PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

130th SESSION OF THE EXECUTIVE COMMITTEE

Washington, D.C., USA, 24-28 June 2002

Provisional Agenda Item 4.7

CE130/14 (Eng.)
10 May 2002
ORIGINAL: SPANISH

EXTENSION OF SOCIAL PROTECTION IN HEALTH: JOINT INITIATIVE OF THE PAN AMERICAN HEALTH ORGANIZATION AND THE INTERNATIONAL LABOUR ORGANIZATION

The extension of social protection in health (ESPH) is a powerful public policy tool designed principally to combat exclusion in health. Although the concept of exclusion in health is multicausal and, hence, difficult to measure, it is estimated that some 100 million people in Latin America and the Caribbean, or 20% of the total population, are not covered by the existing health systems and 240 million are not protected by social security or private health insurance programs.

ESPH can be defined as society's guarantee, through the different public authorities, that individuals or groups of individuals can meet their health needs through adequate access to the health services of the system or those of any of the existing health subsystems in the country, regardless of their ability to pay. Three conditions must be met for the ESPH to serve as a guarantee in practice: (a) access to the services, (b) financial security of the family, and (c) dignity in care.

Analysis of the experiences to date indicates that the interventions most effective in combating exclusion are multiple in nature and must be articulated with the criteria of financial sustainability, social insurance, and a coherent model of care.

The International Labour Organization (ILO) and the Pan American Health Organization (PAHO) have been working together on this issue since 1999. To this end, they signed a Memorandum of Understanding that led to collaboration to conduct studies and define concepts and methodologies in this area, in addition to the holding of a regional consultation on this issue.

The ILO and PAHO have made a commitment to undertaking a regional initiative in the coming years to promote and establish the systematic analysis and diagnosis of exclusion in health, identify solutions, and take appropriate action to minimize the problem in the countries of the Region and strengthen the institutional capacity of the Member States to extend social protection in health.

The proposal includes a regional component to develop methodologies and instruments for training and research and promote exchanges and recommendations on best practice. At the country level, it considers the entire institutional strengthening mechanism established to help defend this cause, promote social dialogue, and support implementation of the national plans that emerge from the process.

An essential component of the proposal is the launching of national dialogues to determine the magnitude of the problem in each country, study possible solutions, and implement them through a national program. The main characteristics of this initiative also are presented in this document, with the dual purpose of informing the Committee and obtaining its comments and suggestions.

CONTENTS

Page

1. Introduction

Despite the health system reforms undertaken in the past 15 years, a significant portion of the population of the Latin American and Caribbean countries is currently excluded from the mechanisms for social protection against the risk and consequences of illness. However, exclusion from social protection in health does not usually figure in the list of priorities of the national and international social policy agenda. As a rule, the extension of social protection in health is not explicitly part of the health agendas of the countries of the Region. Health sector reforms have not concentrated on this issue either, other than indirectly and in a fragmented fashion.

The strategies to eliminate exclusion in health constitute a set of public interventions commonly known as the "extension of social protection in health" (ESPH). ESPH consists not only of strategies to include the excluded, but others designed to improve access to health care for people who are beneficiaries of some social protection system but have incomplete or inadequate coverage.

The effort to combat exclusion in health through ESPH is framed within the mandates of the International Labour Organization (ILO) and PAHO/WHO. 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/WHO, 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 a priority for securing universal access to health services in order to achieve the goal of Health for All.

Responding to the need to extend social protection in health in the Americas, in 1999, the ILO and PAHO launched a regional initiative to support the efforts of the Member States in this area. That year, the two organizations signed a Memorandum of Understanding, establishing a framework for cooperation to develop and execute a joint initiative aimed at promoting the extension of social protection in health in Latin America and the Caribbean.

In November 1999, the ILO with the support of PAHO organized a tripartite regional meeting of governments, workers, and employees in Mexico City, on the "Extension of Social Protection for Health Care to Unprotected People in Latin America and the Caribbean." The objective of the meeting, which brought together key stakeholders, was to recognize the need to support countries in their efforts to extend social protection for health care to the informal sector and excluded populations.

Based on the recommendations issued by that meeting, the ILO and PAHO made a commitment to execute a regional initiative to promote and establish the systematic analysis and diagnosis of exclusion in health, the identification of solutions, and the execution of relevant actions to minimize the problem in the countries of the Region and strengthen the institutional capacity of the Member States to extend social protection in health.

