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ILO - PAHO JOINT INITIATIVE ON THE EXTENSION OF SOCIAL PROTECTION IN HEALTH

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International Labour Organization

Pan American Health Organization
Regional Office of the World Health Organization

Area of Strategic Health Development
Health Policies and Systems Unit

ILO-PAHO
JOINT INITIATIVE ON THE EXTENSION OF SOCIAL PROTECTION IN HEALTH

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Preface

One of the fundamental challenges facing the health systems in the Americas is to find a way to guarantee all of their citizens a basic level of social protection in health that can serve to eliminate inequities in access to quality health services for all and that is made available to the social groups that, until now, have been excluded from the opportunity to receive essential health care to meet their needs, independent of their ability to pay. The social groups that cannot make use of guaranteed access to health care constitute those who are "excluded".

In order to face the challenge, the International Labour Organization (ILO) and the Pan American Health Organization (PAHO) developed an Initiative that aims to contribute to the greatest well-being of a significant sector of the population of the Americas by extending social protection in health to excluded groups. The Initiative was adopted by all PAHO Member States through resolution CSP26/12 at the Pan American Sanitary Conference in 2002.

The effort to combat exclusion in health through the extension of social protection in health is framed within the mandates of ILO and PAHO. The principal goal of the ILO is to promote opportunities for women and men to obtain decent, productive work under conditions of freedom, equity, safety, and human dignity. One of the strategic objectives for achieving decent work is to improve the coverage and effectiveness of social protection for all, including social protection in health. For PAHO, the struggle against exclusion in health is directly related to its mandate to reduce inequities in access to health services and their financing. Furthermore, this struggle is one of the tasks that the Organization has designated as a priority for securing universal access to health services in order to achieve the goal of Health for All.

This book constitutes an example of the joint work done by ILO and PAHO. The pages that follow present, in chapter 1 through 5, the Conceptual Document of the ILO-PAHO Joint Initiative and, in chapter 6, the report of the Partners Meeting of the ILO-PAHO Joint Initiative that took place in Stockholm, Sweden in October 2003, that was jointly sponsored by ILO, PAHO and the Swedish Agency for International Development (SIDA), which was the host entity.

1. Introduction

There is growing tension between the current realities of social exclusion and exclusion in health in Latin America and the Caribbean and the global consensus that recognizes health and a decent standard of living as human rights and conditions of citizenship. It is this tension that drives all efforts currently being made to reform health systems and expand access to social security in health. Such efforts express the determination of nations to promote social protection and to restructure the application of these protections in light of new circumstances.

Health should be considered simultaneously as a goal and as a means of human development that conditions economic growth and competitiveness. That is, health is an objective because it is a fundamental human right, because of its well-known impact on the quality of life of citizens, and also because of its contribution to higher productivity. Currently, a wide-ranging consensus exists that the attainment of good health is essential in fighting conditions of poverty that affect millions of people in the world. Therefore, **social protection in health has become increasingly important on national agendas**.

The current problem that most Latin American and Caribbean countries face with respect to social protection in health is that past efforts to build health systems never succeeded in giving shape to any of the various models of welfare states that they intended to create. This means that, during the last few decades, nations have lived with considerable degrees of social exclusion and exclusion in health. It is estimated that between 20 and 25 percent of the total population of the Region does not have access to health services. Clearly, there is a wide gap between the current state of development of the national social protection systems in health and the objectives formulated by public policies.

In most of the countries of Latin America and the Caribbean, current conditions do not provide an adequate framework to move forward in a logical and sustained manner, towards the extension of social protection. In general, the countries of the Region have been experiencing rather unfavorable demographic conditions that combine with other challenging phenomena such as economic stagnation, rising unemployment, growth of the informal sector of the economy, intensification of poverty (in absolute and rela-

tive terms), and widening disparities in income distribution. All these are manifestations of the destabilization of societies brought about by the development of a new global world. Societies now struggle to incorporate themselves into a competitive global structure while at the same time they attempt to restructure themselves in ways that preserve social cohesion and national unity.

Given this situation, the existing mechanisms of social protection in health are insufficient. Declarations on universal access to health care, written into the national constitutions or similar documents of most countries, are mostly statements and do not correspond to the real situation, while the agenda of the health sector and the social security reform agenda do not seem to be in a position to take action successfully vis-à-vis the current disparities in access to health care of large majorities of the population.

In such an unfavorable context, the responsibility of governments and policymakers to analyze, design, propose, and implement appropriate mechanisms for the extension of social protection in health has become a pressing matter. An active response, managed with sound social and economic criteria, and supported by solid evidence, can help substantially change the situation of social protection in health in the Region.

The International Labour Office (ILO) and the Pan American Health Organization (PAHO) are committed to implementing a regional initiative that promotes and establishes a systematic process of analysis, diagnosis, identification of solutions and execution of pertinent actions designed to minimize exclusion in health care in the countries of the Region, and to strengthen the political, institutional, organization and human capacities of the member countries in order to expand social protection in health.

Efforts against exclusion in health care are well within the mandates of ILO and PAHO. One of the fundamental missions of ILO is to promote opportunities so that women and men can obtain decent and productive jobs, under conditions of freedom, equity, safety, and human dignity. In turn, one of the strategic objectives to be attained in order to make jobs more decent is to improve coverage and the effectiveness of social protection in health for all.

For PAHO, efforts against exclusion in health care are directly related to its mandate to reduce inequities in the access to and financing of health services. This effort is one of the tasks that PAHO has defined as a priority in the

search for universal access to health services that would help it to reach the goal of "Health for All."

This document, prepared jointly by ILO and PAHO, presents an overview of the current situation in Latin American and the Caribbean and the progress achieved to date with respect to social protection in health. It also emphasizes the bases and mechanisms for the extension of social protection in health, and establishes a reference framework for the joint work of ILO and PAHO in implementing strategies and actions. It aslo presents, in chapter 6, the report of the Partners Meeting of the ILO - PAHO Joint Initiative that took place in Stockholm, Sweden, in October 2003.

2. The Concept of Extension of Social Protection in Health

Extension of Social Protection in Health involves a group of mechanisms designed to guarantee the access of the population to health protection and health care through the allocation of resources of diverse origin, and not exclusively through the measures taken directly by the State to ensure health care through the public delivery of services. Thus, social protection in health is understood as the State's guarantee of a right that citizens can exercise, and not as a type of social welfare benefit that can be granted at the discretion of the authorities.[1]

In countries where a "welfare state" had been established, the crisis of social protection is new, and the main sign of exclusion is the lack of universal institutionalized care. However, in most Latin American countries, in spite of the progress of their health care systems, this vulnerability is old and has always existed. Consequently, there exists a bimodal system of social protection, consisting of an institutional system and another system based on the community. Indeed, it is not by chance that most of the funds for health care are out-of-pocket in most Latin American countries.

Given current circumstances, it is much less possible than before to implement a governmental solution to the problem of health vulnerability. The building of a "new public model"—which only some countries have been able to implement after decades of efforts, and which has resulted in segmented models in most of these countries—will now require the involvement of both the State and society in efforts aimed at extending access to social protection, although the State should not forgo its role as the guarantor of health care as a right.

Social exclusion in health care should be construed in a broad sense, as a variety of situations, all of which share a tolerance for avoidable morbidity

[1] 26th Pan American Sanitary Conference, 54th Session of the Regional Committee - Extension of Social Protection in Health: Joint Initiative of the Pan American Health Organization and the International Labour Office. CSP26/12, July 16th, 2002.

and mortality. In ethical terms, an unprotected society is careless about life, and this lack of care expresses itself in both institutional and non-institutional realms. It does not only imply that the provision of health services is insufficient, but that there is an inadequate provision of health care services in a wider sense. Such circumstances can include the total absence of access to health care, to the inability to obtain some supplemental services in health care, or even, in some cases, to the absence of, or weakness in, the supporting community and family networks. Given that there is no indicator that encompasses all of these dimensions, it is difficult to measure this area of social exclusion in practical terms.

The leading causes of social exclusion in health, as related to the institutional systems, can be grouped into three sets of obstacles.

In the first place there are the *problems of access*, which are those that can be associated with either the lack of goods and services of a public nature (e.g. drinking water, vaccines), with the absence of health services personnel, or with the lack of protection against the loss of income as a consequence of disease. These *access problems* are related to insufficient infrastructure or to the presence of specific barriers that obstruct access to health care.

These barriers can in turn be categorized as geographical, economic, or cultural; they can be explained by the nature of contractual benefits of employment or to the structure of prevailing health systems in the countries. The way in which health systems are organized is not neutral with respect to social exclusion. On the contrary, such organization is considered to be one of the determinants of social exclusion. It is worth noting that systems characterized by high segmentation or fragmentation, by the predominance of out-of-pocket payments, or by unsatisfactory management have been shown historically to have a limited ability to meet adequately the health needs of the population.

The second obstacle that causes social exclusion in health consists of *financing problems*. These are generated mainly by the absence of sufficient collective financing mechanisms and by the lack of income that characterizes significant proportions of the population in Latin America and the Caribbean. Families with low and insufficient income do not have the ability to contribute in order to obtain access to health services financed through salary deductions and much less through out-of-pocket expenditures.

Wherever the State fails to offer an adequate solution to the health problems of economically vulnerable groups, these groups must resort to direct

payment of health services, which is an expensive and highly regressive funding mechanism.

Finally, the third obstacle that causes exclusion is the *quality of care and intercultural care*. This obstacle encompasses problems associated with the quality of the services offered to poorer groups and the lack of respect for the traditions and cultures of social groups with specific ethnic characteristics.

With respect to *quality of care*, one of the consequences of the segmentation of the health system has been the high level of differentiation, in terms of quality, of the health care services offered to individuals in various income brackets, which has had prejudicial consequences on the quality of the services geared towards poorer groups.

It must be underscored, however, that social exclusion in health in terms of quality is not only a problem for the poor. In many instances, those segments of the population whose ability to contribute to health care is average or high are often not willing to seek care within systems of care that do not offer health services that they perceive to be of good quality. As a result, they are forced to opt for alternative, non-collective solutions, often costly for the individuals and for society as a whole.

The definition of the three above dimensions of exclusion serves as the basis for a set of indicators that allow for indirect measurements of social exclusion in health. The groups of indicators most commonly used are: i) ***outreach indicators:*** those that relate to the service coverage of the health system as directed to the population in general (for example, the percentage of the population without health insurance); ii) ***access indicators:*** those that register the economic, financial and cultural barriers that obstruct the effective obtainment of health care; iii) ***indicators of infrastructure:*** those that reflect the lack of inputs, and resources in general, of the health care system (such as hospital beds, medical staff, nursing professionals, drinking water and sewage, among others); and iv) ***process indicators:*** those that relate to the way in which direct services are provided and organized (for example, coverage of immunization programs).

Nevertheless, it is important to note that it is difficult to adequately quantify the dimensions of social exclusion in health care in the Region, especially because of limited or poor quality existing health information.

The institutional indicators of vulnerability in health concerning access, financing, and quality cannot be interpreted in isolation from each other. All

initiatives that aim at expanding access, increasing funding, or improving the quality of the services are progressive in nature, but the barriers that they seek to overcome are mere expressions of the characteristics of the existing health care systems. The extension of social protection in health cannot be seen simply as adding to the numbers of health providers, with the same modalities of funding and models of care, because they would just replicate the habitual cultural and access barriers. This issue highlights the difference between Europe and Latin America. Whereas the former established welfare states that included almost all its population, in the latter, in spite of the intentions of some of the persons and governments involved, discussions praising and promoting welfare coexist with the practice of exclusion. Specialists find some affinity between this residually liberal model and the old "aristocratic assistentialism", which could barely be considered beneficial to the community.

By contrast, the extension of social protection in health consists of strategies that include providing sustainable protection for the excluded population. In order to build inclusive systems, existing strategies need to be transformed. Non-inclusive models do not become inclusive by their own means. Most countries that historically did not aim at a universal health care system, but instead built "segmented" systems, admit that there are significant per capita differentials in resources assigned between subsystems; that is, services of lower quality for the poor and insufficient coverage of the spontaneous demand. This is compounded by the limitations of the public assistance approach, in which public services are available only to those who have the means to overcome economic access barriers. As a result, access has been made more difficult given that poverty does not permit those who need care to demand it. Lack of financial protection forces poor families to postpone care and tends to make health expenditures catastrophic when they occur.

Within the conceptual framework of social protection and exclusion vis-à-vis health care, the strategies designed to eliminate social exclusion in health are a set of public interventions that are known as "*Extension of Social Protection in Health*" (ESPH). With their joint initiative, PAHO and ILO are encouraging the countries to share experiences, promote projects, and systematize strategies in order to expand, build, and reform their systems of social protection in health in order to implement solutions based on the needs of the excluded people. The interventions are aimed at guaranteeing the access of citizens to adequate and effective health care in order to reduce the negative economic and social impact of adverse personal events, such as disease, un-

employment, or natural disasters for the most vulnerable social groups and for the population in general.

Social protection is understood as a right that citizens can effectively demand, that is guaranteed by the State, and that is offered on demand and not at the discretion of administrators or caregivers.

The mechanisms that can be used to extend social protection in health may take many forms, ranging from actions, programs, and plans that imply profound changes in the structure and operation of the current health systems, to the adoption of initiatives or protection schemes in favor of specific population groups, such as people in situations of poverty, at social risk, farm workers, the indigenous population, the elderly, single mothers, and children, among others.

In direct correspondence with the obstacles that cause social exclusion, there are four conditions identified that need to be fulfilled so that the extension of social protection in health (ESPH) can evolve into a real guarantee:

- ***Access to services:*** Availability of adequate supplies of health services that are physically and economically accessible to the people.
- ***Financial security:*** Funding such that the economic stability of families or the development of their members is not threatened by the need to pay for health services.
- ***Funding solidarity:*** Cross-subsidies should be intergenerational and should flow between various occupational groups and between different income groups.
- ***Quality and cultural diversity in care:*** Quality health care should be provided that is respectful of the ethnic, social, cultural, and economic characteristics of the users. These characteristics should be defined through a process of social dialogue.

These four conditions are indispensable. The absence of one or more of them produces some form of exclusion in health care.

Thus, the extension of social protection in health can also be defined as the variety of initiatives, policies, strategies and interventions—implemented by the health care community and others, with support from the State and society at large—that aim at guaranteeing access to health care services, that do not threaten the economic stability of individuals and families, that are

funded in solidarity among income, occupational, and age groups, and that offer quality and cultural sensitivity in delivering health care.

These four conditions, which are also the final goals of the extension of social protection in health, are also the characteristics of a health care system that provides universal and equitable coverage.

3. Where are Latin America and the Caribbean with Regard to Social Protection in Health?

3.1. Demographic, Economic, Labor, and Social Context that Influences Social Protection in Health in Latin America and the Caribbean

In recent decades, the countries of Latin America and the Caribbean have undergone profound changes in the political, economic, and social orders. A new phenomenon, and one which makes it imperative to rethink social policies, is that Latin American and Caribbean societies, which already had pockets of unemployment and underemployment, now support their growth and social reproduction through dynamics of informal economic groups due to the weakening of the formally employed workforce within the capital-labor relationship.

The links between knowledge and information that have emerged within the context of globalization are rendering obsolete the previous international division of labor between those who produce raw materials and those who do the manufacturing. The importance of using knowledge as an essential productive force in a globalized world, and the flexible treatment that is being given to employment, have reshaped and changed the work force. There is less adequate employment available and better remunerated work is usually skilled and tertiary. Temporary and precarious employment, self-employment, and underemployment are widespread in the Region. This global employment crisis is a new challenge for some developed countries. However, in Latin American and Caribbean countries, it is simply a detrimental change in proportions from the situation of past decades.

The consequence on health care is that the lack of jobs, and the decreasing importance of manual work, could result in much less concern being shown for the health of two-thirds of the population, those whose work no longer adds significant value to production, due to the dematerialization of the productive process.

In general, the new situation being faced by so-called post-industrial societies that, in many cases, never became industrial has resulted in the shrinking of social protection systems, creating more complex social and sanitary challenges. Initially, the drive for globalization came with economic structural adjustments that had a high attendant social cost. During this period, the reduction of social spending, high increases in unemployment, and the reduction of wages converged leading to a marked increase in poverty, both in its extension and in its intensity. Specifically, between 1980 and 2002, the levels of poverty in the subcontinent went from 35 to 43 percent of total households; the number of poor people increased from 136 million in 1980 to 220 million in 2002, where 95 million (18.8 percent) of the poor are indigents (See Table 1).[2] Most of the new poor were of urban origin.

