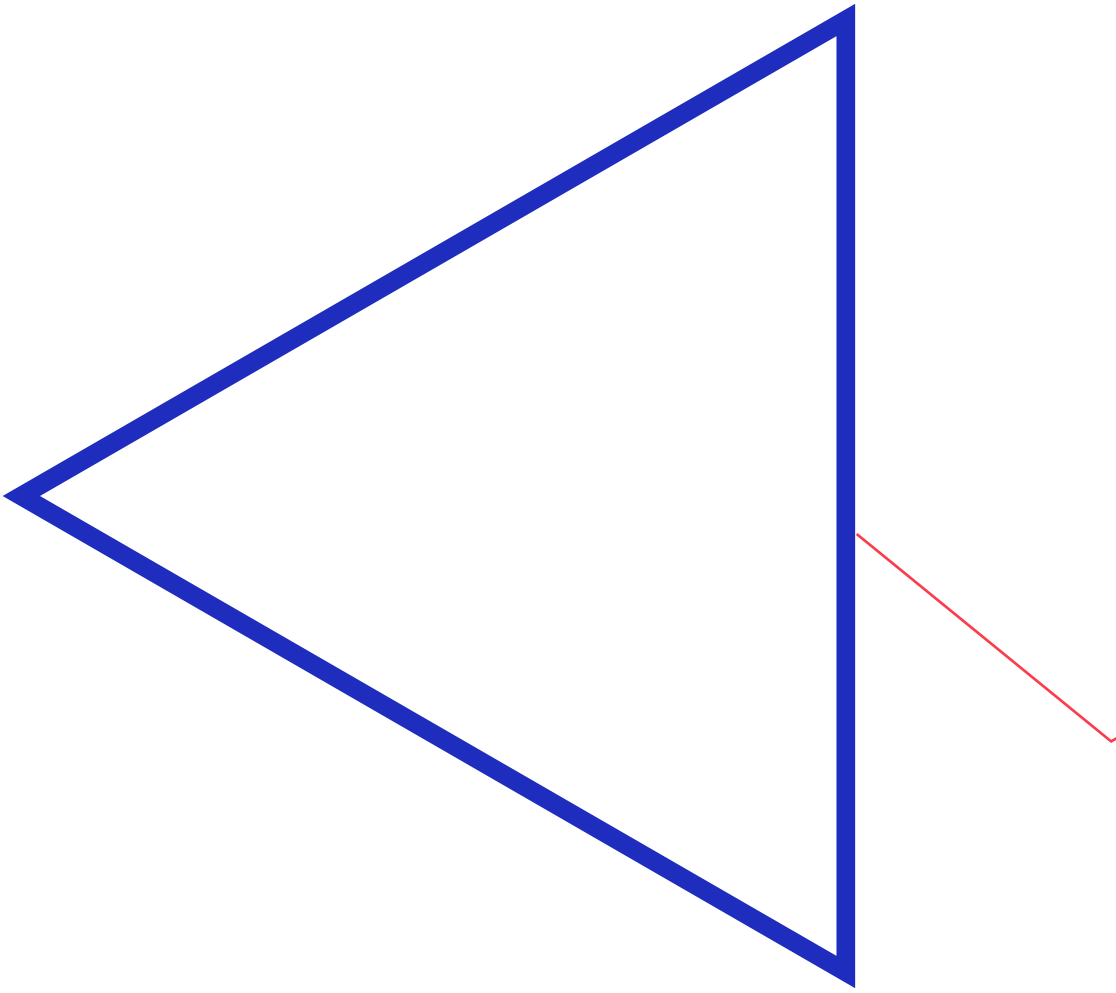
Unique governance

The Management Committee governs the SHIF. It is composed of six representatives elected by all the insured staff members and an equal number of representatives of the ILO Administration, appointed by the ILO Director-General. The ILO administers the SHIF operations, including financial transactions, accounting and investments. The client relationship with SHIF-insured members is undertaken by the SHIF Secretariat based in the ILO headquarters in Geneva, which is also in charge of claims processing. The SHIF operations as well as its accounts and financial transactions are subject to periodic audit by external and internal ILO auditors.


Insured members
3 titular members
3 substitute members
ILO administration
3 titular members
3 substitute members
Management committee
Medical adviser
Standing subcommittee
SHIF executive secretary
SHIF secretariat
13 staff members



Since 2019 (2020 for retirees), SHIF members can file their medical claims and access their SHIF information electronically with SHIF Online.



Chapter

3

Looking back 100 years

From 1920 to 1926, the ILO was housed in this building, which is now home of the ICRC. © ILO

3.1. Solidarity and health protection: Thoughts about the SHIF

"Social security is something that is vital to millions of people. It is too serious an issue to let ideology or profit motives override common sense and experience. Let us not forget that social protection is not a luxury. It is a fundamental human right, enshrined in the International Covenant on Economic, Social and Cultural Rights, adopted in 1966 by the United Nations General Assembly. And [...] social protection remains one of the core mandates of the International Labour Organization." **Manuel Simon**

Manuel Simon is a Spanish trade union leader who wrote that statement in 2000 in the ILO's Workers' Education magazine. Health insurance is the culmination of a long history of social progress. But is it a right? Is it obvious that it should take the form of a mutual or cooperative scheme?

The concept of a mutual or cooperative society goes back to antiquity. Social life and modest incomes inspired the need for mutual aid. Traces of such an arrangement are found in the collective farming system in Babylon, the assistance and burial brotherhoods of Roman antiquity and the companions who built Solomon's Temple in Jerusalem (940 BC). North-western Europe and its craftsmen's guilds established solidarity organizations as early as the eleventh century. Health protection for workers was a later addition to this model. The promotion of general welfare cited in the Preamble to the Constitution of the United States of America of 1787 is the first reference to a constitutional objective.

Mutual aid societies and other forms of collective solidarity developed in Europe throughout the nineteenth century. With unfolding industrialization, these aid societies were often unable to deal with the resulting widespread social misery. A growing number of workers in industry and agriculture were facing loss of economic security due to illness and accidents, while affordable access to health care remained largely a privilege of the wealthier classes of the population.

To prevent social unrest and take the wind out of the flapping sails of the labour movement, the German Empire, more precisely Chancellor Otto von Bismarck, introduced a state-controlled mutual health insurance scheme in 1883. It was compulsory and comprised, among other things, the reimbursement of medical expenses, maternity assistance and a death grant. Bismarck expanded the concept by introducing accident insurance a few years later, followed by old-age and disability insurance. The German social insurance schemes became a model for social reformers and many governments in Europe. The principles behind them were new and groundbreaking: collectivizing individual risk, redistributing responsibility between employers and employees and using actuarial competencies to determine liabilities and premiums.

The establishment of a "sickness insurance", as it was called at the time, for ILO staff members was part of this logic, although its application to an international organization with employees working around the world was a novelty and remains a particular challenge.

The first edition of the insurance regulations, dated 1 December 1922, stipulated in its article 1: "The object of the International Labour Office Staff Insurance Society is to procure for its members, with the financial assistance of the International

Labour Office, benefits in case of sickness or accident. The Society also aims at preventing illness by encouraging prophylactic measures for the improvement of the general state of health of the staff." It is interesting to see that article 11 also states: "Each member shall be entitled to the free choice of his own doctor."

In reading the latest edition of the Statutes and Administrative Regulations of the Staff Health Insurance Fund, we see that these guiding principles remain the same. The principle of free choice even applies today to all medical practitioners, pharmacists and medical establishments, from hospitals and private clinics to long-term care institutions.

The history of the SHIF is deeply connected to the ILO's vision of social justice, which includes the objective of adequate social protection and, more specifically, the protection of workers' health. This objective was enshrined in the ILO's 1919 Constitution, defined as a universal right in the Declaration of Philadelphia of 1944, spelled out in several Conventions and Recommendations and reaffirmed by the 2008 ILO Declaration on Social Justice for a Fair Globalization and the 2019 ILO Centenary Declaration for the Future of Work.

To honour that social justice grounding, this booklet now takes you on a historical tour that highlights important moments in the history of the SHIF. It draws attention to this connection, thus illuminating how the ILO's international social policy has been a strong wind shaping the SHIF into the modern health insurance it is today.

3.2. Protecting Geneva staff: The first years of the ILO health insurance (1922–1928)

After the end of the First World War, the Treaty of Versailles established the League of Nations and the ILO as an autonomous agency. Part XIII of the Treaty became the ILO's first Constitution. It enshrined "the protection of workers against general and occupational diseases and accidents arising out of work" in its Preamble.

Typist wearing mask during the Spanish Flu, New York City, 1918. © Wikipedia

A staff initiative

The ILO permanent secretariat, the International Labour Office, moved to Geneva from London in late 1920. The Great Influenza Pandemic of 1918 was still causing widespread suffering at the time. The newly created Staff Committee (which later became the Staff Union) took the initiative to create a staff health insurance scheme. Referring to the fourth wave of the pandemic in winter 1920, the Staff Committee stated when introducing the scheme: "The present epidemic in Geneva and the consequent additional expenditure for medical assistance, which has been the result for many members of staff, has made the absence of any sickness insurance scheme more than ever noticeable."

The idea was immediately supported by Royal Meeker, an American economist and director of the ILO's Scientific Division. He convinced ILO Director Albert Thomas that the staff should not pay medical expenses from their salaries. For him, these costs were a burden, especially for lower-ranking clerical staff, who were predominantly women. "The effect of this practice is demoralizing," Meeker told Albert Thomas.

Jean-Pierre Seiler in 1921. © ILO

In 1921 and upon request by the Staff Committee, the ILO's Social Insurance Service submitted the first rules for the health insurance scheme. The author of the draft scheme was Jean-Pierre Seiler, a social insurance expert from Geneva.

Using a Swiss insurance company to cover ILO employees was impossible for two reasons: First, Swiss insurance

schemes could not be adapted to the functions of an international organization, which needed coverage for accidents and illnesses occurring while employees were abroad. Second, Swiss mutual health insurance schemes were usually subsidized by the State, which provided some guarantee, even modest, for those persons with limited resources to cover medical expenses.

Seiler thus proposed a scheme based on Swiss legislation, taking the form of a cooperative society with voluntary membership, free choice of doctors and benefits for staff members and, in a separate category, their families. The financing contribution was to come in equal parts from the ILO Administration and staff members.

Following the League of Nations

Seiler also worked with the Secretariat of the League of Nations, which started its own health insurance as of January 1922. It adopted a different model but was based on similar principles – democratic governance, employer contribution and free choice of doctors. Most importantly, the insurance had proved its usefulness in early 1922, when many staff members became ill. The League of Nations' insurance scheme presented a second option for ILO employees.

Then a third – internal – proposal recommended to financially support lower-ranking ILO staff only and to establish a medical service rather than setting up an insurance scheme. After some debate, the ILO Administration drafted its own proposal. It integrated various elements but resembled in most points the health insurance of the League of Nations. The proposed scheme was independent of Swiss law, thus better matching the international character of the ILO's work. However, contrary to the League of

The ILO staff union committee in 1922. The British researcher Sophie Sanger (4th from the right) and Jan de Roode, a Dutch trade unionist (3rd from the right) were staff representatives with an active role in the set up of the ILO staff health insurance. © ILO

Nation's health insurance model, the ILO scheme did not include family members.