2. Concept of Extending Social Protection in Health

The strategies for social protection in health aimed at eliminating exclusion in health are public interventions designed to guarantee access by citizens to decent and effective health care and reduce the negative economic and social impact of adverse personal situations, such as illness or unemployment, or general events, such as natural disasters, on the population or most vulnerable groups in society. In this context, social protection in health can be defined as society's guarantee, through the public authorities, that individuals or groups of individuals can meet their health needs and demands through adequate access to the health services of the system or of any of the existing health subsystems in the country, regardless of their ability to pay. Social groups that cannot take advantage of this guarantee constitute "the excluded" in health.

ESPH involves a group of mechanisms designed to guarantee access by the population to health protection and health care through the allocation of resources of diverse origin, and not only the measures taken directly by the State to ensure health care through the public delivery of services. 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 can be granted at the discretion of the authorities.

Three conditions must be met for ESPH to function as a guarantee in practice:

- *Access to services:* that is, that the necessary services exist for the delivery of health care and that people have physical and economic access to them;

- *Financial security of the family:* that the financing of health services does not threaten the economic stability of families or the development of their members;

- *Dignity in care:* that quality health care is provided in an environment that respects the racial and cultural background of the users and their economic situation, determined through a process of social dialogue.

These three conditions must be met, and the absence of one or more of them leads to some form of exclusion in health.

Poverty is one of the most important determinants of exclusion in health. Although poverty and exclusion are not identical, they overlap. In the absence of social protection systems, not only does poverty impede access to costly benefits, but the poor live and work in environments that expose them to greater risk of disease and death. These risks are directly related, *inter alia*, to less and lower quality food, the absence of adequate housing, overcrowding, and a scarcity of suitable recreational spaces. Communicable diseases are found largely among the poor. Diseases and injuries have both direct costs (prevention, cure, and treatment) and opportunity costs (days of lost work or school), which depend on the duration and severity of the disability and often accentuate poverty.

Poverty has even more devastating effects on people: it undermines the "basic functional capacities of individuals," erodes the quality of life, shortens life expectancy, and triggers the "vicious circle of exclusion": poor family, interrupted education, unemployment, and poverty. This circle interacts with other vicious circles, such as the lack of access to basic services, disease, problems in the workplace or dropping out of school; or, criminal behavior, subsequent inability to find work, recidivism, and marginality. All of this accentuates and perpetuates exclusion in health.

ESPH is a powerful weapon in the struggle against poverty and the development of greater social cohesion in the Member States. Not only is it a social policy line that is manifestly inclusive, but it translates into a social wage that provides for social security in health and improves living conditions. Increasing access to health services leads to better health for family members, permitting them to opt for productive development that will enable them get out of poverty.

3. Exclusion in Health: Its Magnitude and the Difficulties in Measuring It

Measuring exclusion in health is a complex process, since it involves a multicausal problem. There are a variety of ways to measure exclusion, but none of them describes the phenomenon in all its dimensions. Exclusion can be measured directly through population surveys, but these tend to ignore part of the excluded population (i.e., the rural population or the poor, or people who live in remote areas) or do not adequately study the various dimensions of the issue. Because of this, indirect measurements based on the causes of exclusion are customarily used. The table below presents some of the indicators used for measuring exclusion in health.

Table 1 Levels of Exclusion from Social Protection in Health in Latin America and the Caribbean

Indicator	Reference Year	Estimate of excluded (%)	Excluded Population (Thousands)
Coverage			
Population without health insurance	1995	46.0	217,779
Access			
Economic	1989 – 1994	27.0	121,245
Geographic	1995	22.0	107,013
Infrastructure			
Shortage of hospital beds	1996	55.3	267,537
Health Care Processes			
Births not attended by trained personnel	1996	17.0	83,558

Source: Based on levels of exclusion from social protection in health in Latin America and the Caribbean, ILO/PAHO, Mexico, 1999.

These figures are global estimates and are useful for indicating the magnitude of exclusion in the Region as a whole. However, they do not reveal the enormous differences among and within the countries. Furthermore, the data yield no information on exclusion for reasons of culture, employment, or factors associated with the quality of care, sex, or age. Nevertheless, according to some of these measurements, an estimated 20% to 25% of the total population of the Region (some 100 to 150 million people) are excluded from health care.

4. Extending Social Protection in Health and the Health Systems

Service delivery is where the population's health needs are met. However, the health service delivery network is only the most visible part of a complex assortment of institutions, regulations, and values connected with the steering role, financing, and insurance that significantly influence the operations of the health service delivery network. In other words, the organization of the health systems is not neutral with respect to exclusion in health but, rather, is a determinant of it.