Table 1
Latin America & the Caribbean: Poverty and Indigence (%)
1990-2003

	1990	1997	1999	2000	2001	2002	2003
Indigent	22.5	19	18.5	17.9	18.2	18.8	19.4
Non-indigent poor	48.3	43.5	43.8	42.1	42.5	43.4	43.9

Source: ECLAC - Household surveys data – 2004

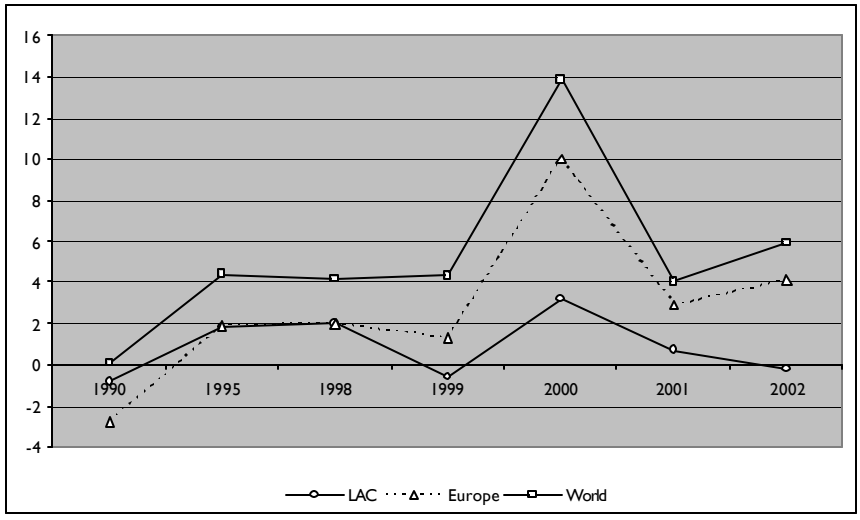
On the other hand, the substantive economic growth that took place in the 1990's—3.6 percent on average—placed many countries by the end of the decade at levels of economic output similar to those before the "debt crisis." Nevertheless, 44 percent of the population in the Region still lives in poverty.[3]

[2] "Social Panorama in Latin America 2002-2003." ECLAC, 2003.

[3] "El contexto de las reformas del sector salud." Carlos Vergara, en la Revista Panamericana de Salud Pública, Vol. 8, Nos. ½, Julio-Agosto 2000.

Under such circumstances, Latin America and the Caribbean, having achieved significantly low economic growth rates in the decade of the 1990s, was the region of the world with the most unequal distribution of per capita income (See Figure 1). Contrary to what might be expected from its level of development, as compared with other regions, Latin America and the Caribbean presents extreme degrees of poverty, inequality, and instability with respect to its level of income.[4] The richest five percent of the population receives 25 percent of the national income, a proportion higher than that recorded in any other region of the world. This figure compares with the poorest 30 percent that receives less than 7.5 percent of such income. Moreover, the richest 10 percent of the population has an average income that is 84 times that of the poorest 10 percent.

Figure 1
Latin America and the Caribbean / World - Economic Growth (GDP %)
1990 - 2002



Source: The World Bank Indicators Online - 2004.

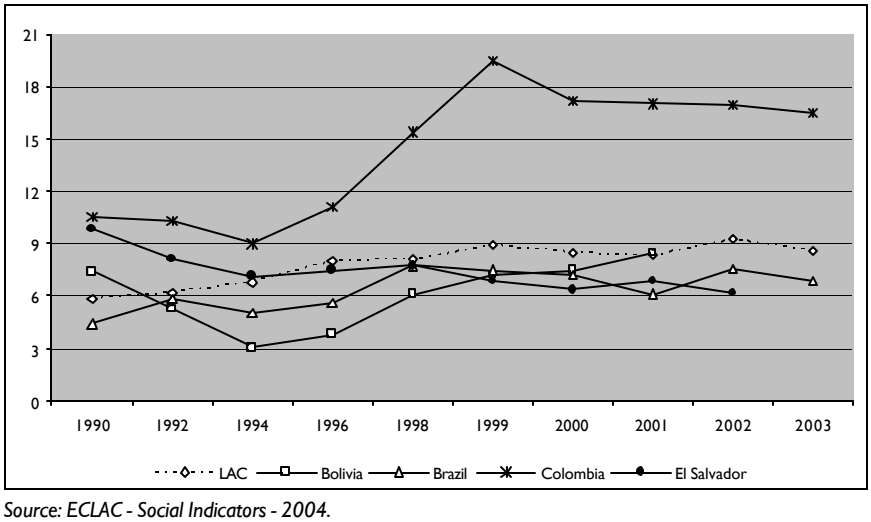
With respect to labor, the new development model carried with it a flexible legal framework and flexible contracts, together with an ever-growing pressure by firms to reduce their production costs, especially those asso-

[4] "Shielding the poor: social protection in the developing world." Edited by Nora Lustig. IADB, Washington D.C., 2001.

ciated with labor. The economic growth of the 1990s did not generate a sufficient number of new jobs, and those created were mostly in the precarious informal sector. Accordingly, they did not add significantly to the amount of resources collected for social security and millions of people remained deprived of social protection, especially in the areas of health care, occupational risks, and the contingencies of disability.

Between 1990 and 2001, 69 percent of the new jobs created in the Region were informal. The proportion of this type of employment with respect to the total rose from 42.8 to 46.3 percent in the same period; while formal employment declined from 57.2 to 53.7 percent in the same period of time.[5] This trend, mostly concentrated in urban areas, facilitated social exclusion, marginality, and social problems in the urban and peri-urban more disadvantaged sectors. Despite a modest economic recovery in the following years, high unemployment persists and weighs heavily on the Latin American and Caribbean economies. High unemployment, coupled with poor quality jobs, falling real wages, and losses in productivity pose a challenge to the Region if the objective is to create a pool of decent work as the central pillar of development (See figure 2). To the former, it is necessary to add the unfavorable situation of migrant workers who, for the most part, do not enjoy social protection.

Figure 2
Latin America & the Caribbean- Unemployment Rate - Urban
1990 - 2001



Source: ECLAC - Social Indicators - 2004.

[5] Oficina Internacional del Trabajo (OIT), Panorama Laboral 2002 en América Latina y el Caribe, Lima Perú.

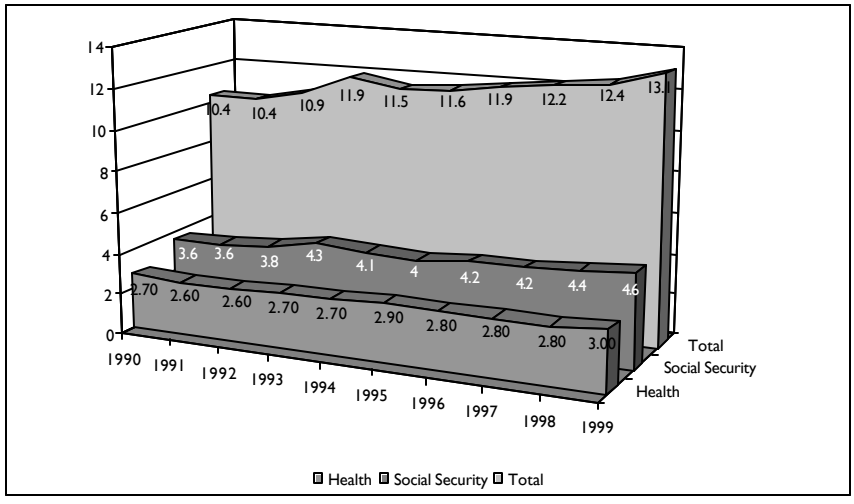
Contemporary social problems raise concerns that a new social dualism is being created. It is not only caused by the existence of poverty, but also by disorder, atomization and fragmentation, social anomie, violence, increases in crime, "narco-politics," extension of corruption, and crisis in the administration of justice. Our nation-states have partly lost the monopoly on the use of violence in given areas of their territories, and some countries experience periodic convulsions that result in the deposing of elected authorities. Internal social fragmentation in the countries experiencing exclusion appears to have led them into a transition towards the condition of being non-governable countries.

The questioning of the role of the State in economies that set their preferences on the merits of the market, propitiated the emergence of new pension systems and health insurance schemes, as well as the emergence of the private sector as an important actor in activities traditionally performed by the State (such as the administration of social services and public monopolies). In these circumstances, the network of social protection has had to reduce its coverage and scope, a phenomenon that has sharpened citizens' uncertainty of the reliability of new programs and of their administrators. It has also generated feelings of mistrust and vulnerability with respect to already known threats such as poverty, unemployment, disease, and old age.[6]

Despite what may have been expected, social spending as a proportion of GDP grew rapidly in the 1990s. It went from 9.1 percent, on average, during the 1980s, to 12.4 percent in the 1996 to 1999 period (see Figure 3). The main cause of the growth in social spending has been spending in social security, an item whose relative proportion of the GDP almost tripled, approaching that of education and health taken together.

[6] Op. Cit, Carlos Vergara, 2000.

Figure 3
Latin America & the Caribbean - Public Social Spending (GDP %) - Total, Health, Social Security
1990 - 1999



Source: ECLAC Social Indicators - 2004.

Equity in the allocation of expenditures for social security programs in health has for the most part worsened in the last two decades. Considering the predominance of an essentially curative model of care, investments have been concentrated in specialized services at the hospital level; that is, in those levels of services to which lower income groups have less access, and those levels of service which have a smaller impact on health improvement for the most vulnerable groups.

The current processes of health sector reform in most countries of Latin America and the Caribbean, processes which are as varied in their formulation as in their expected scope and their degree of actual progress, are still in debt with the neediest groups in the Region. According to solid evidence, the groups of people with higher income usually benefit more from greater investment in health, and receive more resources than those assigned to serve lower income groups.[7]

One of the possible causes of the limited impact of the reforms has to do with the meager role assigned to the State, a principle on which the reforms

[7] "La necesidad de hacer reformas del sector salud orientadas hacia la equidad", Davidson R. Gwatkin, en la Revista Panamericana de Salud Pública, Vol. 11, Nos. 5/6, Julio-Agosto 2000.

were initially based. In a context of insufficient public social protection, this minimalist approach did not take into account that the network of social protection administered by the State, which may have been worthy of praise or criticism, was nevertheless a guarantee against the risk and shocks associated with unforeseen social or personal events. The Extension of Social Protection initiative returns the Latin American social agenda to the critical issue of the need for providing collective guarantees in the face of risks and social contingencies.

Within a more recent context, another element that could help shape the current state of social protection is that, during the last two or three decades, the regional population underwent a demographic transition, with predictable effects in terms of aging and longevity. Over the last fifteen years, life expectancy in the Region increased from 68.7 to 71.1 years, and is expected to reach 74.3 years in 2020. (See Table 2).

Table 2
Latin America & the Caribbean and Selected Countries
Life Expectancy at Birth
1980 - 2020

	1980-1985	1986-1990	1991-1995	1996-2000	2001-2005	2015-2020
Latin America & the Caribbean	65.4	67.1	68.6	70	71.2	74.3
Bolivia	53.9	57.3	60	62	63.8	68.7
El Salvador	57.1	63.4	67.1	69.4	70.6	73.9
Haiti	61	62.1	63.8	63.6	63.2	66.7

Source: ECLAC Social Indicators - 2004.

Systematically applied massive health campaigns have also contributed to a considerable reduction of infant mortality rates, reducing the years of potential life lost throughout the Region, especially by means of reducing mortality caused by communicable diseases in the first years of life.[8] As a result, the regional population has increased and still shows a high growth rate of approximately 1.4 percent per year for Latin America and 1.0 percent for the Caribbean. This scenario anticipates a population increase of 7.5 million people per year during the next two decades, so that the total population of the Region, which was estimated at 520 million people in 2000, will reach 800 million in 2025.[9]

[8] "Health in the Americas" Vol. I, Pan American Health Organization, 1998.

[9] In accordance with projections of the CELADE (Centro Latinoamericano y Caribeño de Demografía).

Given its predictability and magnitude, however, population aging is likely to seriously affect the overall health situation in Latin America and the Caribbean, and is likely to create an extraordinary challenge to current and future efforts to extend social protection in health.

It has been observed that the aging of the population in the Region is the result of public health improvements that steadily reduced infant mortality since the late 1940s, although fertility levels did not start to decrease significantly until two decades later. However, in the 1970s, when fertility rates did decline, they were followed by increases in the life expectancy of cohorts older than 60 years of age. Thus, during the first 25 years of the 21st century, the population over sixty is expected to increase at a rate of 3.5 percent per year—i.e. three times the rate of growth of the population as a whole. In absolute numbers, this means an increase from 42 million inhabitants older than 60 in the year 2000 to 97 million in 2025, and to 181 million in 2050.[10]

As was the case in Europe, this demographic transition has been closely shadowed by an epidemiological transition that has steadily increased the prevalence of chronic and degenerative diseases, and will continue to do so. Unlike Europe, however, the process has been remarkably faster in Latin America and the Caribbean, where infectious diseases have also shown significant resilience. Whereas common infections have not been fully controlled, the Region is also facing emerging epidemics—e.g. health effects of environmental pollution, hepatitis B, AIDS—and re-emerging infections—e.g. cholera, chagas, dengue, and tuberculosis. Such a protracted epidemiological transition is occurring together with a polarization in the distribution of disease, in which women of reproductive age, poor people of all ages, and the elderly are most affected by all forms of significantly prevalent diseases.

Indeed, the very same cohorts that benefited from unusually large improvements in survival, particularly during early childhood, will reach 60 years of age during the first 25 years of the 21st century. At this stage, without improvement in other conditions of life, this large proportion of elderly people in the Region are likely to spend a sizable proportion of their "gained" years in ill health.[11]

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[10] Peláez, Martha and Javier Martinez: "Equity and systems of intergenerational transfer in Latin America and the Caribbean;" Revista Panamericana de Salud Pública, mayo/junio 2002, vol. 11, no. 5, pp. 439-443.

[11] "Aging in Latin America and the Caribbean," by Alberto Palloni and Susan de Vos, from the Center for Demography and Ecology, University of Wisconsin; and Martha Peláez, Pan American Health Organization, 2002.

In turn, this will add to the challenge of providing an adequate level of financial transfers to the health system in order to provide for large cohorts of the old that, more often than not, will be unable to contribute financially to their own care. As for care provided by the families, as has traditionally been the case, changes in the rates of dependency because of old age will place an extraordinary burden of mere support, and also of health care, on the working age population. This may adversely affect the culturally ingrained solidarity among age groups in the Region to the point of rendering it socially ineffective.

Finally, it is important to point out that in the last twenty-five years, approximately 100,000 people in the Region died as a result of natural disasters and almost 12 million lost their homes.[12] Armed conflicts and population displacements have led to significant increases in malnutrition, disability, death, destruction of resources, and mental health disorders that have not been met with adequate responses by social protection in health systems.

Nevertheless, in a less obvious realm, there is set of opportunities to counteract this trend and advance decidedly toward the extension of social protection in health. Identification of such opportunities constitutes a priority task in each country, and the approach to this multi-sectoral problem should engage the participation of all the various interested actors.

3.2. Overview of Exclusion from Social Protection in Health

There have been three waves of exclusion in Latin America and the Caribbean. The first is still rooted in historical exclusion, and usually affects the indigenous and rural populations. It weighs against the descendants of the original inhabitants of the American hemisphere to the extent that they have never been fully incorporated into the national economic, social, and political communities. In their case, the original concept of exclusion applies in the sense that there is a global fracture that precludes participation in a community of rights.

The second wave is represented by another "surplus" social group: the urban and marginal, or informal, population that tends to physically surround

[12] "Health in the Americas, Edition 2002." OPS-OMS, Washington DC, 2002.

the urban realm of our societies. This excluded—or semi-excluded—population was subject of the Latin American theories on marginality, in which the social sciences confirmed that this sector of the population was not absorbed by the existing productive apparatus nor by subsequent expansion, and thus constituted a form of unforeseen structural "unemployment" in the process of import substitution.

The third wave of exclusion is the current one in which structural adjustments and globalization have given way to the emergence of the new poor; that is, the underemployed, those employed in the informal labor market, and casual workers. This is not only the realm of precariousness and vulnerability but also, unfortunately, the realm of discrimination.

Health systems have dealt differently with each type of excluded group. For health systems in the Region, the historically excluded have always been a "blind point" to the extent that institutionalized medicine has always had difficulties in establishing links with popular medicine codes and practices. Exclusion in health language has eluded this problem by grouping it with cultural and geographical barriers to access, but it goes beyond these barriers.

However, for the urban and marginal groups, with whom the health systems tend to share cultural codes, the formula consisting of fictional legal equality and real inequality has persisted in Latin America and the Caribbean. Public services in most countries have been available to those who can afford the opportunity cost to use them, a pattern which is inexcusable since it mostly grants use of health services only in the case of emergency.