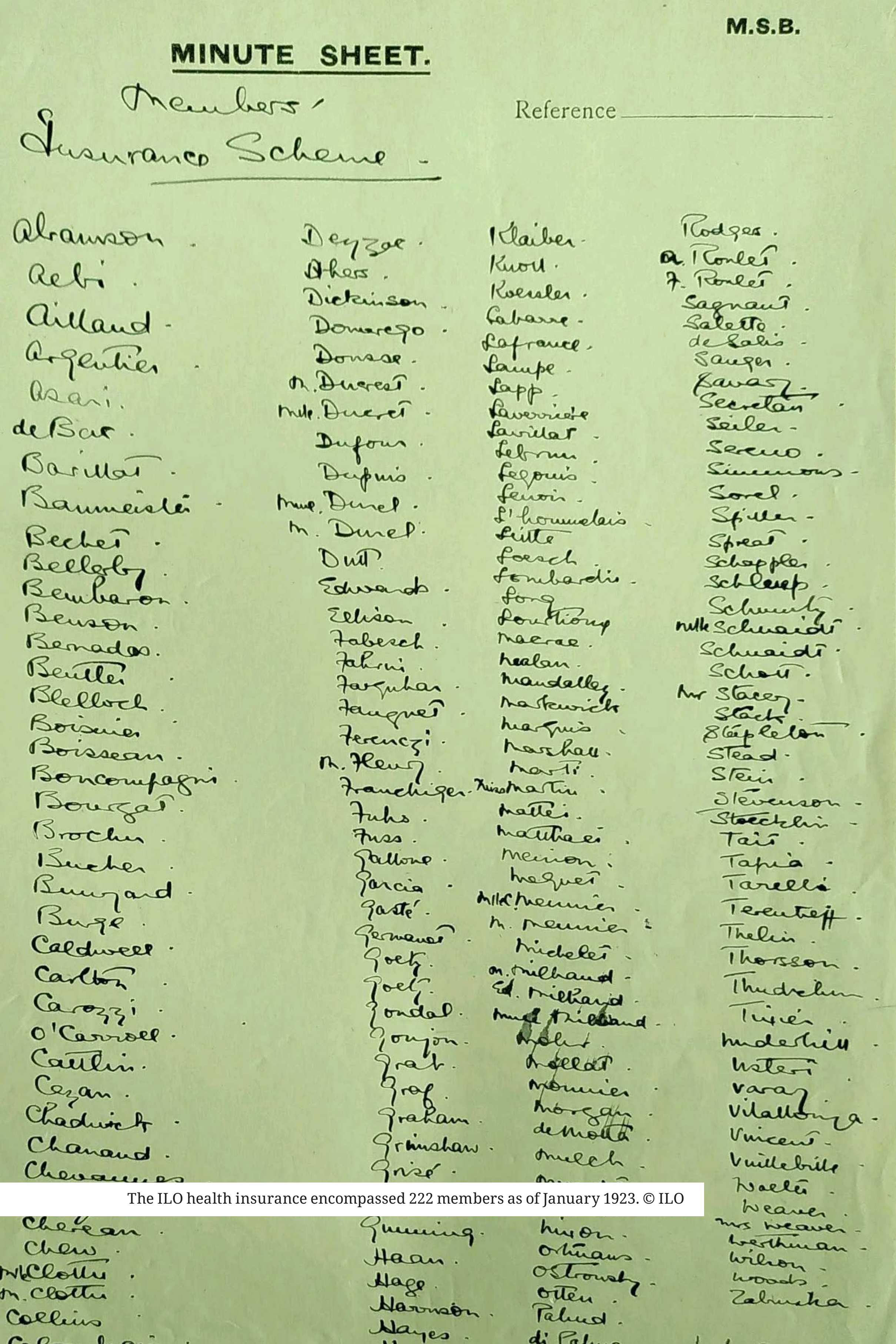
The similarity of the proposed scheme to that of the League of Nations reassured the ILO Governing Body, which gave a green light in April 1922 to transfer the necessary moneys to launch the ILO health insurance. A few months later, in September, the staff union organized a referendum, and the ILO staff approved the draft rules of the new insurance scheme.

The constituting General Assembly took place on 15 December 1922. The provisional rules of the new International Labour Office Staff Sickness and Accident Insurance Society entered into force retroactively on 1 December 1922.

The new ILO health insurance was based on the democratic principle of self-governance, with staff representatives elected by the General Assembly and representatives of the ILO Administration, nominated by the Director (later the Director-General) in the Executive Committee. Any amendment of the rules needed to be approved by the ILO Director and, as far as financial matters were concerned, by the Governing Body. The first statutes further stipulated the financing of the health insurance through contributions from members and a grant by the Administration. Later versions were more precise: The amount contributed by the Administration should be equal to that of the members. This important principle of equally shared financial responsibility remains valid today. The statutes also stipulated the constitution of a guarantee fund with a fixed amount per member and the Committee's statutory responsibility to reconstitute it whenever it fell under the defined minimum level.

The first Executive Committee took up its work in January 1923. It consisted of nine persons, two of whom were nominated by the Director to represent the Administration and seven were elected by the members of the insurance scheme. They came from different categories of staff. Among them were two women.

From then till now, the democratic principles of the ILO health insurance have not changed in substance. Over time, however, the responsibilities of the Management Committee, as it is called today, expanded, eventually replacing the General Assembly as the SHIF's supreme decision-making body. Its composition now is also more balanced than in the early years because both the insured persons and the Administration are represented by three titular members and three substitute members.



M.S.B.

MINUTE SHEET.

Members' Insurance Scheme.

Reference

Abramson. Aebi. Aillaud. Argentier. Asari. de Bar. Barillat. Baumeister. Becker. Bellerby. Bemberon. Benson. Bernades. Beutler. Blelloch. Boisnier. Boisseau. Boncompagni. Bourgat. Brochin. Bucher. Burgard. Burge. Caldwell. Carlton. Carozzi. O'Carroll. Catlin. Cezan. Chadwick. Chanaud. Chevannes. Chereau. Chew. Mlle Clottu. M. Clottu. Collins.

Deyzac. Ahers. Dickinson. Domerego. Dousse. M. Ducrest. Mlle Ducrest. Dufour. Dupuis. Mme Durel. M. Durel. Dutt. Edwards. Ellison. Fabesch. Fahrni. Farquhar. Fauquet. Ferenczi. M. Fleury. Franchiger. Fuhs. Fuss. Gallone. Garcia. Gasté. Germanet. Goetz. Goetz. Gondal. Goujon. Grab. Graf. Graham. Grimshaw. Grisé. Gunning. Haan. Hagg. Harrison. Hayes.

Klaiber. Knoll. Koessler. Labarre. Lafrance. Lampe. Lapp. Laverrière. Lavillat. Lebrun. Lepouis. Lenoir. L'hommelais. Little. Loesch. Lombardis. Long. Louthiony. Macrae. Healan. Mandalley. Markowich. Marquis. Marshall. Marti. Miss Martin. Mattei. Matthaei. Mernon. Mequet. Mlle Meunier. M. Meunier. Michelet. M. Milhaud. Ed. Milhaud. Mme Milhaud. Molst. Mollat. Monnier. Morgan. de Motta. Mulch. Nixon. Orthuans. Ostrowsky. Otten. Palud. di Palma.

Rodgers. A. Ronler. F. Ronler. Sagnant. Saletta. de Salis. Sanger. Savary. Secretan. Seiler. Sereno. Simmons. Sorel. Spiller. Spreat. Schoppler. Schleep. Schmitz. Mlle Schmidt. Schmidt. Schott. Mr Stacey. Stack. Stapleton. Stead. Stein. Stevenson. Stoecklin. Tait. Tapia. Tarelli. Terentieff. Thelin. Thorsson. Thudichum. Tixier. Underhill. Ustari. Varay. Vilallonga. Vincent. Vuillebille. Walter. Weaver. Mrs Weaver. Westman. Wilson. Woods. Zalmika.

The ILO health insurance encompassed 222 members as of January 1923. © ILO

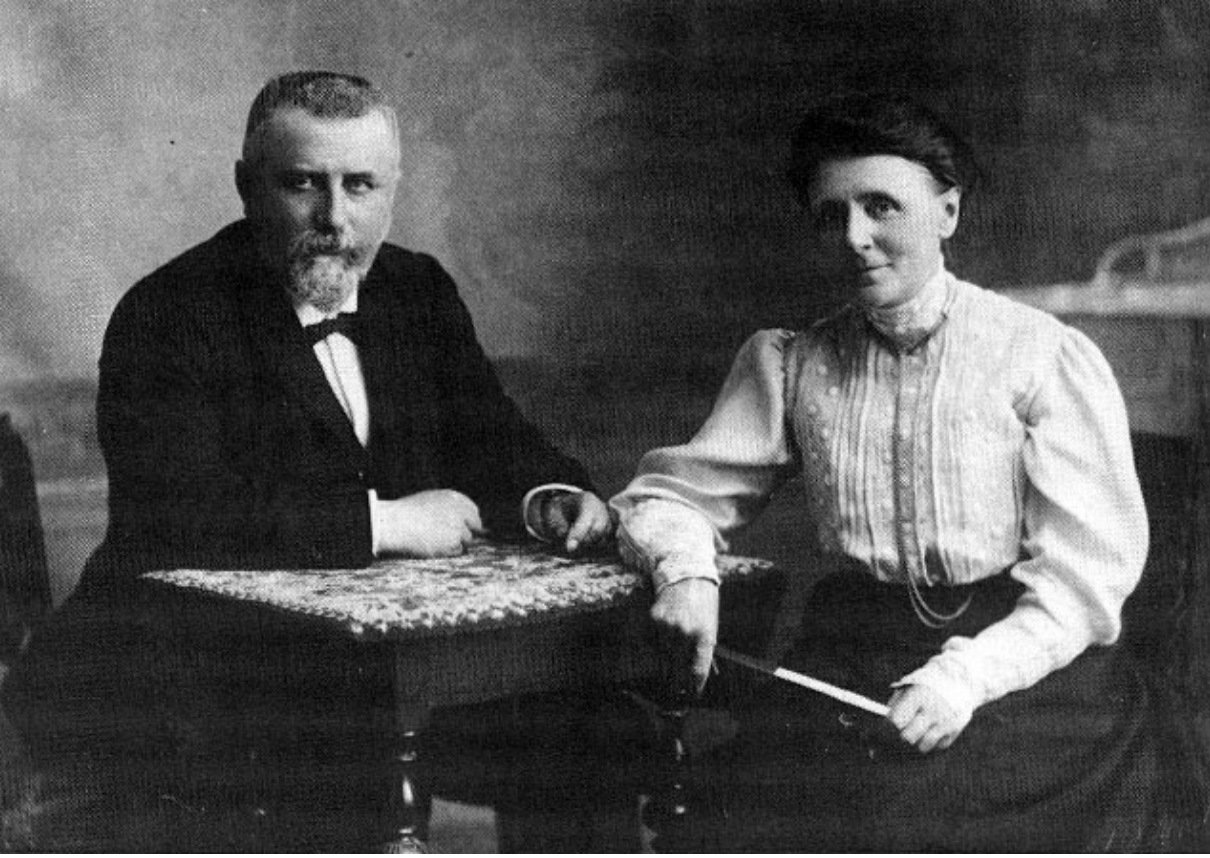
Dr Léon Weber-Bauler worked for the ILO and its health insurance from 1923 to 1940. He was well connected to the Geneva medical community. © ILO

Doctors and nurses

Two Geneva-based doctors, Dr Léon Weber-Bauler and Dr Henriette Saloz-Joudra, both of whom were born in Russia, were appointed Medical Advisers in 1923.

Both doctors conducted the compulsory medical entrance exam of new staff members as well as special exams upon request of the Office and the Committee of the health insurance. Dr Weber-Bauler was also in charge of the general hygiene for the Office and the control of all doctors' bills submitted for reimbursement. The contract of Dr Saloz-Joudra was not renewed in 1924. After her departure, female ILO staff members were allowed to consult a female doctor for the entrance exam if they wanted. The double role of the Medical Adviser, who was serving the Office and the health insurance scheme, was maintained for 80 years. Only in 2004 were the two functions separated, and the SHIF appointed its own Medical Adviser. From then on, medical claims files were no longer shared with the Administration to maintain confidentiality.

In 1923, the position of an Office nurse was created as well. The nurse was to visit staff members who were ill and could be consulted for "minor ailments". She also was to support the medical adviser in his control functions. Annie W. Hedley, an experienced British nurse and widow of a League of Nations official, was the first ILO nurse. Her job was not easy. Because Geneva public transport was still rudimentary in the 1920s, she learned how to bicycle to visit sick staff members. But she had frequent accidents.



Dr Henriette Saloz-Joudra (with her husband) was 68 when she started working as the Medical Adviser for female ILO staff members. She was the first woman doctor to open a private practice in Geneva. © ILO

Her salary was subsequently increased so she could buy a car, albeit an old one, to reach her patients.