Four factors are generally associated with the low response capacity of the systems:

(a) **Segmentation,** or the coexistence of subsystems with different financing, membership, and benefits regimes—usually compartmentalized—covering different population segments and usually determined by their income level or ability to pay. Segmentation is usually manifested in a deficient and underutilized public health system used by the poor and the indigent, and a client-oriented private sector with greater resources, concentrated in the wealthier segments of the

population. Between these two extremes are the social security systems, which cover workers in the formal sector and their dependents. This type of organization generates and accentuates inequalities in access to health services and their financing.

(b) **Fragmentation,** or the existence of numerous entities that are not integrated into a single subsystem. This situation elevates transaction costs in the system as a whole and makes it difficult to guarantee equivalent conditions of care for the people served by the different subsystems. The combination of segmentation and fragmentation often leads to the double and triple coverage within the same family unit, with the consequent inefficiency in resource allocation.

(c) **The predominance of partial or full direct payment** at the point of care or in drug expenditures, which means that receiving the necessary health care depends partially or fully on each individual's ability to pay. This type of financing generates a high degree of inequity in the system and a high proportion of out-of-pocket expenditures, indicative of a lack of protection.

(d) **Weak or unexercised steering role,** which impedes the establishment of fair rules of the game in the relationship between users and service providers and is marked by a failure to explicitly define the basic packages of benefits guaranteed under the different insurance schemes.

5. Causes of Exclusion

Although the current laws in most of the countries of the Region give all citizens the right to some type of health coverage, this is far from the case in practice. Around 218 million people in Latin America and the Caribbean lack protection against the risks of illness, while around 107 million have no access to the health services because of geography.

Exclusion in health has its origins in three dimensions.

5.1 *The First Dimension is Access*

These problems be of three types:

- Lack of access to the benefits related to the supply of public goods (such as drinking water or vaccines);
- Lack of access to personal health care services in general, or to certain services in particular;

- Lack of access to a system that provides protection against the economic and social risks of illness.

In all these cases, the exclusion tends to be related to one or all of the following causes:

- Lack of adequate infrastructure, either for personal or population-based health care delivery (that is, lack of health facilities, and lack of functional coverage of public health programs);

- The existence of barriers that impede access to health care, even with adequate infrastructure. These barriers can be geographic (transportation, roads), economic (inability to finance the health care), and cultural (inappropriate models of care). They can be determined by the hiring regime or employment situation (unemployment, informal nature of the employment), by the structure of the systems (highly segmented systems show a higher degree of exclusion), or by a lack of models of care based on an intercultural approach.

5.2 *The Second Dimension is Financing*

Problems in this are related in particular to the lack of social financing mechanisms. No family should contribute more than an acceptable percentage of its total income (a percentage that prevents impoverishment or indigence) in order to secure access to the health services. In addition to the ethical considerations that sustain the concept of social financing, the need for it is based on the evidence that the cost of services poses an obstacle to access (especially for the very poor), represents a high opportunity cost for maintaining or increasing family well-being (particularly with respect to avoiding or overcoming poverty), and is highly regressive (that is, in the absence of an adequate coverage system, the poorest households are forced to pay more out-of-pocket expenses than households that are not as poor).

5.3 *The Third Dimension is Dignity in Care*

This refers to aspects that are related neither to the utilization nor the financing of the services and are considered elementary for fulfilling the legitimate aspirations of the members of a society. It includes respect for the traditions and cultures of social groups that are ethnically distinct from those of the majority population. This factor also leads to the phenomenon of self-exclusion; that is, people who have the right to services and access to them but prefer not to use them for this reason. This dimension of exclusion is linked to factors such as the patients' language, beliefs, or perception of callous or disrespectful treatment.

6. Strategies for Extending Social Protection in Health

6.1 *Review of Past Interventions*

The available information shows that in Latin America and the Caribbean, strategies specifically aimed at reducing exclusion in health have not been implemented as widely as necessary. The 1970s and first half of the 1980s witnessed a growth in policies and programs to expand health service coverage, especially to marginalized rural areas. Much of this impetus derived from the Primary Health Care Strategy, formulated at the Meeting of Alma-Ata in 1978. The policies deployed in most of the countries over the past 15 to 20 years have been geared to cost containment and the reduction of health expenditure—the result of financial and budget constraints stemming from their economic crises. All in all, the work has focused more on certain targeting tasks and efforts to boost supply, rather than the steady creation of publicly guaranteed health insurance.