According to Castel,[13] situations of social exclusion occur in three areas: a) in the area of integration, safety, or stability; b) in the area of vulnerability, precariousness, or instability; and c) the area of exclusion or marginalization. When it comes to extension of social protection, the areas concerned are b and c.

In the countries of Latin America and the Caribbean, exclusion from health care appears to be strongly tied to poverty, marginality, discrimination (racial, social, and gender) and to other forms of social exclusion, as well as to other cultural patterns including language; employment disadvantages such

[13] Castel, Robert. La metamorfosis de la cuestión social. Una crónica del salariado. Buenos Aires: Paidos, 1997.

as informal employment, underemployment, or unemployment; geographical isolation; and the low levels of education and information that users obtain from their health providers.[14]

Through the use of various indicators,[15] it has been estimated that on average, between 20 and 25 percent of the total population of the Region (100 to 150 million people) do not have access to health services. Indeed, more than 200 million people do not have social security coverage and more than 100 million suffer from some type of exclusion related to geographic inaccessibility. On the other hand, nearly 100 million people suffer from exclusion with respect to the most basic services and 82 million children do not receive necessary vaccines. An element as vital as potable water is beyond the reach of large proportions of the poor: nearly 160 million people do not have access to drinking water.

Recent studies[16] have yielded data suggesting that, in some countries, these numbers may be even higher. In Peru, for example, the data show that 10 percent of the population is completely excluded from the health system and another 30 percent of its total population (8.1 million people) is at high risk of exclusion in health care.[17] In Paraguay, according to data from 1999, 47 percent of the total population in need of care, or injured with non-mild afflictions, did not recur to demanding health services, that is, they remained outside the system for various reasons. Among the most important reasons are self-medication and lack of economic resources.[18] On the other hand, it is estimated that 20.7 and 30.3 percent of the total populations in Ecuador and Honduras, respectively, are excluded from the health care system, even when taking into account all existing subsystems.[19]

The common profile of the excluded individual in these countries consists of persons living in poverty, living in rural areas, being of indigenous or immigrant origin (for example, a Haitian in the case of the Dominican Repub-

[14] La hora de los usuarios. Reflexiones sobre economía política de las reformas de salud. Sánchez, Zuleta Editores. BID/Centro de Estudios Salud y Futuro. Washington DC, 2000

[15] "Panorama de la exclusión de la protección social en salud en América Latina y el Caribe". Documento presentado a la reunión tripartita de OIT con la colaboración de OPS, México, 1999.

[16] Estudios de caracterización de la exclusión en salud realizados por OPS en siete países de la Región a partir de 2001.

[17] Estudio de caracterización de la exclusión en salud en el Perú, OPS 2003.

[18] Estudio de caracterización de la exclusión en salud en Paraguay, OPS 2001.

[19] Estudio de caracterización de la exclusión en salud en Ecuador, OPS 2001 y en Honduras, OPS 2003.

lic, or people who use Guarani as their main language in Paraguay), being female and, in the case of women, being heads of households wherein employment generally means working in the informal sector.

In significant proportions of the populations of the countries of Latin America and the Caribbean, the absence of effective and equitable social protection against the risk and costs of disease creates sharp inequalities in the health situation among regions, countries, and social groups. According to data from PAHO, one out of 130 mothers dies during pregnancy or during childbirth in Latin America; that figure is 28 times higher than in the United States. Eighteen percent of mothers give birth without any type of medical care. In spite of technological advances, the differences between countries and social strata in health status indicators are very acute. In Bolivia, 83 children out of every 1,000 die before reaching the age of one, while in Canada this figure is only 5.7. PAHO estimates that 190,000 children die annually in the Region from diseases that can be prevented or controlled, such as diarrheal diseases and respiratory infections.[20]

Similarly, at the end of the 1990s, life expectancy at birth was seven years higher in the richest quintile than in the poorest quintile (72.5 and 65.8 years, respectively); conversely, the risk of dying before turning one in the richest quintile was less than half of that in the poorest quintile (19.6 and 42.9 per 1,000 live births, respectively).[21]

3.3. Policies and Strategies Followed in the Region for the Extension of Social Protection in Health

The growing process of integration into the world economy undergone by countries of the Region in the last two decades, which has resulted in more intense and free trade among nations, has commenced in the new century in the midst of criticism and protests with respect to performance in the social field, and has created an environment of widespread mistrust related to the projected future impact that these processes portend. The regional

[20] "Hacia una nueva visión de la Política Social en América Latina: Desmontando Mitos". Bernardo Kliksberg.

[21] "Nuevos rumbos para la salud en las Américas. Informe cuadrienal del Director, edición 2002". OPS, 2003.

reality is marked by four basic characteristics: slow economic and irregular growth, persistent poverty, social injustice, and personal insecurity.

By contrast, the 1970s and the first half of the 1980s witnessed the emergence and growth of a variety of policies and national programs that expanded the coverage of health services, especially in marginal rural areas, on the basis of the Primary Health Care Strategy and the consensus of the 1978 Alma Ata Conference. However, the most recent policies, developed within the framework of health sector reforms, have been strongly aimed at cost containment, or at reducing health expenditures, in an environment of fiscal contraction policies. Most of the agendas for change have not emphasized the extension of social protection in health among their objectives. Although the efforts have been directed mainly towards targeting specific populations and at increasing the supply of health services, they have not moved towards the definition of systems of social protection in health that are guaranteed with public funds.[22]

Under the dominant policy framework of the 1990s, increasing resources were not as important as propitiating the adequate utilization of resources. Therefore, since it was considered a region of high social spending, Latin America and the Caribbean stopped seeking budgetary increases for health. In fact, during this period resources were both scarce and ill-administered. The challenge to managing health care systems with efficacy, efficiency, and effectiveness was still considered to be pressing matter. However, it should be emphasized that there was not only insufficient resources and the need to manage them better, but that it was also necessary to turn to another *way of doing health* that requires that social protection in health be restructured. However, the task of restructuring has been treated as if it was secondary, so that most efforts during the decade centered on introducing administrative instruments and techniques to take care of structurally segmented systems.

The first-generation reforms of health systems brought with them an advantageous intra-sectoral vision of health problems, so that the management of social projects and programs dominated the formulation and implementation of public policies. The reforms sought efficacy and effectiveness beyond the scope of action of the State, through social projects and programs that were aimed at specific interventions. However, this view disre-

[22] Op. Cit. 26th Pan American Sanitary Conference, ILO-PAHO, July 16th, 2002.

garded the need for territorial articulation and cut loose from the need of acting in a socially comprehensive fashion and with a vertical approach. In the end, it ignored the debate on the relationship between health and development.

In spite of the aforementioned, some specific mechanisms aimed at reducing exclusion in health care were implemented. In the following paragraphs, such interventions are described and grouped into several categories. Of course, the organization, operation, and results of the interventions depend primarily on the conditions under which they are implemented. By itself, no mechanism guarantees success, and all require specific adaptations to the immediate environment in which they are applied.

Some of the national efforts at building health systems and/or at implementing initiatives to achieve social coverage at the national level have been those of Costa Rica, with its Fund for Social Security; Colombia, with its structured pluralism model; Brazil, with its Unified Health System (SUS); and Bolivia, with its experience in "maternal and child" insurance, among others.

In several countries, numerous plans have been implemented and geared toward the establishment of special non-contributory social security schemes. These have been aimed at meeting the demands for special population groups (such as mothers and the elderly), labor sectors (growers of sugarcane and coffee), or specific subjects, as in the case of the maternal and child care. These plans have managed to be successful in the short term and have been able to effectively incorporate the excluded groups to whom they are targeted. Lack of sustainability, however, is a problem since they are usually funded with extraordinary resources (such as loans and donations from international financial organizations) and do not correlate adequately with other sectoral activities. Once the international financial cooperation is over, they are usually abandoned, or diluted, but rarely included in future budget appropriations.

Voluntary insurance schemes, with government subsidies, have also been implemented in some countries. These make it possible for some excluded groups to become beneficiaries of a given social security scheme without meeting all the enrollment requirements. In this sense, it breaks with one of the characteristic forms of exclusion of social security systems. This modality resolves the problems of the excluded population to the extent that the public authority is willing to continue to finance the program. However, in

the event that the supply of services to groups incorporated is different from those received in other social security schemes, an inequitable modality is created which runs the risk of being perceived as such by the beneficiaries.

Another alternative that has been used is the limited expansion of the provision of certain forms of care. In this case, specific services are brought closer to certain targeted population groups. There is a broad range of experiences in the continent that indicate that this modality can provide a partial solution for better access to populations that are excluded for various reasons, and can therefore be successful in the short term. The main disadvantages of this type of strategy are the possible lack of financial sustainability and the absence of articulation with other categories of services or health programs. At the same time, these interventions tend to be carried out without greater efforts to engage in consultation, which may mean that they do not reflect the real or perceived care needs of the targeted beneficiaries.

By contrast, there are some experiences in developing community and social protection systems whose main characteristic is the participation of potential users in direct management. In the Americas, these experiences usually originate in communities with high levels of exclusion that have no other alternatives to obtain social protection in health. To be successful, these systems require some degree of integration with other public systems; that is, those they tend to interact with through the purchase of services. Another problem they confront is the impact of catastrophic diseases—such as HIV/AIDS—that, given the limited volume of users and low grouping of risks, can rapidly exhaust the financial reserves of local funds. The successful cases observed in the Region reflect situations where it has been possible to establish some mechanism that links these schemes with public programs as well as ensure a variety of sources of funding, while community participation in the decision-making processes is promoted and respected.

The gradual development of standardized systems has been proposed. These tend to combine a public subsystem, to which most of the population has exclusive access, with a complementary private subsystem (private health insurance) that, at the same time, can offer its private clients access to the services of the public system. This modality combines various sources of income (general taxes of the three levels of government, special taxes, and mandatory contributions). The principal limitations of this approach are associated with the lack of resources, and with guarantees of access to the

most complex levels of the health care. This creates the need to implement processes that build integrated networks of services at the regional and micro-regional levels . An example of this modality is the Unified Health System in Brazil.

5. Framework of ILO - PAHO Initiative to Support the Implementation of Strategies for the Extension of Social Protection in Health

The International Labour Office (ILO) was founded as a result of the concern of the countries to establish a social framework that could guarantee peace and stability and, accordingly, prosperity and social justice in the realm of labor. To attain this objective, ILO has taken actions by various means: normative activity, support for the creation and the strengthening of institutions, influence on public policies, and projects of technical cooperation. With the passage of time, the message of ILO has become an important reference in the world of labor.

However, during the last twenty years, globalization and the liberalization of the economy have considerably modified labor relations, job markets, and professional relations. For ILO, this has resulted in a drastic modification of the bases on which it supports its action. The organization has had to undergo a process of radical reforms and of modernization in order to preserve the usefulness and the effectiveness of its activities.

Today, *"the fundamental purpose of ILO is to promote opportunities so that men and women can obtain decent and productive work in conditions of freedom, equity, safety, and human dignity."*[25] It should be noted that the relevance of this objective for the Region has been confirmed by the Delegates of the Fourteenth Regional Meeting of the Member States of ILO in the Americas

[25] Decent Work, Report of the Director General, International Labour Office, 87th Meeting, Geneva, 1999.

(Lima, August 1999) who declared that "the acquisition of decent work constituted one of the highest priorities of the inhabitants of the Americas."

For the attainment of the stated objective, in 1999 a new program for the stakeholders of ILO was adopted, that is designed for the states, workers' organizations, and employers' organizations. This program is structured around four strategic objectives, namely, to promote and to fulfill the fundamental principles of labor rights; to create greater opportunities for women and men with the goal of increasing both income and employment; to highlight the scope and the effectiveness of social protection for all; and to strengthen "tripartismo" and social dialogue. Thus, this program is solidly in line with the current mandate of ILO.

ILO has important experience in this area. From its creation, social security has been regarded as a fundamental concept in the protection of workers and of their families (Preamble of the Constitution of ILO). Its importance was reaffirmed and strengthened with the Declaration of Philadelphia (1944) and later with the Universal Declaration of Human Rights (1948). Throughout its history, ILO has defined and proposed numerous agreements and recommendations with the goal of extending and improving social protection in the field of health and in other fields.[26] Furthermore, ILO has undertaken technical cooperation activities with a view to supporting the creation or the modernization of social security systems in the different regions of the world. Within the framework of its new strategic objectives, ILO assigns social protection to a more important place than it has enjoyed in the past, with a greater emphasis on the extension of coverage to all the inhabitants of the planet.

On 18 June 2003, in Geneva, Switzerland, the Director-General of the International Labour Office, as well as the governmental representatives and representatives of employers' and workers' organizations launched the World Campaign of Social Security and Coverage for All, an initiative focused on the extension of social security coverage to a greater number of people. The first phase of the campaign will last five years, finishing in 2006. During this period,

[26] It concerns mainly Agreements (Núm. 24) and (Núm. 25), that create compulsory health insurance in industry and in agriculture respectively; of the Recommendation (Núm. 69), 1944, that points out the need that medical care «should protect all the members of the community, whether or not they engage in paid work;» of the Agreement (Núm. 102), 1952, that establishes the minimum levels of benefits for the nine principal branches of social security; of the Agreement (Núm. 130) and of the Recommendation (Núm. 134), 1969, that refer specifically to medical care and monetary benefits associated with illness.

the objective is to place, in the greatest possible number of countries, the expansion of social security into the top spot on the agenda for development, and to give support to those responsible for policy adoption as they prepare strategies (at both national and international levels) for the expansion of coverage. These strategies will be inspired by the values of solidarity and universality, and will be based on financially viable modalities for the expansion of social security.

The Pan American Health Organization (PAHO), as a Regional Office for the Americas of the World Health Organization (WHO), and as the specialized organization on health of the Inter-American System, is an international public health organization with more than 100 years of experience in improving the health and the standards of living of the inhabitants of the Americas. Headquartered in Washington, DC, PAHO has scientific and technical experts at its headquarters, in its twenty-seven country offices, and in its nine scientific centers, all working with the countries of Latin America and the Caribbean in order to deal with priority health subjects. The health authorities of the Member States of PAHO set the technical and administrative policies of PAHO through its Governing Bodies. The Member States of PAHO include the 35 countries in the Americas; France, the Netherlands and the United Kingdom of Great Britain and Northern Ireland are Participating States; Portugal and Spain are Observer States; and Puerto Rico is an Associate Member.

The fundamental objectives of PAHO are to promote and coordinate the efforts of the countries of the Region of the Americas to fight against disease, extend life expectancy, and promote the physical and mental health of its peoples. The fundamental task of the Organization is to collaborate with the ministries of health, the organisms of social security, other governmental institutions, nongovernmental organizations, universities, community groups, and other social agents in order to strengthen the national and local health systems and improve the level of health of the peoples of the "Region of the Americas."

In light of the complementarity of its mandates, the joint actions of ILO and PAHO produce important synergies that support the efforts of the countries in terms of the extension of social protection in health. In this regard, in 1999, both institutions signed a Memorandum of Understanding that laid the groundwork for collaboration between the two institutions for the purpose of undertaking studies, defining concepts and methodologies on the subject, and organizing a regional conference on the subject.

Exclusion in health care is a multi-causal and complex phenomenon that presents major variations between and within the countries. Its causes are found both inside and outside of the health sector, and it is important to continue to investigate the relationship between exclusion in health care and other social phenomena such as poverty, inequality, discrimination, forms of employment and underemployment, and an insufficient network of social protection. It is also necessary to pay attention to the impact that some factors characteristic of the health sector have on exclusion, such as health expenditures and the structure of the health protection systems.

The excluded populations face multiple sources of exclusion and the degree of exclusion varies deeply. In the area of policy development, these various degrees and causes of exclusion suggest that policies aimed at mitigating this situation should not concentrate only on a single dimension or factor, but should be multidimensional and inter-sectoral in scope.

Exclusion in health care and its underlying conditions vary by country and within countries. It is recommended that when strategies are developed, they contain regional/territorial elements specifically aimed at extending social health protection in the most affected geographical areas.

Poverty is clearly a significant determinant of exclusion in health care in the countries of the Region, generating a perverse circular dynamic. As a result, strategies of poverty alleviation are closely related to strategies aimed at reducing exclusion in health.

As noted above, it is important to include elements related to the extension of social protection in health into public health policies. First, this requires an adequate description of exclusion in health care, identification of those affected, and an evaluation of the magnitude of the problem in the countries of the Region. Additionally, a national analysis of the health sector (with all its sub-systems. public, social security and private) should be undertaken along with a systematic evaluation of the strategies implemented. This will help to address the problem and identify those strategies that have been shown to be more successful in the particular conditions of each country.