During the first year that the ILO health insurance was available, the important and prevailing question was of course whether it would be financially sustainable. Two years into its operations, to the relief of the Committee, the financial set-up seemed to work well, with all expenses covered. Nevertheless, the idea to diminish the financial risk by making membership in the health insurance compulsory was placed on the table for discussion.

The model to follow: ILO sickness Conventions

The evolution of the ILO's health insurance in the following years must be understood in the context

of the ILO's policies and especially its standard-setting activities in the field of social insurance in the 1920s.

In 1925, sickness insurance appeared on the agenda of the International Labour Conference, which at the time was dominated by European Member States. Employers wanted healthy workers to increase productive capacity; workers wanted social justice and effective protection against health risks; and European governments wanted international regulations in the form of ILO Conventions to make sure that socially progressive legislation in their countries would not create an economically competitive disadvantage. While employers preferred voluntary schemes, subsidized by the State for lower-income groups (as, for example, in Switzerland), the workers favoured compulsory schemes (as in Germany), to which the employers should contribute as well.

Beyond the ILO's tripartite constituency, two other important players entered the scene in these early years: the sickness insurance companies and the doctors' associations. When the ILO started to collaborate with the European health insurance funds, doctors realized that they needed to organize to be represented at the international level. In 1926, they set up the International Professional Association of Physicians to defend their interests. The Association was opposed to any form of compulsory sickness insurance and insisted on the free choice of doctors. Its positions were reflected at the local level by the Geneva Medical Association (Association des médecins du canton de Genève). For the Committee of the ILO health insurance scheme, the doctors became an important entity to deal with.

In 1927, the ILO adopted a Sickness Insurance (Industry) Convention (No. 24) and a Sickness Insurance (Agriculture) Convention (No. 25). Both Conventions reflect the principles on which the ILO's health insurance was based: self-governance,

with participation of the insured persons in the governance, and shared contribution by the insured persons and their employers to the financial resources of the health insurance scheme.

In these years even in countries with a more advanced social security system, such as Germany, workers paid larger contributions than what their employers paid. The equal contribution of the ILO Administration to the insurance fund reflected the ILO's ideal of social justice. However, this was not enough. The Conventions carried further requirements that the ILO health insurance did not yet fulfil: First, sickness insurance should be compulsory. Second, it should not only apply to permanently employed workers and employees, but also to those with limited contracts.

Temporary staff in the field: The case of Paul Hesse

Indeed, ILO's temporary staff were not insured in those years, although they were often sent on missions far from Geneva. In the event of illness or accident, they could claim reimbursement directly from the Administration, but only when they could prove that the costs had occurred because of the mission. This created difficult situations, as illustrated by the case of Russia-born Paul Hesse, whom the ILO hired at the beginning of 1926 on a temporary contract of one year. According to the medical entrance exam, he suffered from a "nervous condition", which seemed to relate to events before and during the Russian Revolution of 1917 and his earlier engagement with the refugee service of the League of Nations. He was sent on a mission to Brazil to work with the ILO's refugee service and soon developed serious health problems that would qualify today as "burnout". His contract was nevertheless extended

SANATORIUM MEDIZINALRAT Dr. WERNER

WAIDHOFEN A. D. YBBS.

RECHNUNG

Hochwohlgeboren

Herrn Paul Hesse

Frau xx

Zahlbar und klagbar in Waidhofen a. d. Ybbs. Druckerei Waidhofen a.d.Ybbs, Ges.m.b.H.

	K	gr.
Zimmer vom 23./VIII bis inklusive 29. VIII.	25	90
Kurrechnung vom " bis inkl. "	105	--
Wochenordination		
Ärztliche Behandlung 5 elektr. Behandlungen	30	--
Röntgenuntersuchung		
Aufzahlung für Spezialbäder		
Besuche		
Separatservice		
Liegestuhl Badewäsche	1	40
	162	30
~~Warenumsatzsteuer xx~~		
Mietabgabe von K 25.90 + 15% v. Zimmer	3	88
Auslagen für Medikamente		
" " Post Porto	1	55
Taxe für Bademeister		
" " 1. Serviererin		
" " 2. Serviererin		
" " Stubenmädchen		
" " Lohndiener		
	167	73
2 % Wust	3	35
Stempel		50
S.	171	58

Waidhofen a. d. Ybbs, am 29. August 1928

Dankend saldiert

Invoice for accommodation and electrotherapy, which was a common treatment of mental health conditions at the time, in an Austrian sanatorium. © ILO

for another year. Despite local treatment at costs much higher than in Geneva, he needed to be repatriated in the spring of 1928 to Europe. He consulted different specialists and was finally diagnosed with anxiety and insomnia, which improved after treatment in a sanatorium in Austria. Not being insured with the ILO's health insurance scheme, he submitted a claim for reimbursement of the considerable medical expenses directly to the Office.

The Office refused to pay but admitted its responsibility for the aggravation of Hesse's fragile mental health, arguing that he had had "problems to adjust to the environment and adapt to the local work, given that he was not familiar with the language and local customs". Hesse pressed the claim and eventually the Office decided to reimburse 50 per cent of the costs.

This early case highlighted the financial risks for temporary staff deployed in the field at the time. It also anticipated a number of problems for the ILO health insurance, most importantly, the cost of treatment outside of Geneva and thus the control of medical bills.

Given the good financial situation of the ILO health insurance, which was due to the relatively young age of ILO staff in the 1920s, and a number of cases similar to the one of Paul Hesse, the General Assembly proposed in May 1928 to extend voluntary membership to temporary staff, following a change in the staff regulations for this group.

The revised statutes came into force on 10 December 1928. Temporary staff with contracts of at least six months could join the ILO health insurance, although admission was conditional on good health, certified by the medical adviser, and benefits were limited. Another important change was that membership of all permanent staff – local and

international – became compulsory. This had a practical advantage. Compulsory membership reduces financial risks, given that higher-ranking officials with better salaries and younger staff with fewer health risks contribute to the scheme. Therefore, compulsory membership brought the health insurance in line with the ILO's Sickness Insurance Conventions and their principle of solidarity between younger and older persons, healthy and more fragile workers and higher and lower levels of staff.

3.3. Adapting to crisis and war (1929–1949)

In 1929, the American Wall Street crash triggered a worldwide financial and economic crisis, the so-called Great Depression, with disastrous consequences that overshadowed the 1930s. Millions of workers lost their jobs. Given that social security systems were not yet well developed, poverty exploded. Political instability grew with the rise of right-wing and left-wing political parties, especially in Europe. Their programmes included social security and health care provisions that competed with the ILO's democratic vision of social security.

A march of unemployed workers in Canada, around 1930.
© Wikipedia

The crisis affected the League of Nations and the ILO, both of which were suddenly facing a difficult financial situation. In 1930, the ILO staff health insurance, for the first time, ran into serious deficit. Several cases of major illness had occurred among the staff, with high costs for surgery

and hospitalization. These costs could not be covered sufficiently by the scheme. In addition, contributions were down because recruitment of new staff had declined. In 1931, the League of Nations, on which the ILO was financially dependent at the time, reduced the amount of money it transferred to the Administration of the ILO for its contribution to the ILO health insurance. It dropped from 50 per cent to less than 40 per cent in 1933. The Committee was confronted with an existential crisis and called for an extraordinary General Assembly, which approved several measures to save the health insurance.

The first measure was to raise the contribution level from staff members. At the time, the level was based on salary category. As of January 1933, the average monthly contribution of 5.50 Swiss francs was increased by 1.50 francs (around 27.3 per cent). The Office continued to uniformly pay 4.50 francs, thus moving away from its commitment to equal contribution. The second measure was to increase membership by making it compulsory also for temporary staff. Revising benefits was a third measure, which was controversial. At the beginning of the 1930s, the Committee reduced benefits for minor illnesses and chronical conditions but increased them for major risks. And then the fourth measure looked to control medical expenses. Starting in 1933, ILO staff had to fill out a special “yellow form” that informed the Committee of medical treatment. If they failed to do so, they would not be reimbursed.

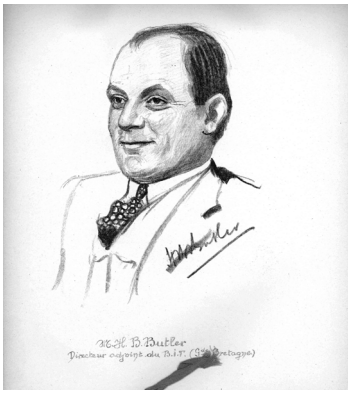
The responsibilities of the Medical Adviser were extended. For the first time, he could express a “reserve” with regard to benefits for certain conditions, based on the medical entrance exam. This article in the regulations was removed 30 years later, in 1963. To not cover illness that fell under the reserve clause or to only provide limited

benefits and thus exclude persons with serious conditions was seen as contrary to the principle that the right to benefits resulted from membership in the health insurance.

Dimensions of solidarity

The principle of employer contribution to a health insurance scheme was still a novelty in the early years. And it came under severe attack in the League of Nations in 1934, when a delegate requested that the employer contribution be reduced and only be used to support staff with low salaries. Employees with high salaries should be excluded from the insurance, the delegate insisted. In the name of solidarity and in reference to the ILO Conventions of 1927, ILO Director Harold Butler energetically defended the contributions of the ILO Administration and membership of the higher-ranking staff. Their contributions, he argued, would pay for the medical expenses of lower-ranking staff, who were statistically more often sick and cost the health insurance scheme more than what they contributed.

Equal treatment of men and women is another dimension of solidarity. Contrary to private companies in Switzerland at the time, contributions to the ILO's health insurance were the same for men and women. However, during the 1936 General Assembly, a criticism surfaced that women cost the health insurance more than men did. Male staff members, in addition, had to bear the medical expenses for spouses and children, whereas female officials were mostly single, the complaint alleged. Therefore, women should pay



Caricature of Harold Butler, who became the ILO's second Director in 1932. © ILO

a larger contribution. Luckily, there was no follow-up to the debate. Quite likely, the Committee realized that the health issues of women in the ILO often related to their predominance in lower-ranking, mostly clerical positions with poorer working conditions.

Finally, concerns about solidarity and fairness directly linked to emerging debates in the Committee on the extension of benefits to family members, to staff who were not working in Geneva and to retirees. The latter were often in a difficult situation, especially in Switzerland, where Swiss health insurance schemes, which were voluntary and based on

ILO staff in the stenographic pool in 1924. Most women in the ILO worked as clerical staff. © ILO

lifelong membership, refused to admit retired ILO officials because they were considered a "bad risk".

Geneva and Montreal: Health insurance for ILO staff in war and post-war times

The Second World War ignited with Nazi Germany's attack on Poland in 1939. In reaction to the increased threat of a German invasion of Switzerland, 44 staff members left Geneva in the summer of 1940 to seek refuge at McGill University in Montreal, Canada.