Nevertheless, the interventions that have been implemented that in some way have helped to reduce exclusion can be grouped into several categories:

6.1.1 *Establishment of Special Social Security Regimes without a Contributions Scheme*

Several countries have established such systems, which are designed to meet the needs of special population groups (mothers, the elderly), productive sectors (sugarcane and coffee growers), or specific priority areas designated by the countries (maternal and child care). These activities are successful in the short term and effectively include the groups that they target. Their main difficulty lies in their lack of sustainability, since they are generally financed with extrabudgetary resources (such as loans from the international financing institutions) and are not adequately integrated with other sectoral activities. Once the financial cooperation comes to an end, they are usually abandoned or watered down because of the failure to allocate regular budgetary resources for the future.

6.1.2 *Voluntary, Government-subsidized Insurance Schemes*

These enable some excluded groups to obtain coverage from a social security system without meeting all the requirements for subscribership. In this regard, they break with one of the characteristics of exclusion from the social security systems. This modality solves the problem of exclusion to the extent that the public authority is willing to continue financing the process. When the delivery of services to this group differs from that of the regular social security regimes, this modality becomes inequitable and can be perceived as such by beneficiaries.

6.1.3 *Limited Expansion of the Supply of Services*

This involves providing specific services to certain targeted population groups. A wide range of experiences in the Hemisphere indicate that this modality can help bring to the health services a population that was excluded for a variety of reasons and that it can be successful in the short term. The main disadvantages of this type of strategy are the potential lack of financial sustainability and the lack of consistency with the other services provided. At the same time, these interventions tend to be implemented with little consultation; thus, they may not reflect the real or perceived health care needs of the population in question.

6.1.4 *Community Systems of Social Protection*

The main characteristic of these systems is their direct management by potential users. In the Americas, these experiences usually refer to communities with such high levels of exclusion that they have no other alternative, given the absence of mechanisms for social protection in health. For these systems to be successful, they must be adequately integrated with the other public systems, from which they tend to purchase services. Another problem is the impact of costly diseases (AIDS, for example), which can rapidly exhaust financial reserves. The successful cases observed in the Region reflect situations in which good articulation has been achieved between these systems and the public services and different sources of financing have been obtained while respecting community participation in the decision-making process.

6.1.5 *Gradual Development of Unified Systems*

These tend to combine a public subsystem, which the majority of the population uses exclusively, with a supplementary private subsystem (private health insurance) that permits simultaneous access to the services of the public system. This modality combines various sources of funding (general taxes from the three levels of government, special taxes, and premiums). The main constraints are associated with the lack of resources and the guaranteed access to the most complex levels of health care, which generate the need for integrated networks of services at the regional and microregional level. One example of this modality is the Unified Health System of Brazil.

6.2 *Proposed Strategies*

An initial conclusion that can be drawn from the experiences described is that reducing exclusion in health requires an approach that will permit a mix of several intervention modalities. Joint efforts are needed to address the issues of the steering role,

financing, insurance, and health service delivery, so that the actions taken in each of these areas are consistent and mutually reinforcing.

With regard to the steering role, the challenge lies in putting the issue of extending social protection in health at the center of the government policy agenda and involving all relevant actors in the efforts to combat exclusion in health. Here, it is fundamental to include the extension of social protection in health under the essential public health function of Evaluation and Promotion of Equitable Access to Necessary Health Services. Periodic monitoring and evaluation of the performance of this function can help sustain efforts to reduce exclusion.

In the area of **financing**, the challenge lies in collectively organizing the various sources of financing to meet the health needs of the population within the framework of equity. Specifically, it is essential to guarantee sustainable social financing of both personal and population-based health services. Although this strategy must be designed within the macroeconomic and social policy framework of each country, publicly regulated, unified funds with social control and accountability, financed by taxes, insurance premiums, and other sources and utilizing equity as the criterion for allocating these funds seem to promote financial sustainability, efficient management, and the reduction of social exclusion in health.

In the area of **health insurance**, the challenge lies in striking a reasonable balance between the compulsory insurance schemes with public or social financing and those with private financing. Specifically, it consists of avoiding the transaction costs and risks of inequity stemming from the segmented, highly fragmented, and poorly regulated schemes that prevail today in many countries of the Region.

The evidence seems to suggest that a public insurer that employs the criteria of solidarity, efficiency, transparency, and accountability in its operations and has a relevant/dominant position in its area of insurance is a powerful factor for putting order in the insurance market and reducing the risk of exclusion. Unified mechanisms for affiliation with the system and good information systems on the profile of the beneficiary and nonbeneficiary populations of the different subsystems have a similar effect.