A Tripartite Regional Meeting of the ILO took place from 29 November to 1 December 2001 in Mexico in collaboration with PAHO and with a focus on "The Extension of Social Protection in Health to the Excluded Groups in Latin America and the Caribbean." Participants made a number of recommendations including the need to continue the joint effort of ILO and PAHO, and urged the organizations to continue their efforts for the sake of support-

ing the national and regional initiatives focused on a resolution of this problem.[27]

The 26th Pan American Sanitary Conference[28] took place in Washington, DC from 23 to 27, 2002. The Document CSP 26/12 "Extension of Social Protection with Regard to Health: Joint Initiative of the Pan American Health Organization and the International Labour Office" was presented, and resolution CSP26R19 was adopted which, among other recommendations, urges the Member States to extend social protection in health, and requests that the two organizations continue their efforts in encouraging a line of work on the extension of social protection in health.

The goal of the Joint Initiative of the ILO and PAHO on the extension of social protection in health is to increase the well-being of a significant sector of the population by including previously excluded groups. To do so, national strategies will be developed to combat exclusion in health care by identifying its causes, magnitude, and possible solutions.

Since 1999, the ILO and PAHO have been working jointly both on activities at the regional level and in specific countries. One example of an activity carried out regionally is the course on Strategies for Reducing Social Exclusion in Health that was offered jointly by ILO and PAHO from 9 to 11 October 2002, in Santiago, Chile. In this course, more than 34 people representing Argentina, Bolivia, Canada, Chile, Costa Rica, Ecuador, El Salvador, Paraguay, Peru and Uruguay met to share their experiences on the diagnosis, analysis, and definition of strategies of policy for the reduction of social exclusion in health. Country-level activities have also occurred in Argentina, Peru, and Honduras.

One of the greatest challenges involves expanding the reach of the health sector from its traditional base in order to achieve greater coverage and better quality services through comprehensive mechanisms that allow public and private actors to work together. It also involves the participation of actors and institutions outside the health sector.

[27] Informe Final de la Reunión Regional Tripartita de la OIT con la colaboración de la OPS sobre «La Extensión de la Protección Social en Salud a los Grupos Excluidos en América Latina y el Caribe» México, 29 de noviembre al 1 de diciembre de1999.

[28] 26th Pan American Sanitary Conference, Washington DC from 23 to 27 September of the 2002.

Today, the fundamental challenge facing the countries of the Region is how to guarantee all their citizens adequate and permanent access to health promotion and to key preventive, curative and rehabilitative health interventions in a timely, respectful, and quality manner according to the principles of dignity, and regardless of ethnic background, social class, gender and ability to pay, thereby achieving equitable access to health care.

The pressing task of Latin America and the Caribbean in terms of the extension of social protection in health to our people involves envisioning a goal, wherein ILO and PAHO will work together with countries of the Region to promote economic growth and comprehensive strategies based on the study of the problem of social exclusion in health. Reaching this goal will make it possible to share the vision of an America wherein all individuals will enjoy sustained human development in the years and generations to come.

6. Partners Meeting ILO - PAHO Joint Initiative on the Extension of Social Protection in Health

27 and 28 October 2003
Swedish International Development Cooperation Agency (SIDA)
Sveavägen 20, Stockholm, Sweden

The extension of social protection in health motivated the meeting on 27 and 28 October 2003 in Stockholm, Sweden, jointly sponsored by the International Labour Organization (ILO), the Pan American Health Organization (PAHO) and the Swedish Agency for International Development (SIDA), which was the host entity. International and bilateral development agencies and technical cooperation organizations participated in the meeting. The purpose was to present the initiative to potential partners and identify areas of possible collaboration in its promotion and application.

6.1. The PAHO ~ ILO Initiative on ESPH

Although the current laws in most of the countries in the region grant all citizens the right to some type of health care coverage, in practice it is not so: Nearly 135 million people in Latin America and the Caribbean lack permanent access to health services.

Accordingly, the fundamental challenge facing the health systems in the Americas is to find a way to guarantee all of their citizens a basic level of social protection in health that can serve to eliminate inequities in access to quality health services for all and that is made available to the social groups that, until now, have been excluded from the opportunity to receive essential health care to meet their needs, independent of their ability to pay. The

social groups that cannot make use of guaranteed access to health care constitute those who are "excluded" in health.

Social protection in health can be defined as the guarantee that society offers, through public authorities, that individuals, or groups of individuals, can meet their health needs, by obtaining adequate access to services, either through the national health system or any of the current health sub-systems in the country, without their ability to pay as a restrictive factor.

In order to face these challenges, ILO and PAHO have developed an Initiative that aims to contribute to the greatest well-being of a significant sector of the population of the Americas by extending social protection in health to excluded groups. The Initiative was adopted by all PAHO Member States through resolution CSP26/12 at the Pan American Sanitary Conference in 2002.

To achieve this extension, it will be necessary to promote policies, reforms and instruments that guarantee access to health care, with funding solidarity, adequate financial protection for families and dignified care for their members. The anticipated activities within the framework of the Initiative include those to be carried out in the countries, with the objective of supporting governments' efforts in this matter and complementary regional and/or sub-regional activities, in order to promote the sharing of experiences among countries, and to inform and conduct research from a regional perspective.

The *extension of social protection in health* includes mechanisms designed to guarantee the population access to health protection and care through a broad range of mechanisms and not only through services delivery by the State. Thus, social protection is understood as the State's guarantee of a right that citizens can exercise, and not as a type of social welfare benefit that the State provides.

However, four conditions should be met in order for the extension of social protection in health to function as a guarantee in practice:

- *Access to services* (not only curative): Necessary health care services, which are physically and economically accessible to the people, should be available.
- *Financial security*: Health care payments should not threaten the economic stability of households or the development of their members.

- *Funding solidarity*: Cross-subsidies should be intergenerational and should flow between risk groups and between different income groups.
- *Dignity in care*: Quality health care should be provided in a setting that is respectful of people's racial and cultural characteristics and economic situation.

These four conditions are indispensable, since the absence of one or more of them produces some form of exclusion in health.

Thus, ILO-PAHO actions aim to strengthen countries' political-institutional, organizational and human capacity to:

- Promote the extension of social protection in health, raising awareness and explaining it whenever necessary, in addition to proposing potential instruments to achieve it.
- Identify the causes and magnitude of exclusion from social protection in health and the means for confronting the problem at the country level and creating the necessary links with different interested parties and local organizations.
- Establish a baseline on the status of exclusion in health within the countries as well as in the Region.
- Analyze the current poverty reduction policies and their impact on exclusion in health.
- Create the capacity to face the problem, both at the national and sub-national levels.
- Promote partnerships with multilateral and bilateral agencies, international financing institutions and other partners involved in development, in order to promote the social protection in health agenda.
- Establish a documentation center on lessons learned and knowledge about exclusion from social protection in health.
- Develop methods and instruments to support those responsible for making decisions as they design, apply and evaluate policies that aim to extend social protection in health.

6.2. The Meeting

6.2.1. Scope and Purpose of the Meeting

The cost of providing the technical and financial support required for such a comprehensive Initiative exceeds the possibilities of both organizations. What is intended instead is a substantive effort to mobilize resources and defend the cause, so that the group can be expanded beyond those who sponsor it from the outset. ILO and PAHO/WHO have the conviction that the only way to confront the problem is to create links among the interested parties and to establish a rigorous, effective social and political dialogue. This two-day partner meeting was held for that purpose, to address the problem of extending social protection in health within the framework of the Initiative proposed by ILO and PAHO. Invited participants included organizations with technical functions and those at the decision-making level.

Participants talked about the different types and levels of collaboration that different institutions can provide and the way in which the Initiative can gain a place in their current lines of work. The discussion was organized around the contribution that the meeting participants could make with regard to the following issues:

- Raise awareness about the extension of social protection in health to excluded groups, which entails motivating governments to position the issue as a priority on the political agenda.
- Financing mechanisms that take into account the fact that, in order to meet the population's health needs, it is necessary to act according to principles of equity and solidarity.
- Insurance mechanisms that should be targeted at establishing a reasonable balance between compulsory insurance schemes and public and private financing.
- Organization of services delivery in a manner that takes control over substantial changes in health care services models, through the introduction of provider incentives to be able to reduce or eliminate the causes of exclusion.

6.2.2. Agenda

Monday, 27 October

9:00–9:15 a.m.	Words of welcome
	Britt Hagström, director, Department for democracy and social development, Swedish International Development Cooperation Agency
9:15–10:15 a.m.	The need for cooperation to extend social protection in health in Latin America and the Caribbean
	ILO, Ricardo Hernández Pulido, director, ILO Sub-regional Office for the Andean countries, Lima
	PAHO/WHO, Daniel López-Acuña, director of program management
10:15–10:45 a.m.	Discussion
10:45–11:00 a.m.	Coffee
11:00 a.m.–12:00 m.	The ILO-PAHO Initiative: What it is, what it does, ways to participate
	PAHO/WHO, Pedro Brito, area manager, strategic health development
	ILO, Emmanuel Reynaud, chief of the social security policy and development branch
12:00–12:30 p.m.	Discussion
12:30–2:00 p.m.	Luncheon
2:15–3:30 p.m.	National experiences and cooperation activities on the issue of the extension of social protection in health—panel
	Mexico: Dr. Asa Cristina Laurell, secretary of health, Government of the Federal District, Mexico
	Peru: Dr. Moisés Acuña, director, Comprehensive Health Insurance Plan, Peru
	Honduras: Ms. Martha Rosibel Garay Flores, Director-General of social security, Honduran Ministry of labor and social security
3:30–3:45 p.m.	Coffee
3:45–4:30 p.m.	National experiences and cooperation activities on the issue of the extension of social protection in health—panel (continued)
	Suriname: Dr. Harold Radmani, president of the State Social Security Board, Republic of Suriname
	Bolivia: Dr. Javier Torres-Goitia Torres, adviser to the minister of health
	In order to link research with decision-making in the extension of social protection in health, Dr. Roberto Bazzani, program officer, regional office for Latin America and the Caribbean, IDRC
4:30–6:00 p.m.	Plenary discussion

Tuesday, 28 October

9:00–11:00 a.m.	Possibilities for participation by partners in the Initiative
11:00–11:15 a.m.	Coffee
11:15–12:00 m.	Possibilities for participation by partners in the Initiative (continued)
12:00–12:30 p.m.	Closing: ILO, PAHO/WHO, SIDA

The words of welcome by Mrs. **Brit Hagström**, director of the department for democracy and social development at the Swedish Agency for International Development (SIDA), initiated the presentations for the first day of the meeting, which focused on the state of social exclusion in health. ILO and PAHO staff members and participants from Latin American and Caribbean countries and IDRC-Canada were responsible for addressing the related issues.

6.2.3. Presentation by Ricardo Hernández Pulido (ILO)

Ricardo Hernández Pulido, director of the ILO sub-regional office for the Andean countries, discussed the region's socioeconomic problems and the ILO mandate on social security and medical care and its application in recent years.

The substantive economic growth that took place in the 1990s, equivalent to an average rate of 3.6 percent, made it possible for many countries to position themselves, by the end of the decade, at levels similar to where they had been before the "debt crisis," even though 44 percent of the Region's population still lives in a state of poverty.

Latin America is the region with the most unequal income distribution in the world. The wealthiest 5 percent of the population receives 25 percent of the national income. On the other hand, the poorest 30 percent receives less than 7.5 percent of such income. In other words, the wealthiest 10 percent has an average income that is 84 times that of the poorest 10 percent.

With respect to labor, the new development model carried with it a flexible labor market, together with an ever-growing pressure on companies to reduce their production costs, especially those associated with labor. The economic growth did not generate a significant number of new jobs and, since those that were created were mostly in the precarious informal sector, they generated a labor bulge. This in turn had enormous repercussions such as reduced social security contributions, which has translated into millions of people deprived of social protection in old age, and in case of illness, work-related injuries or other contingencies inherent in the life cycle. Between 1990 and 2001, 69 percent of jobs were in the informal sector. The proportion of this type of employment relative to the total rose to 63 percent in the same period, while formal employment declined from 57.2 to 53.7 percent of the total in the same period.[29]

[29] Panorama Laboral, 2002.

Despite what may have been expected, social spending as a proportion of gross domestic product (GDP) grew significantly in the 1990s. It went from 9.1 percent, on average, during the 1980s, to 12.3 percent in the 1996-1999 period. It is necessary to point out that spending on social security tripled its participation in social spending relative to GDP, approaching the combined spending on the health and education sectors.

Another process that affects the state of social protection is the demographic evolution of the regional population during recent decades. Over the last 15 years, life expectancy in the region increased from 68.7 to 71.1 years, in great part due to a significant reduction in infant mortality rates, reducing the years of potential life lost throughout the Region. The regional population has increased and shows high growth rates, of 1.4 percent for Latin America and 1 percent for the Caribbean. This scenario anticipates a population increase of approximately 7.5 million people per year during the next two decades, so that the total population, estimated at 520 million people in mid-2000, will reach 800 million in 2025.[30]

Exclusion in Health

In the region, exclusion in health is closely tied with poverty, marginality and discrimination, and with health service users' cultural, social and economic characteristics, including language, informality, unemployment, underemployment, geographic isolation and low levels of education or information.

Social Security

Social security emerged as early as 1919 as a fundamental concept in the protection of workers and their families against the risks inherent in their social condition.[31] A quarter of a century later in 1944, the year of the Declaration of Philadelphia, the concept was strengthened with the recognition that access to an adequate level of social protection is a basic right of all people. This principle has been recognized over the years, in the Universal Declaration of human rights in 1948, in the International pact on social, economic and cultural rights in 1966, and more recently, at the United Nations

[30] CELADE projections.

[31] Preamble to the ILO Constitution.

Millennium Summit in 2000. This last event culminated in the adoption of the Millennium Development Goals, which consider social protection as an effective instrument for combating the causes and mitigating the adverse effects of poverty.

The basic principles of social security have been successively included in the ILO's international agreements and recommendations related to this issue from 1919, the year of the adoption of the maternity protection convention,[32] until 2000, the year of the adoption of the revised Maternity protection convention.[33] In terms of these agreements, the one related to social security[34] (minimum standards) stands out. This agreement still remains in full force, as demonstrated in the general discussion at the International Labour Conference in 2001.

Globalization, the persistence or spread of poverty and its social and economic consequences, the notable increase in accidents and fatal diseases, the AIDS pandemic, among other factors, exert enormous pressures on social protection systems. These factors have caused, above all, serious deficiencies in the reach and coverage of those systems. Therefore the public, and in particular governments, are immersed in the task of: reconciling favorable economic policies related both to growth and to adequate social protection; and making social protection more solid, strengthening its relationship to the profound social and economic transformations that have taken place in recent years.

The concern is justified given that what actually occurs is very far from the ideals sanctioned in the previously mentioned international instruments and that only a minority of people in the world, mainly from developed countries, enjoy the right to social protection. It is true that almost all countries have a social protection system but, especially in developing countries, these systems cover only certain categories of the population—public sector and formal sector workers. The excluded people are major population groups given that the number of workers in the informal sector has been growing at a rapid rate. These workers have access to limited protection in the best cases and no protection in the majority of cases.

[32] Num. 3.

[33] Num. 183.

[34] Num. 102.

It is due to this situation that the ILO has been organizing its work around four strategic objectives:

- To promote and fulfill fundamental principles and rights at work.
- To Create better opportunities for decent incomes and employment for women and men.
- Highlight the scope and effectiveness of social protection for all.
- Strengthen tripartite interactions and social dialogue.

This third objective is the one that is closely linked with the problem of the social protection. It is part of the ILO agenda and aims to improve the coverage and effectiveness of social protection so that all citizens, men and women, can obtain dignified, productive work in conditions of freedom, safety and human dignity, as expressed by the ILO Director-General in his Address to the International Labor Conference in 1999.

ILO programs geared toward reaching the strategic objective of the organization of the social protection sphere are part of an integrated approach to making decent work a reality in its Member States and will constitute an essential characteristic of the ILO contribution to international socioeconomic development initiatives.

The ILO's extensive knowledge and experience in this issue are used to implement new or revised instruments and innovative approaches in the national and regional plans that contribute decisively to expanded coverage of social protection schemes. This is the raison d'etre for the assistance in preparing global, suitable strategies and for the technical support so that social protection becomes, in effect, an instrument of struggle against poverty and social exclusion. However, from the perspective of our organization, these activities should not be developed in an isolated way, but need to be accompanied by social dialogue among the social interlocutors, governments, and representatives of workers' and employers' organizations. Issues related to gender equality in social security should not be put aside, since they are increasingly important due to the profound transformations in family structures and the massive incorporation of women into the working world.

