PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

152nd SESSION OF THE EXECUTIVE COMMITTEE

Washington, D.C., USA, 17-21 June 2013

Provisional Agenda Item 4.3

CE152/12, Rev. 1 (Eng.)
6 May 2013
ORIGINAL: SPANISH

SOCIAL PROTECTION IN HEALTH

(Concept Paper)

Introduction

1. The purpose of this document is to present a conceptual proposal to the Governing Bodies of the Pan American Health Organization (PAHO) and report on the situation of social protection in health in the Region. In addition, the Governing Bodies are asked to consider a series of recommendations for implementing technical cooperation activities at the regional and country level. The result of an extensive consultation process, this paper includes numerous contributions from the groups of experts consulted in 2012 and part of 2013.

2. Subsequent to the joint initiative of the International Labour Organization (ILO) and PAHO in 2002 (Resolution CSP26.R19 [2002]), PAHO has undertaken numerous activities aimed at extending social protection and reducing levels of exclusion in health in the Region. This is reflected in Strategic Objective 14 of PAHO's Strategic Plan 2008-2012 (*1*).

3. In recent years, significant progress has been made in social protection in health in the Region of the Americas. Nonetheless, it is necessary to continue to develop policies and programs that contribute to the construction of integrated, equitable, solidarity-based health systems centered on people's specific needs and legitimate demands.

Background

4. While an historical link can be observed in the origins of social protection and social security—such as the introduction of health insurance systems in 19th century Europe—today they are recognized as two distinct concepts. Social security refers specifically to social protection benefits derived from a solidarity-based approach of

pooling employment-related contributions. In some countries, however, the terms social security and social protection are used interchangeably.

5. From the historic perspective, in the first half of the 20th century, the countries of the Americas initially adopted an employment-based approach to protection in social security and health. In the latter half of the century, social protection—known as welfare—emerged mainly in response to social emergencies Since the beginning of this century, social protection measures have been premised mainly on the active involvement of the State interested in social development through the practical application of citizen entitlements (*2*). This contemporary approach to social protection emphasizes assurances of universal social rights that require state intervention, among them the right to the highest possible level of health (*3*).

6. In 2002, a joint initiative of the Pan American Health Organization and the International Labor Organization established the initiative of extension of social protection in health and urged Member States to scale up their activities in this area (*4*).

7. In 2005, the 58th World Health Assembly urged Member States to "include a method of prepayment of financial contributions for health care, with a view to sharing risk among the population and avoiding catastrophic health-care expenditure and impoverishment of individuals as a result of seeking care" (*5*).

8. The *Social Protection Floor for a Fair and Inclusive Globalization* initiative, which the ILO and WHO launched in 2009, adopts the concept of social protection floors to promote "an integrated set of social policies designed to guarantee income security and access to essential social services for all, paying particular attention to vulnerable groups and protecting and empowering people across the life cycle" (*6*).

9. During its 67th Session, the United Nations General Assembly invited the Member States to recognize the importance of universal health coverage in national health systems, especially through primary health care and social protection mechanisms, including the minimum levels of social protection determined at the national level.[1] It also recognized that improving social protection towards universal coverage is an investment in people that empowers them to adjust to changes in the economy and the labour market and helps support a transition to a more sustainable, inclusive and equitable economy.[2]

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[1] United Nations. Press Release: Adopting Consensus Text, General Assembly Encourages Member States to Plan, Pursue Transition of National Health Care Systems towards Universal Coverage [Internet]. Sixty-seventh General Assembly; 2012 Dec 12; New York (NY): UN; 2012 (document GA/11326, 53rd Plenary Meeting). Available from: http://www.un.org/News/Press/docs//2012/ga11326.doc.htm.

[2] Ibid, United Nations.

Current Situation

Scope of Social Protection in Health

10. Social protection is a broad concept that encompasses all measures taken by a State to achieve the universalization of priority services and benefits, understood as housing, work, education, pensions, and health.

11. Social protection in health is "society's guarantee, through the different public authorities, that individuals or groups of individuals can meet their needs and demands in health through adequate access to services of the health system or any of the existing health subsystems in the country, regardless of their ability to pay" (*7*).