In a number of countries, the utilization of a guaranteed, publicly financed package of benefits, based on the epidemiological patterns and priorities of the country and periodically updated, is proving a useful tool for increasing legal security, extending coverage, and contributing to more efficient resource allocation. The more unified and integrated its content, the greater the impact, regardless of whether the insurer is a public or a private entity. In mixed insurance systems, the public authorities face the challenge of orienting the competition among insurers toward extending the guaranteed package of

benefits to populations that still lack coverage, or toward offering benefits not included in it (supplementary benefits).

It is especially important to mention community health insurance, plans organized by small groups of people to pool risks. These organizations predominate in contexts in which traditional insurance schemes have not been effective. The predominant source of financing is a mix of different types of voluntary contributions and public or external subsidies, both national and international. The delivery of services can be contracted out to public or private providers. The challenge in this case is to promote the financial sustainability of these organizations and contribute to coordination between them and the existing formal insurance and health service delivery systems.

In the area of **service delivery**, the challenge lies in reorienting the model of care and introducing adequate incentives to induce intermediate and final providers to act in a way that will reduce or eliminate exclusion.

As to the model of care, special priority should be given to strategies designed to: improve access to the health services (for example, reorienting the services through the application of health promotion criteria and strengthening the primary care strategy); guarantee the continuity of care between the different levels and subsystems of the health system; and increase the demand for services among populations at greater risk of exclusion (for example, strengthening users' capacity to recognize and exercise their right to health care). With regard to incentives, payment mechanisms should be introduced for intermediate and final providers who do more to help reduce exclusion (for example, public subsidies to health facilities that provide care to excluded groups) and avoid practices that can promote it (for example, direct out-of-pocket payments or public subsidies to patients covered by private insurance). Introducing appropriate incentives should ensure that the management model for health facilities and services is consistent with the content of the guaranteed package of benefits.

6.3 *Political Economy of the ESPH*

Advancing these strategies requires recognition of the legitimate interests of different groups of stakeholders in the process and analysis of how these groups can influence the strategies to combat exclusion.

Stakeholders tend to be located in sectors that are not related solely to health (for example, finance, social policy, labor and employment, education, industry, etc.). This means that, from the very outset, the emphasis should be on both the intersectoral nature of the analysis and dialogue in the design of response strategies.

In order to discover the interests of the people affected and advance with the strategies, it will be necessary to create the conditions and dynamics that will lead to a social dialogue that will encourage stakeholders to make appropriate the proposal and facilitate its implementation over time.

In fact, because of their potential articulating effects and impact on productivity, employment, and the quality of life of citizens, combating exclusion and promoting the extension of social protection in health should be understood as a long-term sustained effort and considered one of the most important of State policies. This effort should be reviewed periodically, generate successive plans of action with specific goals, and be accountable to the highest political levels in the countries.

7. Joint Response of the ILO and PAHO to Assist the Member States in Extending Social Protection in Health

The ILO and PAHO believe that an innovative approach is needed to address the issue of extending social protection in health. Given the complementarity of their mandates, they have envisioned potentially significant synergies based on joint action to support country efforts to extend social protection in health in the Americas. To this end, they have been engaged in joint efforts since 1999, producing four regional studies: a determination of the magnitude of exclusion in health, a comparative analysis of policies governing social protection in health, an analysis of regional experiences with micro health insurance schemes, and the characterization of out-of-pocket expenditures in health. Furthermore, in December 1999 they convened a tripartite meeting of governments, workers, and employers on extending social protection in health to excluded groups and drew up a joint initiative for the next five years, which is summarized below.

7.1 *Goal*

To contribute to greater well-being for a significant sector of the population of the Americas by extending social protection in health to excluded groups. To accomplish this, it will be necessary to promote policies, reforms, and mechanisms that socially guarantee access to health care, with adequate financial protection for families and dignity in care for their members.

7.2 *Purpose*

To extend social protection in health, understood as guaranteed access to priority health services with adequate financial protection and dignity in care, as defined through a social dialogue in each country.

7.3 *Expected Results*

7.3.1 *At the Country Level*

- Greater knowledge of the problem of exclusion, its dimensions, and potential solutions;
- Greater social awareness of the importance of ESPH;
- Effective social and political dialogue established on ESPH;
- Technical cooperation mechanisms established to support the execution of ESPH.