Only one out of five people currently enjoys adequate social protection coverage and approximately half of the world's population does not have any type of social protection. The people who lack social protection come from a wide spectrum, including salaried small business employees, self-employed workers, migrant workers and the people that make up the informal sector,

a great percentage of whom are women. This dramatic situation inspired a general discussion on social security at the International Labour Conference in 2001. At the close of the Conference, the governments, employers and workers reached a *new consensus on social security,* which recognizes that, "it is necessary to give maximum priority in social security policies and initiatives to those people that are not covered by the current systems."[35] One of the conclusions resulting from that consensus granted the ILO the mandate of initiating an important campaign to promote the extension of social security coverage, which also pursues guaranteed access to medical care and income security for all. However, the new consensus also emphasized that the extension of coverage in social protection, as well as in medical care, should take into account the specific needs of different population groups and their ability to contribute.

This consensus led to the official launch of the **Global Campaign on social security and coverage for all**, which took place in June 2004 at the 91st Session of the International Labour Conference, and included the presence of governmental representatives and representatives of employers' and workers' organizations.

This campaign is a direct response to requests from all regions to emphasize the need for concrete, practical instruments for the extension of social security. The campaign is an innovative element that permits the development of associations and makes it possible to provide the necessary assistance to the Member States and the employers' and workers' organizations, with a view toward significantly improving the coverage for groups that until now have lacked protection, thus contributing to the strengthening of the social dimension of globalization. Furthermore, the campaign is closely linked to the promotion of workers' rights, the creation of productive, quality jobs, and the consolidation of tripartite interactions and social dialogue. The campaign's emphasis on workers in the informal sector and vulnerable groups represents a valuable contribution to the reduction of poverty and social exclusion as well as to gender equality. The campaign encompasses three types of activities: the first are regional and sub-regional activities; the second correspond to long-term technical cooperation; and the third are related to short-term assistance. Finally, the campaign represents an excellent opportunity for the ILO to promote the extension of social security on an international scale in order to achieve concrete results in extending coverage.

[35] Social Security: A new consensus, ILO, 2002.

The **ILO/PAHO Joint Initiative on the extension of social protection in health** is also one of the fundamental components of the ILO global campaign. The signature of the Memorandum of Understanding between the two organizations in 1999 represents the first step in the Initiative. The memorandum establishes the framework for cooperation for the formulation and execution of a joint initiative. The first activity carried out in the context of this effort was the Regional tripartite meeting on the issue that was held in Mexico City in November 1999. ILO and PAHO committed to implementing the present initiative based on the recommendations from that meeting.

This initiative fulfills one of the active guiding principles of social security, contemplated in ILO's international agreements and recommendations, especially in Convention 102 on the minimum standard, Convention 130 on medical care, and Recommendations 67 and 69 on the security of life means and medical care, respectively. This final principle, on guaranteed medical care, represents the standard for our organization's intervention in activities related to medical care delivery in the Member States. Implementation of this principle means facing the challenge of guaranteeing that all people have access to health services, but not at any price, instead making sure that there is a reasonable balance between the quality of services provided through different modalities and the costs that this represents. This principle is widely accepted in all countries, mainly when it is demonstrated that the extension of quality health services to the least favored groups impacts positively on productivity, an indispensable requisite for socioeconomic development, which also signifies improvements in the standard of living to which citizens have a right.

In short, and in line with the spirit of the ILO mandate in the medical care arena, the joint action that we undertake with PAHO with a view toward extending health services to the entire population, should be accompanied by the creation of appropriate means of financing that come from the State's financial resources and mechanisms for compulsory and voluntary contributions. These means of financing will facilitate the provision of health services to the population based on equity and with an important element of solidarity among people from different income levels and age groups. This also requires the existence of effective means and institutions to administer and supply these services that constitute a universal need.

In closing, it should be recalled that the ILO has been working for almost 80 years in the health sector, either in the preparation of standards, the implementation of technical cooperation activities, the training of human resources, and the dissemination of information on medical care, all of which has been made available, with very satisfactory results.

6.2.4. Presentation by Daniel López-Acuña (PAHO)

The presentation by Dr. Daniel López-Acuña, director of program management at PAHO, addressed the need for cooperation to extend social protection in health in Latin America and the Caribbean.

The fundamental challenge that the health systems in Latin America and the Caribbean face is that of guaranteeing all citizens a basic level of social protection in health, ensuring the access of excluded social groups to quality health services, without ability to pay as a restrictive factor.

It is possible to identify the following dimensions of exclusion from health care:

- Lack of access to collective health activities.
- Lack of access to dignified individual health care services (in general or in selected services).
- Lack of access to protection against the economic and social impact of illness.

Diverse social, economic and health indicators from the Region make it possible to take control of this considerable problem.

- The population of Latin America and the Caribbean is 500 million.
- 27 percent of the population (135 million people) lack permanent access to basic health services.
- 46 percent of the population (210 million people) do not have any type of insurance, social or private.
- The average per capita income for the Region is 3,289 United States dollars.
- The average national health expenditure, as a percentage of the gross national product, is 7.3 percent.
- In absolute terms, the average national health expenditure is 240 dollars.

- There are 220 million people below the poverty level.

The previous statistics arise in the context of political and social dynamics that are not very encouraging and characterized by a variety of difficulties:

- Economic, social and political volatility.
- Population growth.
- Slow economic growth.
- Fragile governance.
- Increases in absolute poverty.
- The greatest regional inequality in income distribution.
- Expansion of unemployment.
- Growth of the informal economy.

A comparison of the growth in per capita income between Latin American and other nations during the periods from 1971 to 1980 and from 1991 to 1995, shows that the high growth economies in Asia and the industrialized countries experienced increases of 110 percent and 25 percent, respectively, while the Latin American economies did not even reach 10 percent.[36]

In the same way, the inequality coefficients (Gini) for the diverse regions of the world clearly indicate that the greatest income disparity is in Latin America, where poverty, both in terms of proportion of the total population and absolute number, had decreased steadily until 1983.[37] However, it increased again between the early 1980s and the end of the 20th century, and has now reached alarming levels. One contributing factor is the trend in average real wages, which were cut in half between 1980 and 1990, and then rose between 15 and 20 percent, stabilizing at those levels.[38]

At the same time, economic activities moved to the informal sector. Between 1990 and 1996 alone, the proportion of urban employment in the informal sector rose significantly in at least 16 Latin American countries, even in those where the informal economy was already the source of employment for large proportions of the economically active population in previous decades.[39]

[36] IDB: Latin America after a decade of reforms, Londoño and Székeli (1997).

[37] Ibid.

[38] Ibid.

[39] ILO.

However, in general, the countries of the Region maintained or reduced their social security spending as a proportion of the gross national product between 1990 and 1995, sustaining the trend that began in the 1980s.[40]

Meanwhile, the national health systems in the Region face considerable problems:

- Segmentation of institutions and coverage.
- Fragmentation of health care.
- Predominance of direct payments (out-of-pocket).
- Insufficient development of social security systems.
- Lack of solidarity in financing of public health and health care.
- Weak regulatory role of the health authorities.

The segmentation of health systems tends to arise in the three traditional forms of coverage:

I. Ministries of health.

II. Social security organizations.

III. The private sub-system.

Thus, in the Latin American and Caribbean countries, almost 40 percent of health expenditures are directly defrayed by beneficiaries or their families (out-of-pocket expenditure), in addition to almost 20 percent on indirect personal expenditures. As a consequence, central governments contribute less than 16 percent, in addition to less than 9 percent by local governments and little more than 17 percent by social security.

These figures translate into public sub-sector contributions to health care that are very low when measured as a proportion of the gross national product (3 percent) and compared with relative figures of the same type for European countries (OECD, 6.6 percent), the United States (6.3 percent), and Canada (7 percent).

Another way to confirm the insufficiency of the public sub-sector's contribution in the Region is to compare public expenditure on health as a percentage of total health expenditure. Public expenditure on health is lower than 42 percent in Latin America and the Caribbean and only 44 percent in the United States, but rises to 71 percent in Canada and exceeds 76 percent

[40] IDB, op. cit.

in the OECD-European countries. The contrast is even greater when public spending on health is compared in absolute terms across regions: While it is 1,628 dollars per capita in the United States, and 1,314 dollars and 1,310 dollars in Canada and Europe (OECD), respectively, it is only 102 dollars per capita in Latin America and the Caribbean.

Clearly, the health reform processes that the countries of the Region experienced during the 1980s and 1990s have had defects and shortcomings that we can summarize as follows:

- The motivations driving the reforms have been primarily economic.
- Considerations of equity and public health have been relegated to a secondary level.
- The models of quality of care and of health care services delivery have been marginal.
- The need for the extension of social protection in health has been insufficiently addressed.

Social protection in health is defined as the guarantee that the citizen can care for his or her health needs, through adequate access to quality health services and independent of his or her ability to pay.

The extension of social protection in health is a set of strategies that aim to eliminate exclusion from access to health care, within the framework of public interventions and accompanied by measures that reduce the negative economic and social impact of adverse health events on the population, especially on society's most vulnerable groups.

The extension of social protection in health is currently a priority in the Region for the following reasons:

- Social, ethnic and cultural exclusion persist.
- The current social protection mechanisms are not adequate for responding to new problems.
- More than ever, it is crucial that reforms contribute to building societies that are inclusive of all citizens, and not to greater exclusion, marginalization and lack of social protection.

Furthermore, it is necessary to define a guaranteed package of health benefits or credits, understood as an *explicit health benefits package that is a citizen's right and that is a health services agent's duty to provide*. Certainly, such agents are both service providers and insurers and regulators.

In terms of strategies for extending social protection in health, it is worthwhile to take into account successful interventions in the recent past:

- Establishment of special social security schemes without a beneficiary contribution component.
- Voluntary insurance systems with a governmental subsidy.
- Expansion of the service supply.
- Progress toward unified systems.

However, the expansion of social protection in health is subject to a political economy that makes its strategies contingent on the following requirements:

- Recognition of the legitimate interests of the different groups of parties interested in the process.
- Creation of conditions and dynamics that favor the social dialogue that makes it possible for the interested parties to formulate appropriate offers and facilitate their implementation over time.

It is necessary to advance toward a new generation of reforms whose focal point is the health of the people. This means generating a new impetus for concrete actions and processes:

- Strengthen the infrastructure and practices related to essential public health functions.
- Strengthen the steering role of the health authorities.
- Expand social protection in health and ensure universal access to services, independent of the patient's ability to pay.
- Facilitate the reorientation of health systems and services, making use of criteria for health promotion (which is the basis for modifying health care services models).
- Improve quality of care.
- Develop and administer human resources in order to sustain the changes described above.
- Ensure efficient, solidary and inclusive mechanisms for health financing and resource allocation.
- Promote social participation at the different levels of the system.

These needs make international cooperation indispensable in the expansion of social protection in health, given that it is necessary to supplement deficiencies such as:

- Countries' institutional capacity, which is insufficient for formulating and implementing policies and strategies for the expansion of social protection in health.
- Immediate social need to initiate and consolidate innovative insurance systems.
- The expansion of social protection in health has been neglected as a component of the health reform and State modernization agendas.
- Such expansion is, in addition, a critical component of the promotion of democratic governance, human development and the achievement of the Millennium Development Goals.

6.2.5. Presentation by Emmanuel Reynaud, ILO

Emmanuel Reynaud, chief of the social security policy and development branch at the ILO, discussed the participation of donors and cooperation agencies in the ILO-PAHO Initiative.

The Initiative itself provides a coherent framework for integrating actions and the impetus necessary for making advances on the high-priority issue of extending social protection in health to the entire population of the Region. The Initiative strengthens ongoing activities and promotes new activities.

Since the Initiative includes several actors, there are also various types of possible participation. Both donors and cooperation agencies have several ways to contribute at their disposal.

If participation is understood as the sum of the contributions and benefits carried out, it is possible to participate by coordinating the actors involved and by contributing with financial or non-financial resources. Financing can be provided directly (through ILO and PAHO), indirectly, or by offering resources to co-finance activities with other sources.

The Initiative includes the following regional activities:

- Establishment of an information and communication center.
- Development of instruments and methods.

- Training.
- Research.
- Development of support networks.
- Promotion of supports.
- Monitoring and evaluation.
- Mobilization of resources.

The regional project is organized into modules according to these different activities, and was not envisioned to be financed as a whole. The number and variety of modules depend on the priorities and interests of the actors. As stated earlier, participation in the Initiative can be financial, direct or indirect, or non-financial. However, one of the Initiative's essential needs is the establishment of a continuous secretariat.

At the national level, the activities will depend on each country's context and decisions, and will not follow a single model or process.

6.2.6. Presentation by Pedro Brito, PAHO

The substantive concerns that motivated the meeting were presented by Dr. Pedro Brito, manager of the strategic health development area.

The most important challenge facing the Region's health systems is that of guaranteeing all citizens an appropriate level of health care in terms of access, quality and timeliness, independent of people's ability to pay.

This supposes the orientation of health systems toward equity, universality, solidarity and social inclusion.

When viewed from this perspective, the magnitude of the problem is considerable, as confirmed in the data presented by López Acuña and Pulido:

- 17 percent of the births in Latin America and the Caribbean are not attended by skilled personnel.
- 82 million children do not complete the immunization protocols.
- Almost one-third of the Region's population, that is 152 million people, do not have access to drinking water or basic sanitation.

The background and origin of the mandate for the Joint Initiative that motivated this meeting are the International Labour Organization (ILO) conference, *Social security: a new consensus*; and the resolution of the Directive Council of the Pan American Health Organization (PAHO) [R. CSP] 26/12,

Policies, strategies and activities to support the extension of social protection in health.

In 1999, ILO and PAHO initiated a collaborative effort to promote and develop policies for achieving social protection in health at the "Tripartite Meeting on the extension of social protection in health to excluded groups in Latin America and the Caribbean" in Mexico City. At this meeting, both ILO and PAHO agreed that exclusion from social protection in health can be confronted through a systematic process of design and application of public policies, which can be achieved using social dialogue as a framework for the analysis, diagnosis and execution of actions.

Between 2000 and 2003, PAHO and ILO promoted and supported country studies on exclusion from social protection in health in Argentina, Bahamas, Brazil, Chile, the Dominican Republic, Ecuador, Guatemala, Honduras, Mexico, Paraguay, Peru, and Trinidad and Tobago. The two entities have also provided assistance to several countries on the design, reform, and application of social security and health policies.

Interventions include the application of guaranteed rights portfolios, the establishment of standards to guarantee the provision of appropriate funds and financing, and the adaptation of the organizational and human institutional capacity for health planning. These efforts will help to define the current situation and to carry out the expansion of social protection in health and the restructuring of current programs, with the goal of achieving universality.

The interventions are developed within the framework of certain strategies: expansion based on typical social security mechanisms; promotion and support of innovative systems, including community-based initiatives; extension of health care coverage; the design of links, synergies and continuities between earlier forms of social protection and new social protection schemes and public initiatives.

In short, it involves *overcoming social and institutional segmentation in the coverage and operational fragmentation of services*.

The sustainability of what is proposed is conditional on: social dialogue, as the basis for defining policies and interventions; the development of political, institutional, organizational and human capacities, so that the skills remain in the countries following the implementation of the initiative; a joint effort by the agencies, which is the sum of the partners' technical capacity

and experience and the emphasis on the local level that, in turn, strengthens decentralization.

6.3. Country Experiences

6.3.1. Presentation by the Government of the Federal District of Mexico City

Dr. Asa Cristina Laurell, secretary of health, gave the presentation on behalf of the Secretariat of Health of the Federal District of Mexico City, which is responsible for the health of eight and a half million citizens.

The presentation provided a comprehensive, detailed tour of the current health situation and its determinants in the country and in the jurisdiction, the problems and challenges resulting from that situation, the strategies for confronting these problems and challenges, and the values and principles that guide the policies of the Federal District's government. The details are provided below since, for the most part, they are analogous to or representative of the changes in health and health care in the Region.

I. Introduction

The Federal District houses 21.3 percent of the Mexican population, including 1.8 million people in very highly marginalized areas, with profound degradation of the social and ecological environment and serious lack of services, and an additional 4.1 million in areas of high and medium marginalization. Of the Mexicans that live in the Capital, 3.3 million live in extreme poverty (38.3 percent) and another 2.3 million (26.6 percent) live in moderate poverty.

Trends in National Health Policy

The reorganization of medical services is under way at the social security institutions. Service delivery by the private sector has grown and insurance companies have emerged as an actor in the health sector, with the establishment of the Specialized Health Insurance Institutions (ISES), which administer private health funds.