12. Social protection is the frame of reference for ensuring access to health care, in the understanding that society has enshrined health as a right or merit good. Social protection in health is premised on the notion of health as a basic human right and a requirement for human and social development. Social protection policies should be guided by universality in order to ensure effective access, as well as timeliness and quality of health care services. While universal in nature, however, these policies must include specific responses to special needs, be sensitive to the gender focus, and proactively address the needs of ethnic and cultural minorities. Social protection in health policies in a given society are consolidated progressively, effectively expanding the common good in the health field.

13. A certain degree of social consensus is required to sustain a social protection approach to public health policy. These consensus-building processes, in turn, reinforce social cohesion around democratic values, as society takes ownership of the concept of the right to health and the roles of the State and the public in ensuring the enjoyment of these basic rights (*8*).

14. Furthermore, a social protection in health approach is consistent with the goal of universal coverage understood as the ability of all citizens to access the health care services they need without incurring individual financial hardship, through pooled, social solidarity-based financing systems. Universal coverage should be the objective of policies for social protection in health.

15. From a strategic perspective, social protection in health is implemented through primary health care based on its three core values: the right to the highest attainable level of health, equity, and solidarity, and in keeping with its principles.

Health Systems and Social Protection in Health in the Americas and the Caribbean

16. While social protection in health still poses a challenge for the Region, significant progress has been made (*9*). Developments have included expanded coverage, changes in

financing mechanisms, and improved models for health care delivery and services management and integration.

17. Over the past decade, Brazil has extended access to health services through its Family Health Program (PSF), which currently reaches 95% of its municipalities. The PSF provides services to more than 101 million people through a model that assigns first level health care teams responsibility for a specific, identified population. Canada's universal coverage policies serve as an example of social protection in health. After launching its Universal Access with Explicit Guaranteed services (AUGE) system in 2005, Chile progressively increased the number of condition-response pairs served by the system, which are selected based on epidemiological criteria and effectiveness, according to the available evidence. Colombia's General System of Social Security in Health, with its two main regimens—contributory and subsidized—, has maintained high coverage levels; in 2010, only 4.3% of the country's total population was not covered by the system. The coverage plans of both regimens were standardized in 2008, pursuant to a ruling handed down by the Constitutional Court of Colombia. By 2009, El Salvador had eliminated all types of point-of-service payments in the public health network, increased public spending on health, and designed a health care model based on Community Health Teams (ECOS). In recent years, the United States has promoted an intense political and social debate on social protection in health and the mechanisms for implementing it. For its part, Mexico, which launched its public health insurance program (Seguro Popular) in 2008, had extended coverage of its health care services to over 46 million people in 2011 by gradually expanding its services package. Since the creation of the National Integrated Health System in 2007, Uruguay has increased effective coverage levels by progressively extending its services package to new beneficiaries according to criteria. By 2011, the country had extended coverage to over 50% of the population (*9*).

18. Yet despite significant progress made by countries, segmentation and fragmentation persist in the Region's health systems and services. In most countries, health systems offer specific sets of services with different financing schemes: some subsectors use contributory mechanisms, while others use noncontributory mechanisms and operate as relatively independent channels for accessing health care.

Social Protection in Health and Programs to Reduce and Eradicate Extreme Poverty

19. In the past 15 years, the countries of the Region have designed poverty-reduction programs based mainly on conditional cash transfers to the most vulnerable population sectors of the population. In most cases, conditionality relates to school attendance and health check-ups.

20. According to ECLAC, 18 countries of the Region have active conditional cash transfer programs in place. These programs benefit over 25 million families or around 113 million people, equivalent to approximately 19% of the population of Latin America

and the Caribbean. Their costs account for around 0.4% of the Region's GDP. The health component of conditional cash transfer programs includes a basic services package created specifically for the beneficiaries or else channels the latter into the health services available to the general population. As for the conditionality attached to these health benefits, cash transfer programs are intended as an incentive to encourage demand for health services, although some establish rigorous monitoring and penalty systems, including suspension of the benefit.