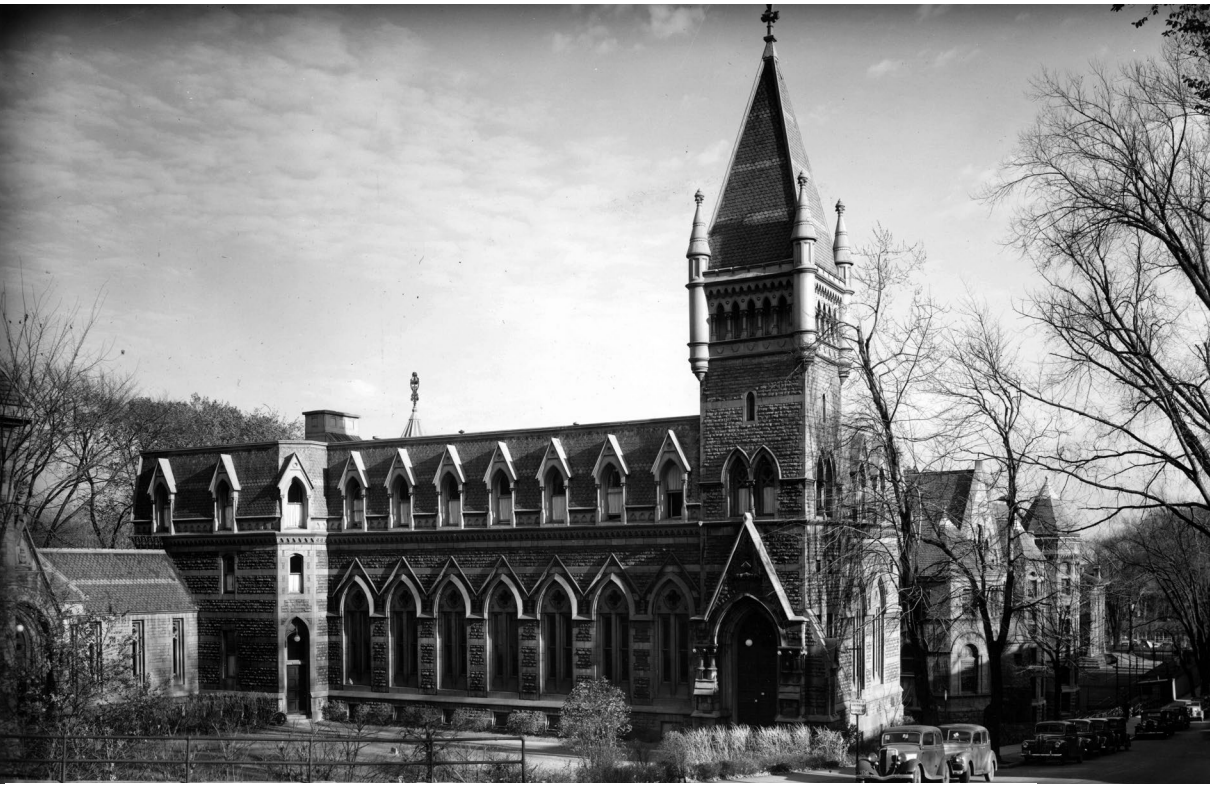
The contracts of most of the other staff members were suspended, and many returned to their home country. Only a few remained in Geneva. For them, the health insurance, after a short interruption, resumed service in October 1940, although only with the resources from their contributions and from the Office. The contract of Dr Weber-Bauler, who was 71 by then, was terminated. In 1941, a separate health insurance fund was established in Montreal. Both the Geneva- and the Montreal-based insurance schemes applied the rules adopted in 1933.

During the years in exile, the ILO developed an ambitious vision of its role in the new post-World War order, embodied in the Declaration of Philadelphia that was adopted in 1944. Based on the experience of the Great Depression and its devastating social and political consequences, the Declaration stipulated the universal right to economic security and the obligation to "achieve the extension of social security measures to provide a basic income to all in need of such protection and comprehensive medical care" as well as "adequate protection for the life and health of workers in all occupations".

The war ended in 1945. The League of Nations had ceased to exist and was succeeded by the United Nations. The ILO became its first specialized agency

one year later. Its major goal was to put the ambitious objectives of the Philadelphia Declaration into practice and to advance social protection in its Member States and also for its own staff.

The ILO officials returning from Montreal rejoined the Geneva-based health insurance, which had shrunk to 14 members in 1944. It was called the Staff Sickness Insurance Fund, which became in 1969 the Staff health insurance fund or SHIF. In 1947 and 1948, after the full return of the Office, a provisional committee was charged to take up the pre-war revision plans and to focus on several priority issues, such as the extension of benefits to family members and the admission of retirees to the scheme. A first step towards the geographical extension of coverage was the admission, in 1947, of



The working conditions at McGill University in Montreal, Canada were less comfortable than in Geneva. © ILO

The United Nations in Geneva, Switzerland. © Jean-Marc Ferré, United Nations

employees of the ILO Liaison Office with the United Nations in New York into the ILO health insurance. This move provided first-hand experience with reimbursement of medical services outside of Geneva.

A new Medical Adviser and a new nurse took up posts in the Geneva headquarters in 1948. In 1949, the United Nations Staff Mutual Insurance Society Against Accidents and Illness was created. It offered the possibility for other United Nations organizations to join, bringing back to the table the idea of a unique staff health insurance scheme for all of the United Nations.

A unique health insurance for all Geneva-based organizations?

In 1931 and triggered by financial constraints caused by the Great Depression, the League of Nations Secretariat started a discussion on merging its staff health insurance fund with that of the ILO. However, the executive committees of both funds decided against such a merger, highlighting the considerable differences in structure and benefits.

In 1949, the executive committee of the newly created United Nations Staff Mutual Insurance Society Against Accidents and Illness approached its ILO counterpart to investigate whether the ILO would be interested in joining the new scheme.

The Committee of the ILO health insurance decided that such a merger was impossible, citing various reasons:

- Membership in the ILO insurance fund was obligatory at that time, while it remained voluntary for the United Nations' scheme.
- The United Nations' scheme covered family members, whereas the ILO's scheme only covered staff members.
- Contrary to the contribution of the ILO Administration, which was raised shortly afterwards to 50 per cent, the United Nations Administration's contribution to its scheme varied. It decreased with salaries and increased with family size but was, overall, less than 50 per cent.
- And the ILO insurance provided slightly better benefits.

The newly appointed ILO Director-General David Morse, however, was clearly in favour of a unified United Nations health insurance arrangement. But he had a different suggestion, preferring to open up the ILO health insurance scheme, which enjoyed a remarkable reputation at the time, to other United Nations agencies. Some of those agencies had had sobering experiences with private insurance options. The Committee supported Morse's proposal, and the ILO actuaries emphasized that increased membership was a good thing, "provided that the composition of staff is similar". The United Nations Educational, Scientific and Cultural Organization (UNESCO), based in Paris, and the World Meteorological Organization

(WMO) contacted the Committee in 1952 to either explore or directly request membership. But technical problems precluded any follow-up to these requests. In addition, the Committee insisted that only staff members based in Geneva could become members.

In 1952, only the International Telecommunication Union (ITU) and the World Health Organization (WHO) were granted access to the ILO health insurance, shifting it into a joint scheme led by the ILO. This was a vote of confidence and a big step towards the ambitious objective of ILO Director-General David Morse to create "a unified international civil service".

Yet, most of the WHO staff lived and worked outside of Geneva and thus were excluded from participation. This quickly became a major point of discord that eventually led the WHO to leave the scheme in 1956.

The merger idea resurfaced in the late 1970s. Based on a comparative report of health insurance schemes in 1977, the United Nations suggested a joint Health Insurance Administrative Scheme for all Geneva-based organizations and their field staff. The SHIF, which by then had also accepted field staff, was seen as the most suitable model. A Geneva-based working group of all self-administered health insurance schemes of international organizations was set up in 1978. It comprised the United Nations Office at Geneva (UNOG), the General Agreement on Tariffs and Trade (GATT) secretariat, the WMO, the United Nations Conference on Trade and Development, the United Nations High Commissioner for Refugees (UNHCR), the WHO, the ILO–ITU collaboration and the World Intellectual Property Organization (WIPO).

The working group focused on the most practical aspect – the harmonization of benefits. After several years of study, it concluded that it would be difficult to envisage any type of centralized management for the

future. There were too many differences regarding the scope of coverage (the WHO and the SHIF covered staff worldwide, while UNOG scheme only extended to staff in Geneva), the basic principles (membership in the United Nations health insurance was voluntary but compulsory in the WHO scheme and in the SHIF), the financing (the SHIF had no separate contribution for dependant family members at that time) and governance (GATT and WIPO worked with a private insurer to provide coverage).

In 2014, after the ITU had left, the SHIF became again a single self-governed health insurance and remains as such to this day. Many of the United Nations organizations, such as UNHCR, UNOG, the WMO, the United Nations Development Programme, the United Nations Children's Fund and, as of 2020, the ITU, have chosen to become members of the United Nations health insurance scheme. Like the SHIF, it is financed by joint contributions from the Administrations of the affiliated organizations and the insured members and is based on the same principle of free choice of providers. Contrary to the SHIF, though, its membership remains until today voluntary. United Nations staff are nevertheless required to have health insurance that offers coverage similar to the United Nations health insurance policy, in particular with respect to worldwide coverage and benefits.

The ILO building in Geneva. © ILO

The United Nations building in Geneva.
© United Nations Office in Geneva

3.4. Towards a universal ILO health insurance (1950–1976)

The 1950s began with a major reform of the ILO health insurance structure due to two important decisions: First, as of 1950, the Administration returned to paying an amount equal to the contribution of each member, which had been the principle until 1931. Staff representatives had pushed for this reform, emphasizing that equal contributions would distinguish the ILO health insurance from the United Nations' scheme, for which the Administration's contribution was based on salary categories and therefore higher for lower-ranking staff. A new salary scale was introduced, and the members' contribution increased by 18.4 per cent. This allowed the scheme to absorb medical costs, which had risen after the war, and to increase benefits.

Second, in 1952, the ILO health insurance was extended to the staff of the ITU and the WHO, at their request for inclusion. The ILO scheme was perceived as an attractive model in these years. Even private internationally operating companies contacted the Committee to learn more about its functioning. At this point, the ILO health insurance scheme became a joint fund and was officially renamed the Staff Sickness Insurance Fund of the International Labour Office and Other Specialised Agencies in Relationship with the United Nations. This led to a steep increase in membership, from 650 persons in 1951 to 1,347 in 1953.

Now that the ILO-led health insurance scheme was a much bigger entity, an important reorganization took place. The Executive Committee grew to 16 members to also represent the staff and Administrations of the ITU and the WHO. All

provisions and statistics needed to be adjusted. The rules were adapted, and the administration of the health insurance was expanded. To oversee coordination between the three member organizations, a secretary position was created. The secretary was nominated jointly by the Secretary-General of the ITU and the Director-Generals of the ILO and the WHO.

The institutional expansion echoed with the considerable expansion of membership in the 1950s and the 1960s. This evolution and the vision behind it reflected the larger historical context marked by the emergence of the modern welfare State, seen as the incarnation of social progress. The ILO was part of this process and adopted a comprehensive Social Security (Minimum Standards) Convention (No. 102) in 1952. In doing so, the ILO asked its ILO Member States to establish, according to their means, effective social security systems to provide income security and health protection.

The Convention provided strong legitimation to improve and extend the ILO health insurance scheme step by step. The proactive stance of the Committee often encountered resistance from the Administration and the Governing Body but also from staff representatives. Actuarial caution clashed with the ambitious goals. The United Nations staff health insurance scheme was perceived as both a model and a competitor in the arguments.

Protecting former officials

Yet, restructuring was sometimes an uphill battle. For example, the ILO Administration in 1950 had rejected a proposal from the Committee to extend health insurance coverage to retirees, whose number was still extremely small. There was fear of financial risk and complications with claims from

retirees living abroad. But the Committee stood firm. It sent a note to Director-General David Morse, stressing that ILO retirees, whether in good or bad health, would not be able in many countries – but especially in Switzerland – to enrol in a decent health insurance scheme.

The Committee revised its proposal to offer that retirees would fully bear the risk by paying both the member's and the Administration's contribution. The Committee contended there should not be much worry about claims from outside of Geneva, given the positive experience with ILO officials in the New York Liaison Office. These arguments convinced the Director-General, and amended statutes entered into force on 1 January 1951 for a test period of five years. Former officials, even those who at the moment of separation had not reached the retirement age, which was 60 at that time, were offered enrolment into the health insurance scheme on a voluntary basis – provided they had completed ten years of service and paid the full contribution themselves. Five retired officials joined the scheme in 1951, and by April 1952, there were 11 such members.

In the following years it became apparent that the retired members of the health insurance were struggling to make the full contribution, especially when they did not have a full pension. In 1959, the Committee openly criticized this untenable situation, which did not reflect the evolution of systems and coverage in many ILO Member States. France, Germany and Italy – countries with an advanced social insurance system, whereby retirees enjoyed free health care or paid only a small contribution to a general sickness insurance scheme – were cited as examples.

Then, UNESCO provided a model to follow: It was the first agency to contribute equally to the cost of

medical insurance for its retired officials, including their dependants and survivors. Although ILO Director-General David Morse supported this solution, there was strong opposition within the Governing Body. A counter proposal was eventually adopted in 1960, in which retired officials no longer needed to pay the full contribution alone. However, their contribution would still be more than that of serving officials.