Today's health system is more fragmented, with differentiated services based on ability to pay. In the decentralized system for the population without social security, «universal» free coverage only covers 13 public health and individual care activities. This reflects the resource deficit for guaranteeing coverage at the first and second levels of care for the uninsured population.

Public expenditure on health in Mexico, which stands at 2.6 percent of the Gross Domestic Product (GDP), is among the lowest on the continent, compared to countries at a similar phase of development. In addition to insufficient financing, the budget is unequally distributed among population groups.

Insufficient public financing in health and its impact on the delivery of quality services, explain a large part of the increase in household expenditure on health that, according to the National Household Income and Expenditure Survey, increased from 2.9 percent of total monetary expenditure in 1984 to 3.5 percent in 2000.

The basis of the reform carried out in this context by the Federal government consists of universal, although voluntary, insurance in order to provide support for market competition in the production of health services, through a public-private combination where both the financial administrators and service providers compete. In such a model, the sole responsibility of the State is to guarantee a minimum of services for the poor and to subsidize an insurance that grants the right to receive other services free of charge. The State is also responsible for regulating the activities of agents that administer the funds and provide the services.

II. Problems and Challenges

Health Conditions

The general mortality profile of the Federal District's population is characterized by chronic degenerative injuries (cardiovascular, diabetes, cancer and cerebro-vascular diseases) as the four leading causes of death, followed by liver diseases in fifth place, mainly due to liver cirrhosis. The first five causes, related to malnutrition, alcohol consumption or hepatitis, are followed by accidents, perinatal causes, the flu and pneumonia, which are associated with deficiencies in medical care.

Cervical cancer is the leading cause of death in women of childbearing age. In the Federal District, mortality due to this cancer decreased from 19.2 in 1990 to 15.2 in 2000; a reduction that is still insufficient, since the registered coverage rate of early detection in at-risk women is only 35 percent.

The different living and working conditions of the capital's residents are reflected in the variations in the incidence of death and diseases across administrative jurisdictions. In general, there is a direct relationship between the degree of poverty and infant, preschool, school and maternal mortality. Causes of death due to non-communicable diseases and lesions are also unequally distributed.

The health conditions and their distribution highlight two sizeable challenges that need to be faced in the coming years: (1) *To improve general health conditions*; and (2) *to diminish the inequality in health among social groups and geographic areas*.

Health Services

The restrictions in timely access to required treatment are due to several causes. The fundamental problems are, on the one hand, the fragmentation of services and on the other, prolonged lack of financing. This is reflected in the deficit and inadequate geographic distribution of care facilities, which cause lack of services in peripheral areas, where most of the city's poor population is located. Furthermore, the available hospitals reflect the demographic structure and health problems at the time they were constructed, and not the current situation.

Similarly, neither the orientation of the hospitals nor the so-called *basic package* at health centers, corresponds to the most important pathologies in the current population. The absence of a unified system is particularly serious in emergency care since it causes delays in channeling patients with serious conditions, who have an impact on the increase in mortality or disability.

The deficit of medical facilities in the metropolitan area places significant pressure on the Federal District's Ministry of Health hopsitals, particularly the general, traumatological and maternal-child areas. This situation is aggravated by the growth of the conurban population in the State of Mexico.

The deficient and unequal quality of services, which originates in the deterioration generated by insufficient financing and abandonment, are exacerbated by the presence of corruption and the diversion of limited resources.

Additional factors are the persistence of an aging institutional culture, in which service delivery is perceived as a favor and not as a citizen's right.

Inequality in access to required treatment and to the benefits of the health system is due to the fact that the patient and his or her family assume most of the cost of the illness when the patient does not belong to a Social Security Institution, which is the case for almost half of all residents of the capital.

The principal obstacle is the economic impossibility of acquiring drugs and paying the recovery quotas, since their cost exceeds the resources of the majority of the poor population. This postpones treatment and means that care, even in the public sector, can lead to a «catastrophic» expenditure for low-income families and, still worse, it can mean that they do not obtain the required treatment.

The work requirement for obtaining social security is another cause of inequality in access to health system benefits. The services are only free for beneficiaries and their families, while others have to make direct payments. Finally, it is necessary to point out the complex cultural facet of inequality in the use of services, in which lack of information, discrimination against specific groups, and citizens' low awareness of rights all play a role.

The health services situation in the Federal District presents four additional challenges: (1) *To guarantee the city's health security*; (2) *to increase timely access to required treatment*; (3) *to diminish inequality in the access to sufficient, quality services*; and (4) *to implement stable, sufficient, equitable and solidary financing mechanisms*.

III. Values and Principles

The basic conviction that sustains the health policy of the city's government is the recognition of the *intrinsic and equal value of all men and all women*. This obligates the government to respect and protect the life of each human being in the same way. The attainment of this value is the right to health as a citizen's right and accordingly, as a responsibility of the government, as guarantor of the common interest.

Within this framework, the *mission* of the Federal District's Secretariat of Health is to make the right to health protection a reality and to advance toward making free, universal and comprehensive care a reality, through a policy that constructs the means to ensure that right by strengthening public services and their solidary financing.

The *vision* of the Federal District's Health Program is the construction of a universal, equitable, anticipatory, resolute, efficient, participatory, and collective health system, where the Federal District's Ministry of Health is designated as the regulatory entity, in order to articulate all of its dependencies and coordinate the health institutions assigned to the entity.

This system requires a new service delivery model–the *model of expanded health care services*–that will employ effective, efficient service delivery, including the dimensions of promotion, prevention, or elimination of risk and restoration of threat, in order to address health and disease processes both at the individual level and at the level of the family and community. It will work to achieve this through the operation of deconcentrated regional health systems, in order to intensify actions and concentrate resources, as well as to strengthen local management, social participation and full citizenship.

Currently, the difference between the distinct health policies is not based on the diagnosis of general health problems and health inequalities, disease and death among different population groups and regions or on the limitations and weaknesses of the current health system. The difference lies in the proposals to resolve these complex problems.

Behind the alternative solutions there are, in addition to technical considerations, conceptions about: the importance of health for the full development of human beings' potential and its position relative to other priorities; and the entities responsible for ensuring the population's access to the health services it needs. In order to address these issues, the health policy of the Federal District's government established the following as its major complementary and interrelated principles:

- *Democratization of health* that signifies, on the one hand, reducing inequality in disease and death, and promoting the full development of individuals' biopsychic capabilities and potentialities for their complete social participation and, on the other hand, removing the economic, social and cultural obstacles that impede equitable access to required treatment.
- *The centrality of the public institution* that is constructed through the strengthening and expansion of public services as the only socially just and economically sustainable alternative for guaranteeing equitable and universal access to health protection.

- *Universality,* which involves extending to all, insured and uninsured, the right to protect their health and to separate it from the economic and labor situation of individuals and families.
- *The expansion of the services* offered to the uninsured population, moving initially from the basic package to comprehensive health services at the first and expanded second level.
- *Equity***,** that is to ensure equal access to existing services for those with the same health needs.
- *Solidarity,* which is realized through the fiscal financing of health and social protection policies, via different contributions according to each person's income, and which distributes the economic cost of illness across the entire population.

IV. Strategies for Confronting the Challenges

The general principles of the Federal District's health policies are applied through a set of strategies that confront the six challenges presented. The strategies are based on social values and ethical convictions that include, as part of their concrete content, the empirical experiences that have proven to be feasible, viable and sustainable solutions.

In order to implement the strategies, it is crucial to strengthen the steering role of the Secretariat of Health by adapting and expanding the regulatory roles and promoting active inter-institutional and sectoral coordination. With regard to *the inter-sectoral strategy to improve living and health conditions*, solving the basic problems of reduced income and lack of dignified, well-remunerated jobs, which have led to the impoverishment of the population, depends on the economic model of the country. Only the national government can handle this, but the city government is in a position to implement specific measures to improve the living and working conditions of the capital's residents.

The government of the Federal District promotes a *comprehensive and redistributive social policy* aimed at strengthening and creating synergies among social policies. It supports this policy with the *Progress with justice* cabinet, which groups together the secretariats of the social and economic sectors under the coordination Secretariat of social development. The policies related to health care and care for older adults is a specific component of this comprehensive social policy.

Today, almost all the developed and middle-developed countries have pension systems with universal coverage. The right to a *universal citizen's pension* means that all citizens of a given age receive a pension, whether or not they have made contributions to a pension fund. This is supported since, with few exceptions, all men and women have contributed to society, even without a formal labor relationship. It is a basic justice that society grants them certain security during their old age.

Health Sector Strategies

The complexity of the health-disease process and the current distribution of faculties among different authorities force the application of a broad policy for inter-institutional coordination, particularly with respect to the city's health security. Coordination with the federal Secretariat of Health, the national health authority and the regulatory entity of the National Health System is key. It is also necessary to develop coordination with neighboring states and federal and local level institutions.

The population's economic limitations, especially for purchasing drugs, stand out among the obstacles to accessing adequate, effective treatment. This is confirmed by evidence that the fee-for-service is a central element of exclusion from health services. Thus, the first main health strategy of the capital's government is the *free use of services*, a fundamental step toward democratizing health.

The *Free medical services and medicines program* covers uninsured families that are residents of the Federal District. The only requirements for inclusion in the program are verification of residence and lack of insurance and registration on the official list in order to receive an affiliation card. Removal of the economic barrier through free services makes it possible to attain the extension of individual services those who register. Initially, the services provided correspond to the first and expanded second level offered by the Social Security institutions in the Federal District.

In addition to democratizing access to and reducing inequality in adequate treatment, free services are a powerful instrument for increasing the effectiveness and diminishing the global cost of services; that is, in order to increase their efficiency. This is why the Program promotes and facilitates preventive, timely intervention, which makes it possible to save more expensive treatments for more advanced stages of illness and to diminish complications.

The establishment of priorities is an outstanding concern of health policies, given the high cost of certain interventions and the relative lack of resources. This dilemma is frequently resolved by reducing it to the economic efficiency of the impact measured using a certain health indicator, such as years of healthy life expectancy, instead of setting *priorities based on equity and need.*

The reduction of inequality in access until equity is achieved, that is, equal access to services for those with the same need, supposes guaranteeing the same interventions for everyone. The definition of these interventions is carried out using a comprehensive approach that is based on the clusters of health needs by age groups and sex. The establishment of priorities requires the integration of the logic of the specialists and the values and perceptions of the population that experiences the problems. The technical responsibility for priorities involves selecting the most effective interventions to address the problems and using the available resources efficiently.

The New Expanded Health Care Model (MAS)

Confronting the six big challenges in health requires the introduction of a new model of care. The *Expanded health care model* (MAS) takes into account the demographic and health characteristics of the capital's population, as well as the status of the health system, the law and health regulation. It seeks to correct the experiences of the previously applied models of care, in order to overcome fragmentation, overlapping and inefficiencies and expand access and the services provided.

This model constitutes the basis on which it is possible to generate the Federal District government's commitments to health care issues, which are: (1) To guarantee the city's health security; (2) to expand and ensure the access of the uninsured population and the population over 70 years of age to timely and adequate interventions, free services at the first and expanded second level, and drugs at the time they need them; and (3) to gradually construct a comprehensive and unique emergency system in the capital. The attributes of the model are:

It is *universal*; it addresses the health security of the entire population, gives priority to the most vulnerable groups, expands the coverage for comprehensive services at the first and second level to uninsured residents of the Federal District, and complements the protection of guaranteed health services for social security beneficiaries.

It is *comprehensive*; it places at the community's disposal a broad range of health care activities for individuals, the family and the community, with anticipatory, promotion, preventive and restorative actions.

It *resolute*; it takes care of the specific health threat using services that provide a sufficient and functional response in terms of their organizational and technical aspects, up-to-date knowledge and quality.

It has a *step-wise* order; it offers services according to levels of complexity of care, where the least complex levels are the point of entry to the system, and guarantees referral within the network of services.

It is *regionalized*; it establishes regional networks in order to organize the entrance to the system, referrals and counter-referrals, the information system and the comprehensive network of services in the city.

It is *participatory*; it involves the citizenship, through the intervention of individuals and group entities, in decision-making about their health and the interventions for positively modifying it, as well as in the evaluation of outcomes.

It has *solidarity*; it is financed with fiscal resources based on contributions that are proportional to income, in which the healthy share the cost of services with the sick.

The MAS model offers a different degree of intensity of action according to the degree of responsibility of the Federal District Government, which is defined with regard to three major groups. It has direct responsibility for the nearly *four million inhabitants that lack social security*. This population receives health security actions, including collective and individual care, through *guaranteed interventions*.

6.3.2. Presentation on Peru's Comprehensive Health Insurance Program

Although national in scope, the presentation about Peru was more specific and less detailed. It was given by Dr. Moisés Acuña, director of Peru's Comprehensive Health Insurance (SIS) program, which is offered as a Continuous national strategy.

At the end of 2003, the population of Peru was slightly over 27 million inhabitants, with a per capita income of 2,080 United States dollars. Twenty-seven percent of the total population is classified as rural and the poor popu-

lation represents 54 percent, with greater prevalence in rural areas, but greater incidence in urban areas. Peruvians in extreme poverty constitute 25 percent of the total. Only 51 percent of Peruvians have access to basic hygiene conditions (water and sewerage) and the per capita health expenditure is only 99 dollars, of which public spending defrays only one-fourth. Almost ten percent of the population experience severe risk of social exclusion in health (2.6 million), slightly over 30 percent have a high risk of exclusion (8.1 million), medium risk of exclusion affects another 30 percent (8 million), and low risk of being excluded from health care only applies to under one-third of Peruvians (8.3 million people).[41] The vast majority of those with severe and high risk of exclusion are poor (87 percent), live in rural areas (80 percent), tend to be workers in the informal sector or relatives of informal workers, are between 17 and 45 years old and have a low educational level (53 percent have elementary school).

The current governmental policy to fight poverty assumes social investment through decentralized policies that serve the poorest population. In the education sector, the application of the Plan Huascarán focuses on learning about the use of new technologies. In the labor sector, the program Working in the City and Rural Areas *(A trabajar)* is an effort to create employment for the unemployed. In the agricultural sphere, the National watershed management and social conservation program (*PRONAMACHS*) aims at improving the production and productivity of small and traditional farmers in Andean areas.

In the health sector, Comprehensive Health Insurance (SIS) is a building block in the struggle against poverty, since it concentrates its efforts on achieving greater access to health care for the poorest population. It is important to point out the complete political legitimacy of the Comprehensive Health Insurance, to the extent that it originates in the mandate of the *National Agreement*, a document signed by all political parties to guarantee the continuity and sustainability of development policies beyond the rule of one or another elected government. The thirteenth policy established by the *National Agreement* urges the "establishment of universal access to social security and health services," as indicated in the Constitution, through:

- Access to health services and provision of drugs for the entire population.

[41] PAHO/WHO Peruvian Ministry of Health.

- Improvement of the quality of health services.
- Improvement of the efficiency and effectiveness of public health expenditures.

The extension of health insurances to the entire population is a health policy priority for the Peruvian government; and the Comprehensive Health Insurance (SIS) program targets this goal. The SIS has several components and plans, organized by beneficiary population groups, which are as follows:

- Maternal and child component
  - Plan A: For children in the first four years of life.
  - Plan C: For pregnant women.
- Other components
  - Plan B: For children and adolescents from 5 to 15 years of age.
  - Plan D: For adults in emergencies.
  - Plan E: For adults in target groups.
- Additional components under development.

The Comprehensive Health Insurance (SIS) components and plans aim to increase coverage and as a result, inclusion, according to the goals presented in the following table:

Affiliation Goals 2004-2006 (thousands of people)

Plans/ benefits	2004	2005	2006
Total beneficiaries	9,749	11,500	13,333
Plan A: (0-4 years old)	2,467	2,537	2,941
Plan B: (5-15 years old)	5,198	6,131	7,109
Plan C: Pregnant mothers	569	672	779
Plan E: Adults	1,515	2,160	2,504

In 2001, health care in Peru reached slightly more than one-fifth of the country's population of 26 million (20.3 percent) through private insurance or direct payments, and almost 30 percent (29.1) through social security in health. Slightly over half (50.6 percent) of the poor population had partial or no access to health care without any type of social security.

In 2003, when the population reached 27 million, almost 23 percent (22.9) paid for care through direct payments or private insurances, and the SIS cov-

ered 27.6 percent of the population. The objectives proposed for the 2004–2006 period are to cover 7.4 percent with defined-contribution insurance as well as another 21.5 percent of the poor, uninsured population. The coverage of almost two percent (1.9) is still pending in the 2004-2006 objectives.