Proposal

21. In light of the foregoing, and with a view to guiding technical cooperation efforts, the Pan American Health Organization has developed the following lines of action in relation to social protection in health in the Region of the Americas:

a) Develop a policy framework and strategy that creates a path to follow in addressing social protection in health in the Region.

b) Create an evaluation framework that contributes to measuring progress and developments in social protection in health.

c) Introduce the concept of social protection in health as a cornerstone of health system governance and transformation processes, through its incorporation into health plans and policies.

d) Facilitate the development of more efficient, solidarity-based financing mechanisms that ensure the sustainability of access to quality health services delivered in a timely manner and at the appropriate level.

e) Review and improve the health components of social protection programs, especially conditional cash transfer programs, and facilitate their integration into the development of social protection in health.

f) Promote social participation and raise awareness about the rights and duties associated with individual, family, and community health in society as a whole and among health system workers

Intervention of the Executive Committee

22. The Executive Committee is invited to review the information presented herein and to consider approving the proposed resolution included in Annex A.

Annexes

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PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

152nd SESSION OF THE EXECUTIVE COMMITTEE

Washington, D.C., USA, 17 - 21 June 2013

CE152/12, Rev. 1 (Eng.)
ORIGINAL: SPANISH
Annex A

PROPOSED RESOLUTION

SOCIAL PROTECTION IN HEALTH

THE 152nd SESSION OF THE EXECUTIVE COMMITTEE

Having reviewed the concept paper *Social Protection in Health* (Document CE152/12),

RESOLVES:

To recommend that the 52nd Directing Council adopt a resolution written in the following terms:

SOCIAL PROTECTION IN HEALTH

THE 52nd DIRECTING COUNCIL,

Having reviewed the concept paper *Social Protection in Health* (Document CD52/__);

Considering Resolution CSP26.R19 (2002), which supports the extension of social protection as a line of work in PAHO's technical cooperation activities;

Taking into account that the United Nations General Assembly, at its 67th session, recognized that improving social protection towards universal coverage is an investment in people that empowers them to adjust to changes in the economy and the labor market;

Recognizing that while the countries of the Region have made significant progress in reforming their health systems, segmentation and fragmentation persist, which creates inequity;

Aware of the need to continue to develop policies and programs focused on the construction of more integrated, equitable and solidarity-based health systems that support the enjoyment of the right to health,

RESOLVES:

1. To take note of the concept paper on *Social Protection in Health*.

2. To urge the Member States to:

a) incorporate the concept of social protection in health as a cornerstone of health system governance and reform processes;

b) establish legal frameworks that set out measures related to social protection in health;

c) strengthen the health components of social protection programs, especially conditional cash transfer programs;

d) promote social participation and raise awareness about the rights and duties associated with individual, family, and community health in society as a whole and all workers in the health system.

3. To request that the Director:

a) strengthen technical cooperation for social protection in health as a priority work area on the path toward universal coverage;

b) promote the systematic production of information and evidence on the gaps and progress in social protection in health observed in the countries of the Region;

c) disseminate and promote good practices for social protection in health;

d) strengthen inter-institutional efforts in relation to social protection;

e) develop a policy and strategy based on this concept paper that sets a course for addressing social protection in health in the Region.

PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
WORLD HEALTH ORGANIZATION

CE152/12, Rev. 1 (Eng.)
Annex B

Report on the Financial and Administrative Implications of the Proposed Resolution for PASB

1. Agenda Item:

Item 4.3: Social Protection in Health (Concept Paper)

2. Linkage to Program and Budget 2012-2013:

(a) Strategic Objective:

SO14: To extend social protection through fair, adequate and sustainable financing

(b) Expected Result: RER14.4

Member States supported through technical cooperation to reduce social exclusion, extend social protection in health, strengthen public and social insurance, and improve programs and strategies to expand coverage.

3. Financial implications:

(a) Total estimated cost for implementation over the lifecycle of the resolution (estimated to the nearest US$ 10,000, including staff and activities):

Since this is a concept paper, the draft resolution does not specify a lifecycle. Nonetheless, the activities recommended in the draft resolution should be carried out in the next biennium.