The situation for retired officials remained unsatisfactory from the perspective of the Committee. It launched a new initiative and asked the ILO Social Security Department to prepare a memorandum on national medical care for pensioners. This memorandum reflected the progress that had been achieved in many countries to protect retirees. It was sent in 1964 to the Director-General, together with a note that stressed: "The principle of social insurance implies the sharing of risks by all insured persons and their employers, irrespective of whether anyone protected is a good or bad risk." Therefore, the Committee argued, ILO pensioners should pay the same contribution from their income as active officials, and the Administration's contribution should be equivalent.

Caricature of Director-General David Morse. During his 20-year tenure, the ILO health insurance scheme became a joint fund and significantly expanded its membership. © ILO

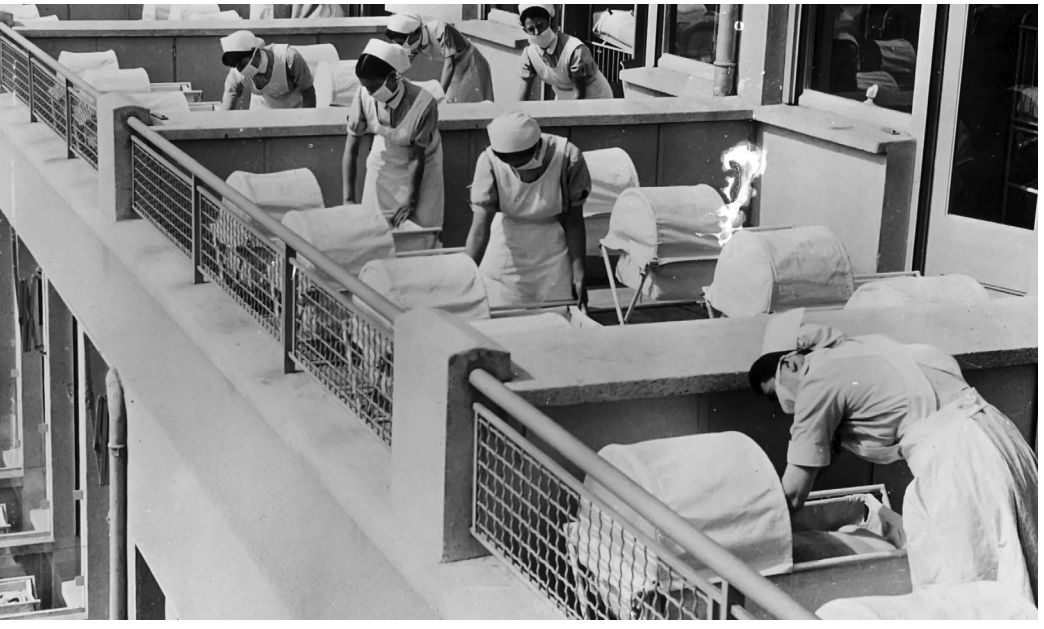
Two years later, in 1966, revised rules came into force. While the total contribution[1] for retired officials remained higher than for serving officials, the Administration

1 The total contribution comprised the share from staff members and from the Administration, at a ratio of 1:1.

covered half of it. Six years later, in 1972, when pensioners began to suffer from a devaluation of the US dollar, the Committee decided to reduce their contribution so that it became equal to what serving ILO staff were paying. The goal of equal treatment of serving and retired officials was finally achieved.

Extending coverage to families

The idea to offer some form of protection to family members had been discussed since the early years of the ILO health insurance. After the Second World War, these discussions quickly resumed. The new United Nations health insurance scheme at that time provided coverage for family members. But the Committee hesitated to expand the ILO scheme, fearing increasing costs. In 1950, an interim solution was found: The amended statutes allowed reimbursement for family members but only for hospital



A nursery for children aged up to 3 years, created by the regional health insurance fund at the Lyon Social Centre in France. In the 1950s, France was one of the most modern welfare States. © ILO

costs. This reflected a minimum requirement long requested by the staff representatives.

In the following years, the debate on an extension of full coverage to family members gathered volume. Actuarial studies revealed that this expansion would lead to a substantial rise in expenses and therefore to larger contributions. In a referendum in 1954 among the staff of the ILO, the ITU and the WHO (still members at that time), many officials without dependants voted against the extension. But they did not have a majority. Those in favour of full benefits won out due to having the stronger argument: First, Convention No. 102 stipulated that the members of a breadwinner's family should be eligible for the same benefits as the breadwinner. Second, family members of officials in many European public administrations (such as France, Switzerland and the United Kingdom) received full benefits. The ILO health insurance should thus provide the same standard, the voters said.

In February 1958 and based on in-depth actuarial projections, which were difficult to make at the time due to the lack of electronic means for data collection and analysis, the rules were finally amended and full benefits extended to family members who were dependants of insured staff members. To cover the additional medical expenses, the contribution system changed to a percentage basis, and the total contribution for serving officials increased. It was fixed at 1.8 per cent of the salary in 1958, then 2 per cent in 1961, with half of it covered by the Administration.

ILO offices around the world: Insure locally recruited staff?

During the 1950s and against the backdrop of decolonization, the ILO expanded its regional presence. It opened offices around the world, such as in Bangalore, Istanbul and Lima, and became more involved in technical cooperation projects.

The numbers of locally recruited staff of ILO branch and field offices rapidly grew. But they were not entitled to membership in the health insurance scheme, which largely covered Geneva-based staff and internationally recruited officials posted away from Geneva. In 1952, that condition changed when a provisional solution admitted locally recruited staff of branch and field offices if they wanted to enrol. However, the staff of these offices could only join collectively – to avoid unequal treatment – and based on a case-by-case decision by the Director-General. Not everybody was in favour. In Paris and London, for instance, ILO staff preferred to remain with their national health insurance. In addition to the New York office, only the staff in the New Delhi and Rome offices opted to join the ILO scheme.

In the following years, the Administration tried to shelve the issue because it represented a major source of tension between the ILO and the WHO, which had most of its staff in the field. Because their field staff were not allowed into the joint health insurance scheme, the WHO left the ILO-led scheme in 1956. But pressure grew within the ILO, especially from the directors of the field offices. Finally, in 1961, all locally recruited staff of the ILO's external offices and their dependants were offered membership in what was then the ILO-ITU health insurance scheme, on the same conditions as headquarters staff.

ILO experts and field project staff: The thorny path to adequate protection

During the 1960s, the number of new ILO Member States, especially from Africa, grew quickly with accelerating decolonization. The ILO broadened its development activities and massively expanded its technical assistance programmes, which were funded by the United Nations and often carried out in close cooperation with other agencies and programmes. More and more field projects were established, and the health insurance coverage for the ballooning number of international ILO experts and locally recruited project staff became the most urgent question for the Administration and the Committee in the 1960s. Asking host governments to provide that coverage became a solution.

Because the request for technical cooperation typically originated with a host government, the ILO asked that government to provide free medical care for the required field project staff and to cover their expenses for private care if necessary. If that government was reluctant to agree to this arrangement, the staff could claim reimbursement from the Office, based on a medical report of the attending doctor to the ILO Medical Adviser. In the 1960s, the ILO still did not cover costs for dependants or chronic diseases of field project staff.

This situation was more and more openly criticized, especially by the experts working in the field. They wrote directly to the Human Resources Department in Geneva. The problems they reported were numerous: Some governments did not provide any health care. If they did, it was often described as insufficient, with long waiting periods and sometimes appalling conditions. One ILO official posted in Asia noted in 1963, “From my visit to Asian hospitals, which have occurred from time to time in

ILO expert teaching staff of a coffee packaging cooperative in Madagascar in 1962. © ILO

connection with my duties, I can assure that if you require hospitalisation, I would be on the first plane back to Europe – ILO rules non-with-standing."

When ILO officials turned to private health care providers, governments frequently did not reimburse those medical costs or did so only partially, and the procedures were often lengthy and complicated. In another country, an ILO official complained that "the ILO was the only international organization to force officials to bargain with the host government". Other agencies were dealing more efficiently with the problem. For instance, they admitted all field staff into their health insurance scheme (such as UNESCO) or arranged private insurance coverage (such as the WHO).

The situation was not practical for the ILO Office back in Geneva either. It had to reimburse the full amount of medical expenses once they were approved by the Medical Adviser. In 1967, the Director-General and the Committee confronted the issue as

part of profound reforms of the staff health insurance scheme. Two years later, in 1969, experts and field project staff, including their dependants, were finally entitled to coverage.

A new ILO–ITU health insurance fund

The reforms were partly motivated by the deteriorating financial situation of 1965 and 1966, which led to a substantive rise in the total contribution, from 2 per cent to 2.7 per cent in 1967 and then 2.8 per cent in 1968.

It was also motivated by a general optimistic outlook of the time that health insurance schemes and national health services, which continued to expand in Europe and other industrialized countries in the 1960s, could be introduced in developing countries as well. There was an engulfing belief that welfare systems worldwide could be financed by continuing economic growth based on industrialization.

The Medical Care and Sickness Benefits Convention, 1969 (No. 130) reflected this confidence. Within its provisions, it states that each Member State "shall extend coverage and increase the number of persons protected, the range of medical care provided [and] the duration of sickness benefits".

Director-General David Morse wanted the ILO health insurance to be "the best health insurance scheme of all international organisations". In April 1969 and with the 50th anniversary celebration of the new ILO–ITU Staff Health Insurance Fund, or SHIF, was inaugurated. It would be the last time the name changed.

Universal membership, substantially increased benefits and a modernized administration

The SHIF embodied several major reforms. First, the already-mentioned extension of coverage to field project staff and their dependants, who joined in far greater numbers than expected. In 1971, voluntary membership was extended to the international staff of the ILO's International Centre for Advanced Technical and Vocational Training in Turin. Five years later, enrolment became compulsory for all Turin staff on the same conditions as Geneva staff.

The SHIF was now a universal insurance scheme covering all categories of staff around the world. Especially for staff in the ILO field offices and in the numerous technical cooperation projects the situation steadily improved.

The second reform concerned the benefits. After a further raise in the total contribution in 1969, to 3 per cent of staff persons' salary (4 per cent of retirees' income), the SHIF was in excellent financial condition, and benefits were substantially improved.

The third reform at this time aimed to modernize the governance and the administration of the SHIF. The Executive Committee was renamed Management Committee, and an Arbitration Committee was created to deliberate controversial cases.

From 1971 onwards, computerization was introduced for the registration of members as well as the calculation and payment of their SHIF benefits, which greatly improved the efficiency of settling claims. This was important because the volume of work had dramatically increased with the affiliation of new groups of insured persons.

A short history of benefits

The history of the ILO health insurance is one of continuous improvement and diversification of benefits. But each iteration has been the product of contentious negotiations in which the Executive Committee had to balance the long-term financial objective of stabilizing the scheme with members' interest to receive new and better benefits. Even when in financial crisis, benefits were rarely reduced or only for a limited time.

Until the mid-1950s, the benefit structure was fairly simple. It comprised doctors' fees, medicine costs as well as hospitalization and cures, such as staying in a sanatorium. Before the widespread use of antibiotics, these cures were frequently prescribed to help people who were treating or recovering from long illness, such as tuberculosis.

The ILO health insurance scheme offered from its beginning a modest reimbursement for dental care, with a fixed maximum amount. ILO staff representatives constantly complained that it was not adequate coverage. Especially in the 1950s, when the United Nations and some of its agencies offered staff and their dependants the possibility to become voluntary members of a dental care plan based in New York, the staff representatives urged better dental benefits because (according to meeting records at the time) "tooth decay was widespread in Geneva" while treatment was often a "very long, drawn-out procedure" and the financial burden for ILO staff was extremely high. However, the dental benefits improved only insignificantly.

Reflecting medical and technological progress, the costs for laboratory exams and X-rays became a benefit in 1956. Limited benefits were made available for "special treatments", such as psychotherapy, some

vaccinations, physiotherapy and medical massage, upon prescription by a doctor.