Between only January and September 2003, the Comprehensive Health Insurance (SIS) accomplished the affiliations shown in the following table:

Benefit plan	**Affiliations in 2003**	
A: Children up to 4 years old	2,300,584	32.96%
B: Adolescents from 5 to 17 years old	3,874,573	55.51%
C: Pregnant women	605,919	8.68%
E: Adults	198,380	2.84%
Total	6,979,456	100%

In terms of its distribution by degree of geographic concentration, almost 47 percent (46.8) of affiliates were in rural areas, in addition to 36.7 percent in urban fringe areas and 16.5 percent in urban areas

The financial sustainability of the Comprehensive Health Insurance (SIS) is, however, very fragile due to three principal causes:

- The chronic deficit of the public health budget despite growing service delivery needs.
- The financial crisis in traditional Social Security (ESSALUD), a scheme that employs contributions from employers and workers in the formal sector of the economy, due to low growth, avoidance and evasion.
- The informal character of 60 percent of the economy, which poses the challenge of establishing mechanisms to receive contributions from those who are able to pay in that sector.

These factors demand preventive measures for the immediate and long-term future, by *strengthening the social dialogue* to:

- Develop an active policy of information and sensitization for the current financing providers.
- Review the coverage procedures for social health insurances in order to gradually incorporate the entire economically active population (EAP).

- Guarantee public financing of the entire per capita insurance quotas for the poor population.
- Promote the formal organization of self-employed workers.
- Evaluate non-poor workers' ability to pay and affiliate them into social health insurance.
- Guarantee the quality and effectiveness of all public health services.
- Develop a health policy based primarily on general agreement among economic and social actors.

6.3.3. Presentation by the Honduran Social Security Institute

The presentation by Ms. Martha Rosibel Garay Flores, Director-General of social security, ministry of labor and social security, focused on the Honduran Social Security Institute (IHSS).

The IHSS is one of four social welfare entities in the country; the others are the National public employees retirement and pension institute (INJUPEMP), the National teachers pensions institute (INPREMA), and the Military pension institute (IPM). Norms for INJUPEMP, INPREMA and IPM have established worker and employer contributions, as a percentage of wages, which far surpass the ones financed by the Social security institute, as seen in the following table:

Organization	Members	Employer contribution	Employee contribution	Total
IHSS	424,427	2%	1%	3%
INJUPEMP	109,215	11%	7%	18%
INPREMA	5,595	12%	7%	19%
IPM	7,830	18%	9%	27%

The contrast is even greater between the sector of the adult population covered by the welfare organizations described above, which in 1993 approached 550,000 people, and the workers that did not have any insurance coverage, which exceeded 1,700,000, over three times larger than the covered population. Among the latter, there are two times more men than women (and the lack of coverage, as would be expected, is concentrated among 20 to 49 year olds).

These statistics contradict the doctrine-based principles of social security that the Honduran Institute strives to promote: Universal, compulsory, specialized, unified, participatory, equitable and solidary.

The Institute is an autonomous entity with its own patrimony. Its governing board includes two secretariats from the executive branch (Work and social security and Public health), three representatives of the Honduran private enterprise council, and three representatives from worker unions (CGT, CTH and CUTH).

Its illness and maternity scheme (EM) covers disability, old age and death, illness and maternity, and occupational risk. It provides health care to more than 20,000 retirees. In addition to offering attention at the three levels of care through direct medical services at its own facilities, it also provides care for a private care network and by coordinating services with the Ministry of Health. The Institute offers pharmacy, dentistry, radiology and laboratory services, and special examinations, in addition to supporting the Medical system and the company-based system. Finally, it pays subsidies for temporary disability and maternity.

The Honduran Social Security Institute (IHSS) suffered a crisis between 1994 and 1998, when it gained the reputation of being one of the country's most inefficient entities. Important legal reforms approved in mid-2001 established the following:

- Financial and administrative separation of the three benefit schemes.
- Prohibition of the transfer of funds from one scheme to another.
- Abolition of limits and establishment of criteria for modifying rates, in successive periods of no more than five years.
- Expansion of medical care coverage to boys and girls from 5 to 11 years old.
- Reduction of administrative expenditures to 30 percent of the total.
- Delivery of medical services to workers' spouses.
- Changes in the maximum wages subject to contribution.

The situation encountered by the current administration, in March 2002, presented difficulties that had to be faced immediately. The new administration therefore proposed an *institutional vision* that defines the IHSS as a modern, leading and prestigious entity, with universal coverage based on principles and values, and skilled, creative and stable human resources, which

provide comprehensive health and social security services targeted at the individual. This vision should produce a high degree of satisfaction and credibility and help to improve the quality of life of Honduran families.

The vision is used to derive an *institutional mission* that requires the IHSS to be a security entity that, through modernized organization and national coverage, guarantees people's access to services with an emphasis on quality, efficiency, effectiveness, equity and warmth, focused on the person and also of benefit to the family, in order to contribute to the overall prosperity of the country.

Both the vision and institutional mission served as the foundation for the formulation of the following specific objectives for the modernization of the Honduran Social Security Institute:

- Develop the organization's economic and financial policy.
- Expand the number of people who contribute.
- Diminish evasion.
- Design, develop and implement a centralized system for the collection of quota contributions.
- Diminish the inefficiency of payments.
- Elevate to the utmost the performance of financial investments, maintaining an acceptable level of risk.
- Develop a plan for investments in infrastructure and technology.

The *long-term strategic plan*, which would made it possible to move toward the objectives indicated, implies working, between 2002 and 2006, on the systematization of information, the improvement of the quality of medical services, the expansion of coverage, the evolution of the institutional culture, the administrative formulation of unique and integrated individual accounts, and the application of the program for developing investments. In addition, the programs highlighted as priorities are: the creation of schemes for occupational hazards, with an emphasis on prevention; maternal and child care; comprehensive care for the older adult; and care for the HIV-positive or symptomatic AIDS patient.

With restructuring under way, the current administration has already attained tangible achievements in the incorporation of new quota payers, in income and expenditure balances, in the construction of new facilities, in the procurement of new equipment, and in the incorporation of more recent

technologies. However, the most valuable advance up to 2003 is the provision of 200,000 more consultations and 4,000 more surgical interventions than in the previous period and the provision of 800,000 drug prescriptions, 94 percent of which were filled.

Of course, the Health reform program has not been alien to this progress, with 14 million dollars in support from the World Bank, for purposes of institutional modernization, financing of sub-projects and the purchase and delivery of health services; the advisory services and management of the International Labour Office (ILO), with regard to social security coverage, the tripartite social dialogue, and the preparation of the National action plan (PAN) in 2003 and its subsequent application; and finally, the technical, training and financial support of the United Nations Development Program (UNDP) and the United Nations Population Fund (UNFPA), for sexual and reproductive health issues.

6.3.4. Presentation by Bolivia

Dr. Javier Torres-Goitia Torres, adviser to the new minister of health, presented a general overview of health in Bolivia and the models of care and financing that have been implemented since 1982.

Dr. Torres-Goitia asserted that social exclusion in health cannot be analyzed using an approach that is isolated from the general social context. Access to services, financing, the per-patient cost, and the quality of service delivery represent important components that are necessary for evaluating the services related to the provision of care. It is important to recall, however, that those components on their own do not necessarily produce better health. It is therefore necessary that the health care services contribute to improving the determinants and conditions of quality of life within the framework of the comprehensive «well-being-illness» concept that emerges within the economic and social process.

Social exclusion in health in Bolivia is not a problem of the minority; it is part of the many elements of social exclusion that affects more than half of the population. Its origins date back to the colonial era, and the establishment of a feudal regime that oppressed the local indigenous population. This situation was maintained, without changes, during the first 125 years of independent republican life, dominated by creoles and mestizos who did little or nothing to change it.

The national revolution of 1952 changed the country's social structures through three principal measures: the nationalization of the mines, land and property rights reform, and universal suffrage.

These changes improved the civil and political rights of the entire Bolivian population but they did not do a great deal to diminish the situation of material poverty of indigenous inhabitants, who became owners of land parcels, but maintained the same low levels of productivity they experienced during the feudal regime.

Since the ethnic exchange has been so considerable in Bolivia, where 80 percent of the population is indigenous, the entire population can today be considered hybrid, that is, of white and indigenous ancestry. However, most of the population is rural (62 percent). They maintain their native language, do not complete primary school, maintain their old traditions and native culture, and consider themselves to be different ethnicities than the urban groups. They are, therefore, socially excluded in all aspects of their existence.

The fact that such a broad proportion of the population is excluded has a decisive influence on the country's poverty indicators. It is easy to observe that poverty is concentrated mainly in rural areas, although it is also found in the urban environment. The cities were, many years ago and still today, invaded by peasants that left their native lands because of impoverished, overworked soil. Once in the cities, and without adequate means of survival, their situation has not improved as they had hoped and instead, they have added their poverty to the urban areas.

Health indicators are general expressions of social inequity and poverty. There are significant differences in the probability of dying at two years of age, when classified by mother tongue, comparing Spanish speakers and those who speak indigenous languages. Given this difference, language does nothing less than indicate the exclusion of the population.

The same phenomenon arises with the population's access to basic services. The rural population is always at a disadvantage. The causes of death in children under 5 throughout the country clearly show the preponderance of the evils known as the diseases of poverty. This also holds for the causes of malnutrition, maternal mortality, infant mortality, etc. All of the indicators show the precarious health conditions in the country, in addition to a wide difference between rural and urban areas.

Reaction of the state

The Bolivian state has carried out a variety of efforts to confront this situation, some of which are explained below.

Capitalization. During the period in which the international trend aimed at separating the state's productive enterprises, in order to transfer them to the private sector, Bolivia preferred capitalization. The latter refers to a procedure that allows the country to maintain the property of the companies, and invites the private sector to invest the amount equal to their original value and administer them, with the obligation of sharing the earnings. It was therefore possible, in the case of Bolivia, to attract capital that otherwise would not have reached the country. The companies found themselves in a position to double their productive capacity. Unfortunately, and due to the inefficiency of the control and regulation systems, it was not possible for the country to receive the expected earnings when they should have been distributed. Currently, Bolivia is trying to recover the revenues that correspond to the government from the capitalized companies. The conflict that recently took place and that forced the change of government is closely related to the population's general grievance toward the capitalized companies, mainly those that exploit gas, so that they share more of their profits with the country.

The decentralization law and in particular the popular participation law have made it possible to deliver greater resources and power to rural areas through the constitution of the 311 municipalities that make up the country. The 20 percent of the general national treasury's income that the municipalities currently receive is distributed equitably in relation to the number of inhabitants of each municipality, either rural or urban. Before the application of that law, the treasury contribution stood at only 10 percent for the municipalities that were departmental capitals, and the distribution concentrated on large cities, completely excluding rural areas.

The municipalities' current economic and administrative situation and their participation in the management and operation of health and education services have permitted the creation of a new public insurance system that differs completely from the Bismarckian social security model. In this model, individual contributions are made indirectly by the municipality, which obtains the funds by reserving a percentage of the amount it receives from the treasury. Coverage is universal and without direct payments by the beneficiary.

The country has experienced several stages, beginning with the first mother-child insurance system, applied in 1996, which provided medical care only for pregnancies, childbirths and the prevalent pathologies in children under five, and followed by the inclusion of additional services within the basic insurance formula. The country currently has a universal mother-child insurance system.

This insurance system was initially sustained by the 7 percent co-participation that the municipalities receive from the national treasury; the next year, the percentage rose to 8 percent, and continued rising successively until reaching the goal of 10 percent. The system ensures the coverage of all pregnancy pathologies, whether or not they are related to the pregnancy itself, as well as all of the health care that is necessary during the six months following childbirth. It also guarantees comprehensive health care for all children below five years of age. In both cases, the necessary drugs, hospitalization and all diagnostic resources are ensured without patient contribution. For the first time, traditional medicine has been included in health care since the demand of the communities made it necessary.

Even more important than the insurance system itself is the establishment of a new administrative model in the country, which represents the state's great efforts on behalf of the poorest population, who have not had the opportunity to access medical care. The model does not allow the government to evade its corresponding responsibilities, but does involve municipalities in the administration of services. It is important to recall that the structures and infrastructure of those services were already in the hands of the municipalities. The model adds popular participation to this shared administration, based on the excellent experiences that the country gained with the recovery of democracy in 1982, after a long period of military dictatorships. The administration is now shared and has popular participation.

This modality of administration has been made comprehensive through the "Extension" (*EXTENSA*) program, which is the extension of services to rural areas through the "health brigades." These brigades of health professionals go to the most remote health centers in rural areas with scattered populations to provide basic health care, refer patients to the closest health centers and above all, promote preventive health care. Recently, as a result of this experience, it was concluded that it is indispensable that the brigades expand their functions and also take charge of the collaboration with peasants in order to improve their agricultural production through assistance

with irrigation systems, improvement of seeds and other issues related to social and economic development.

Two important steps foundations are in place within EXTENSA: it is a multi-sectoral effort; and its promotion by the health sector is an additional component for improving the population's health. Progress cannot be achieved, however, if it is not recognized that the poor peasants are responsible for their own development. The objective is not to provide the services as a gift, but to promote the conviction that the peasants themselves assume the defense of their rights to health, understanding health not only as the absence of disease but as improvement in the socioeconomic conditions that define quality of life. This cannot be improved with paternalistic initiatives but with efforts by the people themselves, facilitated by the state. It is expected that through such efforts, the excluded population would be liberated from the conditions that sustain their exclusion.

Political Dispersion

All changes face difficulties. These arise due to the precarious political culture of a population, which results from the conditions of poverty and exclusion in which most of the population lives. Today, no political party in the country can attain the support of the absolute majority of the population. It is sufficient to look at the current political spectrum, based on the information from the 2002 elections.

The concept of democracy, which has recently begun to penetrate the awareness of the urban population, is expressed differently in indigenous cultures, which represent the majority of the country. This difference provokes a sort of cultural tension that is difficult to resolve. The possibility that the confrontation of different trends in thinking and action will result in dialectic national synthesis, characterized by new forms of participatory democracy that can ensure the progress of the country, is closer. Both political capacity and economic resources are necessary for preventing the confrontation of these divergent interests from causing violence and destruction and resulting in a worse situation of underdevelopment. They are also crucial to ensuring that such changes occur peacefully. The country does not have, however, these resources.

The ILO-PAHO initiative for extending social protection in health, with the invaluable support of the Swedish Agency for International Development (SIDA), is of great benefit for a country that is making substantial efforts to

achieve the inclusion of its sizeable excluded population and to offer health care services to the traditionally forgotten rural areas with scattered populations. The universal mother-child insurance system is only a first effort that requires greater economic support in order to expand and to be capable of providing comprehensive medical service.

The social struggle that has taken place during the last several weeks and that resulted in the change of government constitutes evidence of the profound contradictions in the country that have not been resolved. Within the health sector, the magnitude of the problems and the new authorities' understanding of these problems, make it possible to predict that the nucleus of the sector's current policies will remain unaltered. My presence throughout, as a parent, as an adviser to the previous minister of health, and as a representative of Dr. Fernando Antezana, the current minister of health, demonstrates the continuity of policy, something that is very important for the health of the Bolivian population.

6.3.5. Presentation by Suriname

Dr. Harold R. Ramdhani, representative of the ministry of health of Suriname, presented the advances in the extension of social protection in health in his country.

Although Suriname's health system and financial sources portray quite a complex panorama, with a profusion of public and private actors for financing, administration, services delivery and regulation of the system, this does not translate into a desirable state of health for the country's population.

Even though life expectancy at birth has reached 70 years old, the indicators related to health conditions are troubling. Examples include perinatal death, at 38 per 1,000 live births, and maternal mortality, at 153 per 100,000 births. It is true that immunization coverage stands at 70 to 75 percent of the at-risk population, but the detection of cervical cancer is below 27 percent. In terms of HIV/AIDS prevalence, it is estimated at 64 people of every 100,000.

In fact, the per capita health expenditure of 180 United States dollars per year, higher than the regional average, is considerably lower than spending in Argentina (620 dollars) or Costa Rica (230 dollars), although it surpasses countries like Jamaica (115 dollars) or the Dominican Republic (105 dollars).

The health sector is financed through a significant contribution by the government, which represents 44 percent of the total, and valuable donor

contributions, which account for 14 percent of what is applied to the sector. Other contributors include companies, who cover 22 percent of costs. This leaves family economies facing 20 percent of health costs, even though 32 percent of the population is not protected by public insurances, work-based social security, or private insurance.

Although the government of Suriname's goal is *that the entire population has equitable and universal access to health care*, the lack of protection for 32 percent is a clear demonstration of social exclusion. Accordingly, the extension of protection to those who are currently excluded is the objective of the Program for the extension of social protection in health.