7.3.2 *Between Countries*

- Lessons and experiences shared, as well as cooperation among the countries of the Region;
- Effective methods and mechanisms for establishing, evaluating, and implementing policies to extend social protection in health in selected countries of the Americas developed, tested, and validated;
- Support for activities among countries.

7.4 *Proposed Strategy*

For an initiative of this type to be successful, it must be fully appropriated by the participating countries. The role of the government and social partners is critical. The joint action of the ILO and PAHO is geared to strengthening the institutional capacity of the countries to:

- Promote EPSS, publicizing it, and explaining why it is necessary, in addition to proposing potential instruments for achieving it;
- Identify the causes and magnitude of exclusion from social protection in health and solutions for combating the problem at the country level, and create the necessary links with the different stakeholders and local organizations;
- Establish a baseline on the situation of exclusion in health;
- Analyze the policies deployed up to now and their impact on exclusion in health;
- Create the capacity to address the issue at the national and subnational levels;
- Establish links with multilateral and bilateral agencies, foundations, etc;

- Establish a clearinghouse on best practice and knowledge;
- Develop methodologies and instruments to support decision-makers in the execution of policies to extend social protection in health.

The cost of executing the total additional technical and financial support required for this initiative exceeds the capacity of the two sponsoring organizations. A major effort to mobilize resources and defend the cause is envisioned to expand the group of sponsors from the outset. The ILO and PAHO/WHO believe that the only way to tackle the problem is to create links among stakeholders and establish a rigorous, effective social and political dialogue. The potential partners would include other members of the international system, multilateral organizations, and bilateral technical cooperation agencies.

7.5 *Main Activities*

7.5.1 *Country Activities*

Support the development of national strategies to combat exclusion in health, identifying its causes, magnitude, and possible solutions in the participating country. Development of the strategy would include the identification of local initiatives—current or past—to extend social protection in health, with a view to evaluating their potential as mechanisms for extension.

During the preparation of each national strategy, the initiative will support government efforts to organize a social policy and a process of social dialogue at the national level with relevant actors, as necessary. This process will culminate in the preparation of a Plan of Action for ESPH.

During the execution of the Plan of Action, technical cooperation can be provided for any concrete activity or for technical supervision and general support.

7.5.2 *Regional Activities*

The regional activities complement the country activities. The experiences from the various studies and country processes will be summarized to permit the sharing of experiences and the production of general conclusions. Furthermore, research relevant to all the countries (such as better understanding of the barriers to establishing health insurance, incentives for obtaining such insurance, the determinants of demand, the impact of the different subsystems on financial protection, etc.) will be conducted from a regional perspective.

The establishment of a clearinghouse on best practice and knowledge, as well as the monitoring and overall evaluation of the initiative and the lessons learned, will be an important focus of the regional action. The regional level will also be responsible for advocacy, communication, education, and information activities related to problems and needs, as well as the means for addressing them.

A compendium of the instruments and methodologies designed will also be produced to help decision-makers extend social protection in health. The tools can be any instrument considered necessary, whether new or already developed by the ILO, PAHO, the two agencies jointly, or any other agency working in this field.

7.6 *Budget*

The ILO and PAHO have financed the majority of the aforementioned activities of the initiative. This financing includes consultants and staff time, as well as operating expenditures, for a total of approximately US$ 800,000 in the last three years. The two organizations will continue to provide this support, because the issue is central to their work. However, they will redouble efforts to mobilize other extrabudgetary resources in the amount of $25 million for the five-year work period.

The ILO and PAHO expect to make a major commitment to the initiative, especially its regional and coordination aspects. This commitment is estimated to be on the order of $5 million in terms of staff time (in the countries and at Headquarters) and support activities. This will make it possible to use the resources from partners almost exclusively for the substantive regional activities and country interventions. Thus, additional resources are needed to cover roughly half the regional budget and the majority of the national activities. It is anticipated that these funds will come from a variety of institutions and other stakeholders. This budget does not include the counterpart contribution from the countries.

8. Action by the Executive Committee

The present document seeks to summarize for the Executive Committee the problem of exclusion in health, the current thinking on extending social protection in health, and the joint PAHO/ILO initiative to assist the countries in implementing this social policy line.

It has already benefited from the input of the Subcommittee on Planning and Programming. Similarly, the orientation provided by the Executive Committee will be used to guide future ILO and PAHO activities in this area and to open the dialogue with the Member States. This process, which will involve other multilateral and bilateral actors as well as different social groups, will seek to activate mechanisms in each country that will lead to a reduction in the magnitude of exclusion in health and, hence, advance toward the achievement of health for all.