Starting in the early 1970s, benefits were gradually improved. Most importantly, the standard rate of reimbursement was raised to 80 per cent and uniformly applied to most medical procedures. (Since 1922, the reimbursement rate had actually been stable, at 75 per cent, despite some temporary and partial reductions during the Great Depression and the war years). For the first time, benefits for optical lenses and hearing aids were included, and the reimbursement of dental care was finally improved significantly with the introduction of a uniform rate of 75 per cent (today it is 80 per cent), which replaced the system of reimbursement of individual dental care items.

With the admission of all categories of staff, another important and logical change was to no longer base benefits on the rates prevailing in Geneva, especially with medical costs considerably higher in some countries, such as the United States and the Republic of Korea.

Despite its severe crisis at the end of the 1980s, the SHIF continued adapting the benefit schedule to the needs of its members. In 1988, two new benefits were introduced: for post-operative rehabilitation and accommodation for long-term nursing care, such as in geriatric institutions. The reimbursement of nursing care at home was established in the following years. With the cost for long-term nursing care having risen steeply in the past two decades and given that the number of SHIF members in need of this care will continue to increase, the improvement and consolidation of this benefit will be a major concern in the future.

Benefits have substantially improved for medical travel as well. In the 1950s, transport costs were only reimbursed within the Canton of Geneva. But this duty stations around the globe, where appropriate treatment,

Treatment at a dental clinic in Cambodia. Today, the SHIF provides substantial reimbursement of dental costs around the world. © ILO

especially for grave illnesses, was often not available. Today, applying the principle of free choice means that SHIF members can seek treatment worldwide. Following approval by its Medical Adviser, the SHIF covers the costs of travel to the nearest place with adequate treatment, provided that it cannot be found at the place of residence. The reimbursement of some preventive examinations (100 per cent since 2016) and vaccines are further examples of a constantly improving benefit portfolio.

Since its founding, the ILO health insurance has paid supplementary benefits to help members confronted with serious health problems and having reached a limit of out-of-pocket expenses under the regular reimbursement rate. These supplementary benefits are a clear and constant expression of the solidarity principle that the SHIF is based upon. In 2008 and in the context of the important SHIF reforms, the supplementary benefits were raised from 95 per cent to 100 per cent and the threshold beyond which they become payable was set as a percentage of each member's income. As a result, out-of-pocket expenses are now capped at 5 per cent of members' annualized remuneration. This

represents an important guarantee that reduces the need for commercial supplementary health insurance.

The benefits are what defines the quality of a health insurance policy. What can be reimbursed and what cannot be reimbursed will, in the end, remain a question of balancing four factors: (i) most importantly, the financial situation of the health insurance, which depends on contributions, the fluctuation of exchange rates and the evolution of the Guarantee Fund's performance; (ii) the general development of medicine, the available diagnostics and types of treatment; (iii) the health needs of members, which are shaped by their working and living conditions and lifestyle; and (iv) the idea of what constitutes "good health".

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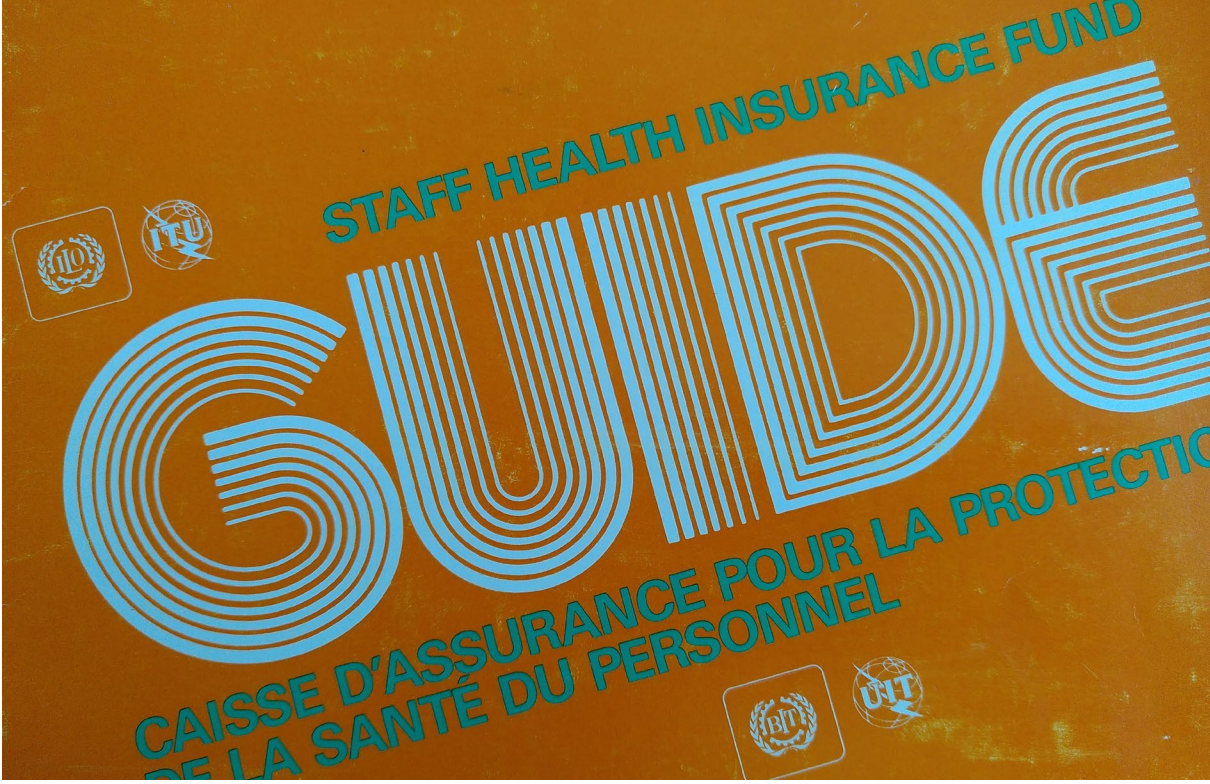
3.5. Stormy weather and necessary adjustments (1977–2000)

In the early 1970s, the value of the US dollar against the Swiss franc – the currency in which the great majority of medical bills were paid – fell exceptionally. Slowly but steadily, depreciation drove up the health insurance scheme's expenditures in dollar terms.

The SHIF's financial situation worsened dramatically in 1977, when the United States withdrew from the ILO for political reasons. Because the United States was the most important sponsor of technical cooperation projects in the United Nations, the withdrawal affected many ILO activities in the field. Technical assistance programmes were cut back, leading to a considerable decrease in the number of field project staff, from 1,072 in 1975 to 801 in 1977. The remuneration of professional staff stagnated, and accelerated departures increased the percentage of retired members in the SHIF.

An actuarial review in 1977 rang an alarm bell when benefits exceeded contributions for the first time in years, by 16 per cent. The guarantee fund could only cover three or four months of benefits. To cope with this difficult situation while preserving the benefits, a 20 per cent rise in the total contribution came into force in January 1978 (from 3 per cent to 3.6 per cent). The "corrective action", as the Management Committee called it, yielded the expected results and stabilized the scheme.

In parallel, efforts continued to streamline the administration of the SHIF and the processing of claims, in line with the objective to do more with fewer people. Because the staff resources for the SHIF secretariat were insufficient to guarantee a



This “explanatory booklet” was a useful introduction to the SHIF, especially for staff working outside of Geneva. © ILO

reasonable turnaround of claims, “customer-coded claims” were introduced. This meant that SHIF members filled out the claim forms themselves. Computerization continued and PC terminals were installed in late 1977. Staff training began and by mid-1978, the computerized system was fully operational. The percentage of errors diminished. A new claim form was introduced, and an explanatory guide was published to help SHIF members file their claims. And yet, the computerizing of membership statistics lagged, even though it was an important tool for accurate actuarial calculations and provisions.

The return of the United States to the ILO in 1980 brought a favourable increase in staff. The Swiss franc further strengthened against the US dollar, inflation slowed and, in many countries, the economic situation stabilized. Thanks to these developments, the SHIF sailed for a while in calm waters. Its membership grew slowly but steadily, and the medical expenditures remained rather stable.

Tackling the multicausal crisis of the late 1980s and early 1990s

The calm water did not last long. The SHIF ran into dramatic problems again by the end of the 1980s due to the mid-decade devaluation of the US dollar, stagnating salaries, rising medical costs worldwide and a growing number of retired members whose benefits frequently exceeded their contribution.

Along with these developments, several problems with the administrative and financial management indirectly compounded the crisis. As it turned out, the SHIF had no overview of the precise amount of paid contributions and the income generated by the guarantee fund. There was no proper proof of payment, and cases of fraud were occurring, especially outside of Geneva. To cope with the crisis, the total contribution was forced to increase in 1986, from 3.6 per cent to 4 per cent.

But this was not enough. The SHIF was close to insolvency for the first time in its history as of 1988. The statutory reserves were down to the minimum of one month of benefits. The first response entailed another hike in the total contribution, from 4 per cent to 4.6 per cent, then to 5.2 per cent in 1989 and 5.6 per cent in 1990. These were substantial increases but justifiable, considering that most comparable health insurance schemes in Switzerland doubled or tripled their insurance premiums during the same period. Additionally, but for only one year and only one time in the SHIF's history, members in Europe had to accept a small deductible.

A viable solution was found for retired officials, with the increase of their total contribution to 8.4 per cent. While they paid the same contribution as serving officials (2.8 per cent), the ILO and ITU Administrations covered the remaining two

thirds – a substantial support and necessary adaptation to the demographic changes. Combined, these measures stabilized the SHIF's financial situation while maintaining the level of benefits.

The administrative and financial management substantially improved as the calendar turned into the 1990s. To prevent irregularities, a proof of payment requirement was introduced in the administrative rules, although it triggered discussion regarding small bills. The prevailing practice of retired officials transferring their contribution, which typically incurred delays, was replaced in 1995 by an automatic monthly deduction of the contribution from their pension.

To speed up the processing of claims despite reduced administrative capacity and an ever-growing number of claims, an electronic health insurance information system was set up in the 1990s. It took several years, numerous setbacks and considerable financial efforts until the changeover from the old IBM computer system to the new information system was finally completed in 1999. Two years later, the SHIF website was launched in three languages to facilitate consultations by serving and retired members.

Despite the progress, the operational balance continued to decline. Long-term and worrisome developments gave the Management Committee considerable cause for concern: rising medical expenses; stagnating salaries; a slow but continuous decline of contribution-paying members, especially in technical cooperation projects; a steadily increasing share of retired SHIF members; and high administrative costs. These developments led to vivid debate on how to make the SHIF more cost-efficient.

This debate occurred as social policies were revised in many countries in light of rising debt and welfare costs. The expansion of neoliberal economic policies led to the privatization of some public services, in particular of social security and health care, which resulted in an increased individualization of risks, including health risks. This paradigm change, which was contrary to the ILO principle of social justice, was reflected in ILO policy debates and also infused the debates about the future of SHIF. Some radical proposals emerged. Contribution rates could, for example, be based on age and health conditions instead of salary, as was done in many private health insurance schemes.

These ideas were firmly rejected by the Management Committee due to the obvious conflict with the principles of equality and solidarity. Still, proposals continued, including attempts to privatize the SHIF or at least decentralize some of its administrative functions.

Privatizing the SHIF to increase efficiency?

Rising medical expenses, stagnating salaries, an ageing membership but also high administrative costs and slow claims processing led to intense debates in the 1990s on the cost-efficiency of the SHIF and how it could be improved. Three scenarios were discussed: (i) Privatizing the SHIF, which would make it a for-profit health insurance scheme, with premiums dependant on risk profiles and restrictions regarding pre-existing conditions. (ii) Outsourcing of the claims processing to a private company to benefit from more professional expertise and better technology support while the oversight and the risk remained with the ILO. (iii) Delocalizing SHIF's administration to an ILO office in another region of the world, with a qualified but less expensive local administrative labour force.

The Management Committee wanted to avoid privatization, which the ILO Administration had indeed considered at the end of the 1990s, much to the dismay of the staff representatives of both the ILO and the ITU. One important argument against it was that the SHIF was a mutual scheme, half owned by staff members.