The Program has as its components:

1. Expansion of health insurance.
2. Improvement of occupational health.
3. Establishment of a partnership for health between the public and private sectors.

The first component entails strengthening the capacity for the preparation and application of policies for the extension of health insurances in the country, to those who are currently excluded from health services. This should have as results:

- Greater national awareness of the need for health insurance.
- A strategy that aims at general health insurance.
- Legislation on health insurance.
- Trained staff and improvement of skills.

A national health insurance system in Suriname should have as its goal to *improve the health status of all of the country's citizens, guaranteeing everyone with coverage through a basic minimum package*.

As can be anticipated, a national health system will have the following elements:

- Target groups.
- Compulsory insurance.
- Compulsory acceptance.
- Costs and premiums.
- Minimum benefits package.

- Service providers.

The second component, the improvement of occupational health, aims to strengthen the capacity for the preparation and application of policies, through the effective validity of legislation related to occupational health. Results of this should be:

- The improvement of labor legislation.
- Laws on occupational accidents.

The third component, the establishment of a partnership for health between the public and private sectors in order to expand the foundation for health sector reform, should result in:

- Greater national awareness of the need for health insurance.
- A network of public and private institutions.
- A training program and a group of trained professionals.

The social partnership needed for the program's implementation includes

- National partners: Ministry of health, State health insurance fund, Suriname trade and industry association, Association of Surinamese manufacturers, Chamber of Commerce, Unions.
- International partners: HVBG (Germany), ILO and others.

The following activities and contributions are required for the launch of the program:

- Awareness campaigns.
- Technical assistance.
- Training and workshops.
- Start-up funds.
- Partnerships with international agencies.

The estimated program costs are 1,924,000 Euros, where the greatest disbursement should be used for the expansion of health insurance (1,209,000), followed by occupational health (380,000), the partnership between the public and private sectors (230,000) and general costs (105,000).

6.3.6. Research on Social Protection in Health in the Americas, Presentation by the IDRC-Canada

Presented by Dr. Roberto Bazzani, principal program specialist, Office for Latin America and the Caribbean at the IDRC-Canada. The presentation explains the current efforts by IDRC-Canada, through a joint initiative with PAHO, to link research to decision-making in the extension of social protection in health.

The background data for the investigation date back to 2000, when PAHO and IDRC conducted a joint review of research on health sector reforms. In 2001, in conjunction with the Summit of the Americas, IDRC and PAHO organized the *Forum on health sector reform in the Americas: Improving the research policy interface,* from 18 to 20 April in Montreal, in order to identify strategies to better integrate research into the development of health policies. This meeting initiated the first phase of research on social protection in health, between 2002 and 2003, which attempts to build and link research on health services and health policy in the Region.

The activities carried out make it possible to provide reflections on the contributions of research on health sector reforms in Latin America and the Caribbean to policy development.[41] A few conclusions from the joint review of the effort are:

- Research has not been integrated into the development of health policies.
- Research on health policies and systems is quite weak.
- While during the 1990s, the majority of health system reforms in Latin America and the Caribbean emphasized the issues of financing and efficiency, there is a growing consensus on *the need to improve equitable access to quality health services* (health exclusion is considered to be evidence of the failure in most countries during the last decade).
- *It is necessary to improve the governance in the sector*: The policy development process–including research on policies–should be opened to wider and more genuine public participation.

[42] Key documents on the issue are "Research on Health Sector Reforms in Latin America and the Caribbean: Contribution to Policymaking," PAHO/WHO/IDRC; and "La investigación sobre políticas de reforma del sector salud en América Latina: iniciativas regionales y estado del arte," Celia Almeida.

These preliminary conclusions are the basis of the following recommendations for action:

- Promote more and better research to help re-direct reforms toward principles of equitable access and quality services.
- Invest in activities to save the discontinuity between research and policies, increasing the interaction between key interested parties in health sector reform.
- At the same time, it is necessary to strengthen the essential public health functions in order to promote, simultaneously, the strengthening of civil society, full citizenship and social participation in health.
- Increase the exchange of experiences and best practices among the countries of the hemisphere.

The previous steps need to be implemented while refining the research scope, from the broad framework of promoting equitable access to quality health services, to the following question that should be resolved by the research: What is the impact (expected or given) of innovative strategies for the expansion of social protection in health? Thus, the Joint IDRC-PAHO Program on research for social protection in health proposes the following objectives:

- Generate knowledge about policies and strategies to improve social protection in health.
- Implement various requests for proposals on social protection in health, launched by sub-regional networks, workshops and regional exchanges.
- Support studies on social protection in health that are designed and carried out jointly by researchers and those responsible for policies.

The Program is carried out in two phases:

The *first phase*, implemented in 2003, consisted of the distribution of requests for proposals from the Southern Cone, Andean Region, Central American and Caribbean sub-regional networks.

Financing made it possible for researchers and those responsible for policies to work together in order to (a) carry out pilot studies, or baselines, to

define and develop the research problem; and (b) design a research project. A total of nine projects were financed, at 15,000 dollars each.

The *second phase*, to be carried out between 2004 and 2005, consists of the implementation of the projects that were successful in the first phase. The criteria that defined success were the achievement of interaction between research and policies, the soundness of the research problem defined, and the relevance and quality of the research proposal.

The following projects were financed during the first phase:

1. Argentina: A public maternal and child insurance system in the Province of Buenos Aires.
2. Brazil: Challenges to social protection in health in the context of inequities in the Brazilian Amazon.
3. Chile: Adapting primary health care service in the context of sweeping reform of the health system.
4. Colombia: Improving the effectiveness of social protection policies for populations displaced by violence in Bogotá.
5. Colombia: Unemployed workers between 1993 and 2003: Alternative designs for guaranteeing the sustainability of health insurance.
6. Ecuador: The extension of social protection in health to rural areas with scattered populations.
7. Jamaica: Evaluation of rates paid by service users for preventive care services and their impact on users' demand for and management of health.
8. Mexico: Social protection in health «for and with» the older persons in the Mexican Social Security Institute.
9. Nicaragua: The prevention of occupational diseases among the companies that reported the greatest numbers of cases in 2002.

The implementation experience during the first phase of the program leads to the following conclusions:

- Early interaction results in greater success, both in terms of reports on the process and the presentation of joint research proposals.
- There has been an excellent balance between the authority of the researchers and that of those responsible for policies.

- The potential issues and contributions are clearly relevant to the expansion of social protection in health.
- The quality of the proposals has improved thanks to the interactive two-stage process and the role of the networks.

Naturally, the objectives for the second stage of the program have a broader scope:

- Support the development of a critical mass of medium-scale experiences that integrate research with the development, application, monitoring and/or evaluation of social protection in health in Latin America and the Caribbean.
- Improve governance in health and social equity through the extension of social protection in health, in response to key challenges in policies and to opportunities.
- Systematize, synthesize and compare both the process and content, as well as the results, of the various projects.
- Support the active dissemination and exchange of experiences and results.
- Contribute to the body of knowledge and experiences related to the links between research and policy development on health and health systems, with special consideration of equity in health.

Thus far, the management and development of the research program for social protection in health has made it possible to learn lessons that we summarize in the following manner:

- Diverse agencies have emphasized the use of research results and the link between research and policies for several years.
- However, donors and agencies also share the responsibility for applying the appropriate strategies and mechanisms to link research to policies.
- The support for academic studies and the inclusion of final workshops with all of the interested and relevant parties (at the end of the research process) has been insufficient *unless*:
  - *It involves the key partners from the outset* and supports *continuous interaction processes,*

- which can lead us to... *successful experiences related to the use of research in the development and application of policies*
- and thus generate examples that are the basis for...*improving governance, equity and social protection in health*.

6.4. Possibilities for Cooperation

The second day of sessions was devoted to examining the international partners' perspectives about participation and to a dialogue with them as donors and/or current or potential members

Thus, the round table of donors/members had the following objectives

- Learn about the reactions of the partners and potential donors, their policies and activities in the field of social protection, in general and in health, and obtain specific information on their interest in participating in the overall, or in specific aspects of the, initiative.
- Discuss and agree on the steps to follow, in the short and medium term, in terms of their probable participation.
- Gather their observations and contributions to the proposal submitted by PAHO and ILO.

Below are summaries of the donors' interventions:

SIDA

1. The organization intends to invest in both social development and economic development at the same time.
2. It has three different cooperation initiatives related to health and poverty reduction.
3. The Swedish agency recommends that each potential donor complete its own appraisal of the capacity of the International Labour Organization (ILO) and the Pan American Health Organization (PAHO) to carry out the program. However, Sweden has familiarized itself with the initiative since the beginning, while supporting the studies conducted by PAHO in several countries of the Region.
4. Currently (2003), Sweden has an agreement with PAHO and expects to sign another one in 2004, including the executive support

of a young professional staff member and other Swedish experts. With regard to the Permanent Secretariat that was suggested, Sweden will analyze the costs and the need for a Secretariat and if one is needed, it can be included in the agreement to be signed.

5. It is also probable that it will consider other agreements with the ILO.
6. Sweden is supporting programs at the global, regional and national levels; however, its principal contribution is made through bilateral cooperation in 50 countries. It would please Sweden a great deal to forge a link across the three levels.

The Netherlands

Unfortunately, the criteria for grant support have changed in the last several weeks. Therefore, they are not in a position to assume commitments during the meeting.

Finland

The initiative conforms with Finnish policy on this issue. Finland has Guatemala and Nicaragua as priority countries in the Americas. Finland's principal policy is poverty reduction and sustainable development in health and education. In principle, it accepts the initiative. However, it is necessary for them to review the proposal and study the budget in greater detail.

Germany

The insurance sector, the Federation of insurance and accident entities, offers the ILO technical expertise on insurance issues.

GTZ

This organization believes that the matter under discussion is very important. They are particularly interested in two related issues: Social security in health and social protection in general.

They added that they have experiences in social security with the World Health Organization (WHO) in Kenya. Similarly, with respect to expanding social security coverage, they have worked in Venezuela, advising the Ministry of territorial planning. Furthermore, in Chile they are collaborating with technical assistance and training in the creation of the solidarity fund.

Other practical experiences that GTZ has had or currently has are:

- Methods for the design and management of social security, which they are evaluating in Peru, Bolivia, El Salvador and Paraguay (the available documents have been submitted).
- For the benefit of the Initiative, it is worthwhile to point out that GTZ has a master's degree project in Health Economics in Latin America with ECLAC. Likewise, they are working with ECLAC on the development of a Social Security Workshop; the document that is currently being prepared will be delivered subsequently.
- GTZ is cooperating in the organization of a conference in Brasilia, in order to study the relationships between the HIV/AIDS pandemic and the role of social protection.
- However, it is necessary to recall that GTZ, due to the decision of the German government, is concluding its work on health issues in Latin America; however, one way of continuing to collaborate in the Region can be through the social protection program.
- The priority for Germany is governance and the fight against poverty, although it is also clear to Germany that social protection is a very important issue for developing strategic partnerships.
- Germany wants to support systems that guarantee the protection of vulnerable groups through health and to this end, offers:
  - The transfer of experiences from Africa to Latin America, based on the current experience in the implementation of a center for the protection of vulnerable sectors of the population in West Africa.
  - The instrument for the evaluation of insurance systems. This has been used in Bolivia, with PAHO collaboration, and also in Paraguay, in order to learn about the social situation related to pensions and health in that country. This program operates in close collaboration with insurance systems.

United States - USAID

The U.S. Agency for International Development (USAID) is a decentralized organization: the country missions make decisions about their operations; and Headquarters acts as a central intelligence network.

USAID has various professional teams for education; health, nutrition and population; rural development; environment; democratic governance, etc.

Within health, there are other specialized groups such as HIV/AIDS, immunization, health reform and others. With PAHO, USAID has programs such as health sector reform.

USAID is undergoing a reorganization process and the regional health team has been reduced from seven to four staff members. Upcoming steps include the reorganization of the health priorities and it is most likely that the new activities will begin in October 2004. Some of those activities are:

- Social participation.
- Improve the competencies of technical personnel.

In short, it is possible that USAID will get involved in the Social Protection Initiative, but not before October 2004. Meanwhile, it will be necessary for both ILO and PAHO to continually coordinate with USAID.

Suriname Asks

Suriname would like to know if there is cooperation from the Inter-American Development Bank (IDB). It seems that the only relationship with international organizations that provide development loans is through the shared agenda that PAHO coordinates with the IDB and the World Bank, specifically with respect to the National Health Accounts component.

IDRC/Canada

For Canada, governance is the priority in the Region. They hope to work through programs such as the strengthening of health systems. They are also interested in civil protection, social involvement and the development of research topics, with the expectation that research be institutionalized in the health sector.

With regard to the ILO and PAHO initiative, Canada would like to have more information, including the results of the Essential Public Health Functions. Canada suggests that greater emphasis on social protection is needed in order to make it compatible with governance.

In the long run, the atmosphere that the meeting facilitates is excellent for creating partnerships with other agencies. They look forward to a second meeting in order to redefine the scope of the initiative.

During the upcoming months, the IDRC management committee will study the proposal.

Spain~AECI

The Spanish strategy for cooperation in Health for 2001 to 2004 includes three lines of action:

- Struggle against poverty.
- Health.
- Environment.

In health, it will support human resources education, the strengthening of the health sector and technical assistance.

Spanish Cooperation has offices in all Latin American countries, which act in the form of a network for monitoring the projects it supports. There are, in addition, Joint Commissions that collect the list of projects for which the countries seek support.

With regard to institution building, the health and work sectors are priorities. AECI has training centers in Santa Cruz de la Sierra, Bolivia; Cartagena, Colombia; and Antigua, Guatemala, which can be used for training courses.

In terms of multilateral assistance, AECI acts by signing framework agreements like the ones they have with the ILO and PAHO (PAC). With the ILO, they have agreements to support the ministries of labor and work plans have been developed. For example, they have a project on the elimination of child labor and the promotion of juvenile work. In Central America, they have a social security project, which will be maintained bilaterally with each country.

Each year, they sign the Program of Joint Actions (PAC) with PAHO, which has several components, including: Service improvement, HIV/AIDS, measles elimination, training courses, among others. Since the proposal is aligned with Spanish cooperation policies, the possibility of including issues related to social protection in the next agreement can be examined. Furthermore, technical personnel can be provided through the AECI centers. With regard to the relationship between AECI and the governments of Latin America, the issue can be used to strengthen the level of action and the capacity of the governments.

It is also recommended that the issue be included in the declarations of the Ibero-American Summits and that it be discussed at subsequent Summits. AECI also recommends reviewing the project proposal to improve its formulation, including the logic framework, indicators, monitoring and administra-

tive reviews. AECI is ready to participate in the proposed directive committee for the project.

PAHO Observations Regarding the Interventions

- It is necessary to lay the foundations for partnerships and strengthen the coordination with the actions that are already in progress.
- It is necessary to establish a health services network in order to guarantee success in expanding social protection in health.
- It is essential to develop social dialogue processes.
- It is indispensable to develop coordination processes at the country level, and it is necessary to continue affirming this concept.
- At the regional level, it is necessary for us to continue to work on the development of documents, policies and partnerships. We have to discuss and identify the technical support of experts to review the project. The central idea is to create more intense partnerships.
- It is beneficial for the initiative to organize joint events, with the participation of donor countries and other international organizations. It is necessary to organize joint missions to countries and selected events and to carry out joint training activities.
- It is necessary to develop new methodologies with the members.
- The need to carry out meetings for the coordination of donors on specific subjects is clear.

ILO Observations Regarding the Interventions

- The partnerships among the bilateral efforts and the international organizations to join efforts should be improved.
- We have the same desires and objectives; social protection is a key factor in development.
- Social participation goes beyond the political sphere.
- Certain definitions of social security, social protection and other concepts need to be reviewed and better defined.

Future Steps:

1. ILO and PAHO will work on the final version of the document, taking into account the suggestions made at this meeting.

2. It is highly probable that another meeting will be necessary to review the document and make practical decisions. ILO and PAHO will make a specific proposal.
3. ILO and PAHO will prepare a meeting report that will be sent as soon as possible.
4. Expanding the partnership with other partners and entities that were not at the meeting is recommended.
5. It is important to advance.
6. PAHO will carry out the monitoring:
    a. The PAHO Strategic Health Development Area should formulate with the ILO-Geneva a regional and country-level work plan for the cooperation plans for the extension of social protection in health initiative in 2004.
    b. The PAHO Strategic Health Development Area should monitor with the ILO (Lima and Geneva) the possibility that PAHO participates in the meeting of the sub-regional country office of the ILO, in January 2004 in Lima.