(b) Estimated cost for the biennium 2014-2015 (estimated to the nearest US$ 10,000, including staff and activities):

$300,000

(c) Of the estimated cost noted in (*b*), what can be subsumed under existing programmed activities?

There are no programmed activities that dovetail specifically with the proposals set out in the paper.

4. Administrative implications:

(a) Indicate the levels of the Organization at which the work will be undertaken:

Central level: approximately half of the budget.

Country office level: approximately half of the budget.

(b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile):

Additional full-time staff is not required.

(c) Time frames (indicate broad time frames for the implementation and evaluation):

End of the biennium 2014-2015.

PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
WORLD HEALTH ORGANIZATION

CE152/12, Rev. 1 (Eng.)
Annex C

ANALYTICAL FORM TO LINK AGENDA ITEM WITH ORGANIZATIONAL MANDATES

1. Agenda item: 4.3: Social Protection in Health (Concept Paper)

2. Responsible unit: Health Systems based on Primary Health Care Area (HSS)

3. Preparing officer: Julio Siede

4. List of collaborating centers and national institutions linked to this agenda item:

No collaborating centers are linked to this item.

5. Link between Agenda item and Health Agenda for the Americas 2008-2017:

In its Statement of Intent, the Health Agenda for the Americas stresses that "The Governments reiterate their commitment to the vision of a region that is healthier and more equitable with regard to health, addresses health determinants, and shows improved access to individual and collective health goods and services – a region where each individual, family, and community has the opportunity to develop to its greatest potential."

Universality and accessibility are among the core values identified for cooperation activities. Social protection is a conceptual framework for policy-making aimed at universality and improved access to health care services. The paper presented herein is directly related to point c of the Agenda: *Increasing social protection and access to quality health services*. This issue is directly related to the political and social dialogue on human development taking place in the Region. The Health Agenda for the Americas notes that most of the countries of the Region have established the right to universal health and the enjoyment of this right "highlights the need to develop insurance systems that reduce the financial burden on families, protecting them from the risk of falling into poverty due to catastrophic out-of-pocket expenditures, and to try to guarantee the population a set of health services" through national dialogue processes. In order to effectively extend social protection, the countries will have to strengthen access, financial protection, solidarity-based financing, and respect for the rights and dignity of patients. Primary health care is the strategy of choice to progress toward universal and fair access to health care.

6. Link between Agenda item and Strategic Plan 2008-2012:

Several of the strategic objectives in the 2008-2012 Plan (in particular SO 3, 4, 5, 10 and 13) are directly linked to social protection in health policies; SO14 refers directly to extending this protection through fair, adequate, and sustainable financing by focusing efforts on aspects related to health system financing. Although the concept of social protection encompasses financial protection, in the health field it is also necessary to include guarantees of effective and timely access to services of adequate quality. A more comprehensive and integrated approach to

social protection explicitly framed within the objective of universal health care coverage can serve as the basis for the strategic plan beyond 2012.

7. Best practices in this area and examples from countries within the Region of the Americas:

It is possible to identify specific social protection actions related to health system reforms that have been taken in the Region, although each country has followed its own rhythm and methods. By way of example:

- Brazil: Family Health Program (PSF).
- Chile: Universal Access with Explicit Guarantees (AUGE) system.
- Colombia: General System of Social Security in Health, with its two main contributory and subsidized regimens.
- El Salvador: Increased public spending in health and implementation of a care model based on Community Health Teams (ECOS).
- Guyana: Development of its own set of services guaranteed through the Package of Publicly Guaranteed Health Services.
- Mexico: Public health insurance (Seguro Popular), with progressive expansion of its services package.
- Uruguay: creation of the National Integrated Health System.
- Canada: a model for the Region in policy-making for social protection in health.
- The United States of America: efforts to promote inclusion of social protection in health policies on its social and political agenda.

8. Financial implications of this Agenda item:

a) Estimated total cost of applying the resolution:

Since this is a concept paper, the draft resolution does not specify a lifecycle. Nonetheless, the activities recommended in the draft resolution should continue after the current biennium

b) Estimated cost for the biennium 2014-2015 (estimated to the nearest US $10,000, including staff and activities):

$300,000

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