The second scenario – outsourcing and subcontracting of SHIF functions – became the subject of heated controversy in 2000. Thanks to the "firm resistance of the Management Committee", according to the UNION magazine, this scenario was avoided, although it returned, albeit unsuccessfully, to the table in 2006 when the SHIF faced yet another difficult financial situation.

In the meantime, the volume of claims had grown steadily and the settlement of claims from around the world had become more and more time-consuming. To resorb backlogs, the SHIF resorted to overtime of staff processing the claims, but this was not a solution in the long term. Complicating matters, the technology platform for the electronic health insurance information system had started to age.

The UNION magazine informed staff members in the ILO about the outsourcing plans. © ILO

In 2010, the ILO Administration commissioned a feasibility study from the consulting firm Dalberg Global Development Advisors. The objective was to analyse potential efficiency gains from transferring some of the ILO financial services

(payroll) and SHIF claims-settlement functions to ILO external offices.

That study clarified that decentralization was not suitable for either service. Regarding the SHIF, language was one obstacle to moving the services abroad (most claims came from the Geneva area and were in French, for example).

That same year, the Dalberg firm was commissioned for a follow-up study on the potential of outsourcing claims-settlement functions to a private sector administrator. Dalberg used information from private insurance companies and interviewed five international organizations (among them CERN and UNESCO), which had a similar staff health insurance scheme but had outsourced the claims settlement. The Management Committee concluded that the Dalberg report did not provide enough evidence for a major financial benefit from outsourcing and that some of the related disadvantages had been underestimated.

With the current digitalization of administrative work, possibilities to delocalize or outsource will probably continue to be subject to debate.

▸ 3.6. Staying the course: The SHIF in the twenty-first century

Adapting to changing societies

As the world moved into the twenty-first century, the ILO and the SHIF needed to adapt to changing societies. In many countries, the traditional breadwinner model, which had been the basis for social policies and the ILO's Social Security Conventions, was increasingly questioned. Family models became

more diverse, and strong anti-discrimination movements pushed governments to recognize partnerships outside traditional marriage, including those between same-sex partners.

In March 2004, the United Nations legally recognized domestic partnerships. This policy affected same-sex partnerships and heterosexual couples outside traditional notions of marriage. United Nations agencies adapted their policies in the following years. In 2006, ILO staff regulations recognized partners of officials living in domestic partnerships, including same-sex unions, as "spouses" if the legislation of their home country provided for comparable benefits and entitlements for the status of "domestic partnership" as for marriage (it is a limitation that remains heavily criticized but sustains). This recognition meant that ILO officials in domestic partnerships as well as their dependants could qualify for enrolment into the SHIF (depending on their home country).

Important SHIF reforms

For the first time since 1987, the SHIF registered a net operating deficit in 2000, which was primarily due to the general increase in health costs in Switzerland and demographic developments. Cost-containment measures acquired particular significance, for their own sake and to show the Governing Body of the ILO and the ITU that efforts had been made to reduce expenditures. In 2001, a working group began examining this question, which, although not new, had become urgent.

In the following years, the situation grew worse, and actuarial studies foresaw that the deficit would eventually lead to a depletion of the guarantee fund in 2008. Because contributions had remained stable since 1990, the first response consisted of yet

The elimination of any type of discrimination at the workplace, including discrimination based on sexual orientation, was one of the four fundamental rights of the 1988 ILO Declaration on Fundamental Principles and Rights at Work. It was embodied in the ILO Discrimination (Employment and Occupation) Convention, 1958 (No. 111). © ILO

again increasing the contribution to be paid by each SHIF member, from 2.8 per cent to 3.3 per cent in January 2006.

In a more long-term perspective of financial stabilization, several reforms were progressively put in place. Most importantly came the introduction of separate contributions for automatically insured dependants: in January 2008 in respect of dependant spouses, at 30 per cent of the insured person's contribution, and in January 2010 in respect of dependant children, at 10 per cent of the insured person's contribution for one child and 20 per cent for two or more children. This way, a member with spouse and two children paid a contribution of 4.95 per cent, compared with the base rate of 3.3 per cent, with the Administration contributing the same amount. The decision to ask families for a supplementary effort was based on careful actuarial analysis carried out by the ILO's Social Security Department. It remained compatible with the 1952 ILO Convention No. 102 concerning social security minimum standards,

which states that “the persons protected shall comprise […] also their wives and children” (article 9) but that “the rules concerning cost sharing should be designed as to avoid hardship”.

On 1 May 2014, an important chapter of the ILO’s health insurance history closed – it was no longer a joint scheme. The ITU decided to leave due to its less favourable demographic structure and because the contributions often did not cover the benefits paid to its officials. This situation had spurred tensions for some time, with many issues settled by arbitration. The ITU began insuring its staff with a private insurance company, although it would shift back to a mutual scheme in 2020 when it joined the United Nations staff health insurance.

In the past decade of its 100-year history, the SHIF continued to protect its staff and improve benefits in a constantly changing context. It has done so with only a slight increase of the base rate to be paid by each member, from 3.3 per cent to 3.55 per cent (in 2017).

A century of cost containment

The viability of a health insurance depends on the balance between expenditure and income. To sustain this balance is a complex task. In times of crisis, when expenditure exceeds resources, there are only two strategies for coping: increasing contributions and/or reducing benefits. However, from a long-term perspective, it is necessary to contain the medical costs.

The most obvious measure is to prevent illness. Afterall, healthy members are the best guarantee of a financially healthy insurance scheme.

Since the early years, ILO Medical Advisers have provided information to staff on how to preserve good health, often in the magazine of the staff union. In 1930, for instance, Dr

Léon Weber-Bauler warned that ILO officials were intellectual workers par excellence and therefore prone to nervous exhaustion. They should adopt healthy habits, he declared, and "eliminate unnecessary paperwork, which only generates dust, open the windows, exercise 'like the British' and limit night time distractions in order to sleep well."

With the constitution of the new SHIF in 1969, preventive medical care was included in the benefit system. In the 1960s and 1970s, when more and more ILO officials worked in the field, the Medical Adviser regularly warned of health risks related to work in locations with difficult climate. Based on better scientific evidence, knowledge about prevention has steadily increased since then. ILO staff can obtain a range of information on how to diminish the risk of such common health conditions as cardiovascular disease, diabetes, cancer and mental health-related illnesses.

Dr Léon Weber-Bauler, on skis in winter 1938, was a model for ILO staff who often lacked regular outdoor activities. © ILO

In 2015 and for the first time in the history of the SHIF, the Management Committee considered that prevention should form an integral part of the policy and that some preventive examinations (such as mammograms and colonoscopies) and the flu vaccination should be reimbursed at 100 per cent.

Another important cost-containment strategy worked on the "supply side" of medical care, such as finding an agreement with the medical community in Geneva, where most of the expenses continue to occur.

In 1923, thanks to Dr Weber-Bauler's good connections with local doctors, a modus vivendi was found with the Geneva Medical Association. The doctors committed themselves to provide the ILO staff with the best treatment under fair conditions, and thus not charging them more than their Geneva patients. However, they refused any formal obligation in this regard.

This modus vivendi was reconducted in the early 1950s but remained as "non-binding" as prior to the Second World War.

Because it was never possible to achieve any substantial agreement with fixed doctors' fees, there were only two solutions: (i) control of medical bills to detect excessive charges or (ii) an upfront decision by the Management Committee as to whether a treatment is justified or a luxury. In the early years, the Medical Adviser had a crucial role in this regard, as did the ILO Office nurse. The nurse had to report "suspected cases of unsuitable treatment by the patients' doctors". Until well into the 1960s, staff members had to submit a form to the Committee detailing each doctor's visit and seek approval from the Medical Adviser for any longer treatment.

With the expansion of membership, these tight controls were not possible any longer. However, even

today, the administrative rules stipulate that the Management Committee may reduce the reimbursement when it thinks that, after consulting the Medical Adviser, certain expenses are excessive. And for certain types of expensive treatment, approval by the Management Committee is still needed.

Another supply-side approach to cost containment is to reduce expenses for medication. Beginning in the 1920s and well into the 1950s, the members of the ILO health insurance benefited from discounts at cooperative pharmacies in Geneva. With pharmaceutical progress and the "scientization" of medicine after the Second World War, the reimbursement of para medical products, which were apparently prescribed frequently to treat minor or chronic conditions, was limited because their efficacy could not be scientifically proven.

Since then, the SHIF secretariat has maintained a list of non-reimbursable products. Today, a medication considered non-reimbursable in Switzerland and France can be reimbursed when it is recognized within the scope of the general health insurance system of the country, other than Switzerland or France, in which the medication has been prescribed.

The most important area of cost containment was and remains institutional care (medical treatment and accommodation in hospitals). As of 2000, it has become the single most critical area of expenditure. Already in the early 1980s the ILO and other Geneva-based international organizations realized that it was necessary to join forces to negotiate acceptable rates with private hospitals. These efforts intensified and led to a well-established collaboration for that purpose between the SHIF and the health insurance schemes of CERN, the WHO and UNOG.

It is more challenging to find agreements with medical care providers outside the Geneva area. The SHIF recently implemented a partnership with a recognized private entity to offer members a network of health care providers in Latin America and the Caribbean, in Asia, Africa and the Middle East, most notably for non-urgent hospitalization. This has allowed the SHIF to achieve greater savings while improving access to health care.

In the past two decades, the supply-side cost-containment strategies gained in efficiency. However, the success of this approach depends on the SHIF members. In 2006, when the financial situation was (again) critical, the Management Committee stressed: "It is up to all of us to ensure that we play our part in controlling costs by questioning charges on our medical bills that we believe are inaccurate or unreasonable."

Cost containment has also a demand-side dimension. The SHIF Management Committee has always been opposed to preventing SHIF members from using certain health care providers or to organize basic medical care in the framework of the ILO and/or the United Nations – solutions that would have contradicted the fundamental principle of free choice of health care provider. It has instead offered alternative options to reduce costs, especially regarding institutional care (providing 100 per cent reimbursement of hospital costs when staying in the public ward or introducing reimbursement for home-based care as an alternative to hospital care). In the end, the SHIF can only continue to provide a comprehensive schedule of benefits if all members take ownership of the cost-containment effort.

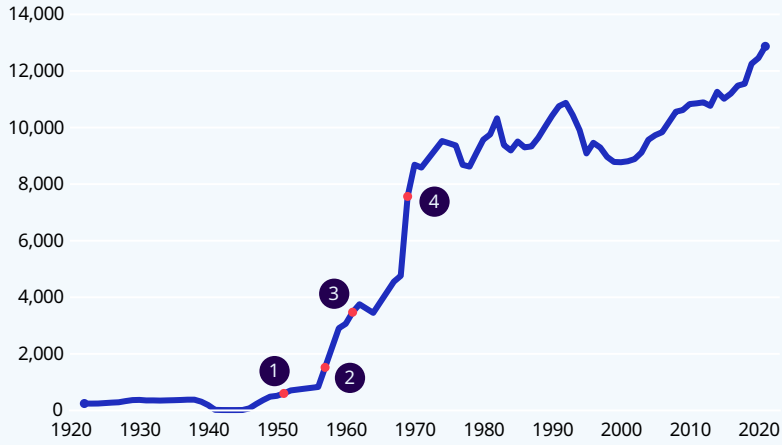
3.7. Numbers and trends at a glance

The quantitative history of the SHIF is not an easy thing to compile. The early statistics do not resemble what is available today due to the technological progress in data-gathering and analysis. And what was measured has changed over time. For instance, membership data were disaggregated by sex until 1950, when the focus switched to the type of insured member (staff, former staff, family members) and location. Expenses were calculated until 1967 in Swiss francs and not in US dollars. The following four figures give an idea of the major trends in membership, contribution rate, financial evolution and average expenses per insured person in the ILO (NOTE: The data for the years 1940–1947 only relate to the reduced number of staff who stayed behind in Geneva.)

The first figure illustrates the expansion of the SHIF over its 100-year history. In the beginning, the contributing members were identical to the total number of protected members (because family members were not covered). The simple two-category system ceased as of 1958. The increase in membership is clearly visible and reflects two developments: the extension of coverage to include retirees and dependants and various groups of staff, and the geographical expansion of ILO activities in the 1960s and 1970s to developing countries.

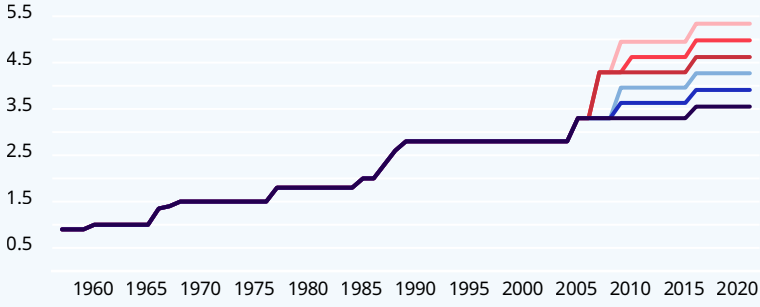
The second figure shows the evolution of contribution rates since 1958, when the ILO switched from the fixed-amount contribution per salary bracket to a unique rate calculated as a percentage of each staff member's salary. The contribution rate for staff members has been going up over time. The increase was particularly strong following the abandonment of the single contribution rate in 2008 and the

Figure 1. Insured members (ILO only), 1922–2021



1. 1951 The retirees can remain insured
2. 1958 Family members are insured
3. 1961 The local staff of ILO offices outside Geneva is insured
4. 1969 The staff of field projects and their families are covered. The staff of the ILO training center in Turin is affiliated as of 1971

Figure 2. Contribution rate for serving officials, 1958–2022

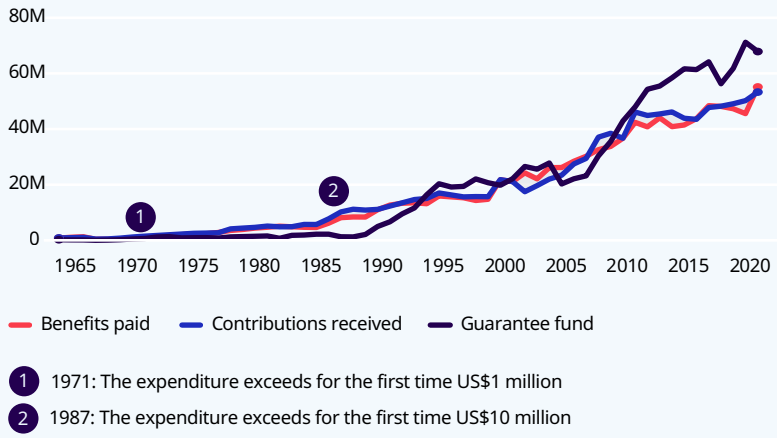


- Staff without dependant
- Staff with a dependant child
- Staff with two or more dependant children
- Staff with a dependant spouse
- Staff with a dependant spouse and one dependant child
- Staff with a dependant spouse and two or more dependant child

creation of specific contribution rates for dependent spouses and children. However, contributions also remained stable for long periods (16 years between 1990 and 2005, for instance).

A continuous upward trend characterizes the financial evolution of the SHIF since 1967, when the accounting system switched to US dollars. The critical phase was the mid-2000s, when expenses exceeded revenue (the contributions and the income generated by the guarantee fund) for several years, and the guarantee fund was close to its statutory minimum. Overall, the third figure shows that the SHIF has always managed to avoid a divergence between contributions and expenditure. We can also grasp from the trend that the guarantee fund has had a buffering role to avoid urgent and drastic measures.

Figure 3. Revenue, expenses and guarantee fund, 1967–2021 (in US dollars)

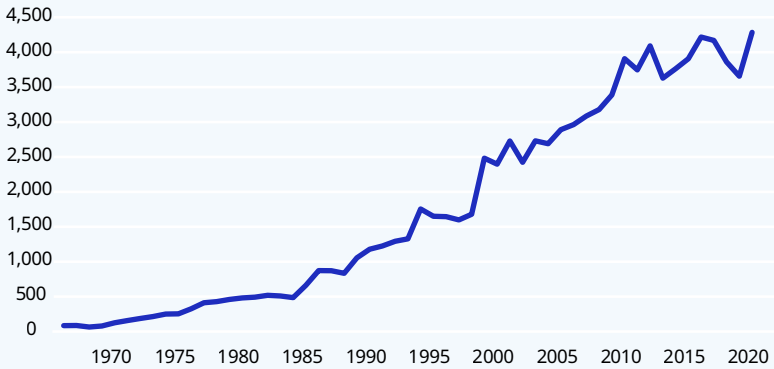


1 1971: The expenditure exceeds for the first time US$1 million

2 1987: The expenditure exceeds for the first time US$10 million

This fourth figure reflects the average yearly costs since 1967. The expenses began to rise steeply in the mid-1980s and have increased steadily since then. There are various reasons for this, most importantly the evolution of medical costs in general and the increasing number of older SHIF members.

Figure 4. Average expenses per insured member, 1967–2021 (in US dollars)



Disclaimer: The data of those graphs have been compiled from annual reports and financial statements of the SHIF. Different sources sometimes present different data for the same year. The authors have done their best to only use data that appeared consistent.


1953
1952

Chapter

4

Thank you SHIF! Three testimonies

From Madagascar

I am working at the ILO Office in Antananarivo, Madagascar. I am married, and we have two grown children. First of all, I would like to congratulate SHIF for its 100th anniversary. Congratulations to all the dedicated colleagues at SHIF who do not spare their efforts to serve the well-being of their colleagues and their respective families all over the world.

My family and I have lived through very difficult moments health-wise. More than once I did not see any more the light at the end of the tunnel. During each of these moments, SHIF was always present to support us, to help us find care solutions, in particular for my husband. We could always count on the professionalism and the human-centred approach of the teams at SHIF and at the Human Resources Department.

In the name of my family and myself, thank you so very much for your unconditional support. You are just extraordinary.

Long live SHIF!

From Bangkok

I would like to express my sincere gratitude to the SHIF on the special occasion of its centenary. During the long recurring illness of my husband, SHIF colleagues provided consistent support with regard to medical treatment, medical supplies and equipment. They gave me advice on how to ensure that my husband received the best treatment. SHIF colleagues not only took care of all problems related to the medical care, they also provided

invaluable moral support during our struggle to help my husband. When his illness was terminal, I again turned to the SHIF to secure necessary medical equipment and nursing care so that my husband could stay at home with me and feel most comfortable, since this was his last wish. I was very grateful that the SHIF made it possible for us. I could not have gone through all this alone without their support.

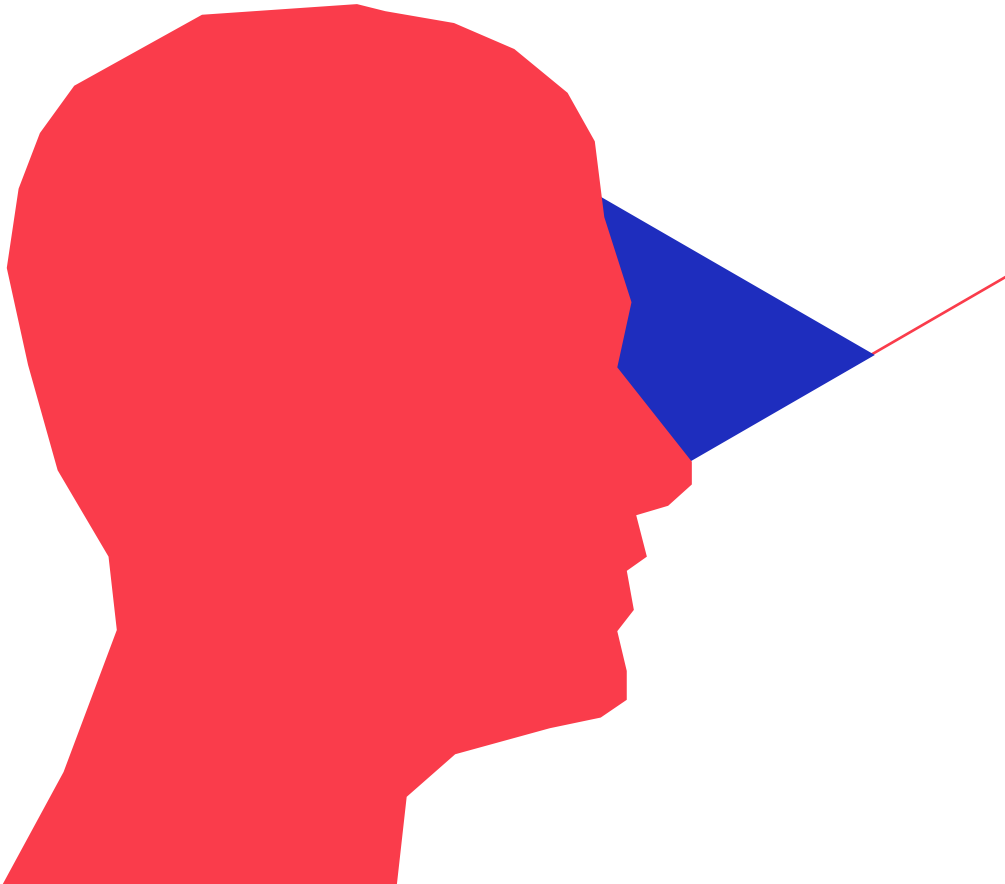
I have witnessed many other critical cases where SHIFprovided comprehensive support. For example, by granting advance payments to medical institutions. This helps to reduce the stress for SHIF members and their families. The SHIF's responsiveness to critical cases makes a big difference compared to the service quality provided by insurance companies. Indeed, the SHIF not only provides medical benefits, it carries out a duty of care and this is most important.

Thank you to all SHIF colleagues.

From Geneva

In my home country, I had received psychotherapy due to the sudden death of my father. But soon the sessions I was eligible for came to an end. I am grateful that I could resume the sessions after I had joined the ILO and was covered by the SHIF. The yearly credits for psychotherapy made a positive difference in my life.

Further, unlike other health insurance coverage, the SHIF enabled my spouse and I to seek in vitro fertilization treatment beyond commonly used age limits. We are now happy parents of a happy child!



Chapter

5

Final thoughts for the next 100 years

Since 1922, the SHIF has provided coverage to protect ILO staff, retired officials and their families worldwide. It has continued to respond to the traditional challenges in the health insurance sector – rising health costs, a growing share of ageing insured persons and fluctuating exchange rates – and zero-growth ILO budgets.

The SHIF has become increasingly aware of the challenges faced by insured persons in the different regions where the ILO works. It has developed new tools to meet their specific needs, which remain one of the top priorities of its client service strategy.

Unprecedented challenges have occurred, such as the COVID-19 pandemic. The SHIF has reimbursed the expenses for tests prescribed by doctors and vaccinations as well as expenses for health problems related to the long-term consequences of the disease and the measures taken to bring the pandemic under control.

In the future, the SHIF must adapt to the health consequences of climate change, which particularly affect staff members working in the Global South. And the increasing digitalization of work in the ILO will come with its own range of health problems, for which ILO officials will seek medical care. Finally, societies change and with them the debate as to whether certain medical treatments should be reimbursable expenses and thus paid for by the community of all SHIF members, in line with the ILO's human rights values and the scheme's principle of solidarity.

These values and principles will continue to guide the Management Committee as the SHIF enters its second century. The history of the scheme reflects the importance of engaging all insured members in shaping the future of the scheme. Opportunities for innovating its operating model will be important to the financial sustainability of the SHIF for the current and future generations of ILO officials. Above all, good governance, transparency and a cost-conscious approach by all insured members to health care expenses will be instrumental to keeping the SHIF viable.

Advancing social justice, promoting decent work

The International Labour Organization is the United Nations agency for the world of work. We bring together governments, employers and workers to drive a human-centred approach to the future of work through employment creation, rights at work, social protection and social dialogue.

The booklet reveals the previously untold history of the SHIF and how it adapted to a changing ILO and the evolving needs of its staff while remaining faithful to its solidarity principles, which are inspired by the values of the ILO. It describes how the SHIF adjusted its coverage policy to address changes in modern civil society and to deliver the health insurance needs of new family structures. It concludes with some numbers and graphs about membership, revenue and expenditure to illustrate some long-term trends.

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