Towards decent work:
Social protection in health
for all workers and their families

Strategies and
Tools against
Social Exclusion
and Poverty

The ILO global program STEP

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STEP global program
ILO Social Security Policy and Development Branch
4, route des Morillons
CH-1211 Geneva 22 - Switzerland
Tel.: (+41 22) 799 65 44
Fax: (+41 22) 799 66 44
E-mail: step@ilo.org
Internet: www.ilo.org/step

Towards decent work: Social protection in health for all workers and their families

Conceptual framework for the extension of social protection in health

WORKING PAPER

International Labour Office

First published 2002

ILO

Towards decent work: Social protection in health for all workers and their families.
Conceptual framework for the extension of social protection in health

Geneva, International Labour Office, 2002

ISBN 92-2-312491-3

The first version of this document was published in Spanish:
Hacia un trabajo decente: Una protección social en salud para todos los trabajadores y sus familias.
Marco conceptual del programa STEP en material de extension de la protección social en salud
(ISBN 92-2-312491-3), Geneva, 2001

This publication can be obtained free of charge from:

STEP global program
ILO Social Security Policy and Development Branch
4, route des Morillons
CH-1211 Geneva 22 - Switzerland
Tel.: (+41 22) 799 6544
Fax: (+41 22) 799 6644
E-mail: step@ilo.org
http://www.ilo.org/step/publs

Printed in Turin

Acknowledgments

This document was prepared by a team lead by Cristian Baeza. Contributors included Pedro Crocco, Marco Núñez, and Michael Shaffer. Fernando Montenegro also provided significant review and comments on the English translation of the framework. Assane Diop is the Executive Director for the ILO Social Protection Sector and Emmanuel Reynaud is the Chief of its Social Security Policy and Development Branch; Christian Jacquier is the STEP Global Coordinator. The writing team would like to thank Christian Jacquier, Philippe Marcadent, Carmen Solorio, Evy Messell, Christine Bockstal, Francesca Moneti, James Cercone, Marisol Concha, Rubén Cano, Diego Capurro and Denis Arends for their contributions to and comments on previous versions of this framework. In addition, this document was enriched by technical discussions on health care systems and financing between the authors and Alex Preker, Philippe Musgrove, Joseph Kutzin, Christopher Murray, Daniel Lopez Acuña, Jack Langenbrunner, April Harding, and Melitta Jakab. We thank them for their contributions.

Contents

I. Introduction

The International Labour Organization considers social protection a key element in the promotion of decent work around the world and the extension of social protection to the excluded a key priority in its agenda. Furthermore, at its 89th Session in June 2001, the International Labour Conference established that policies and initiatives to bring social security to those not effectively covered by existing systems are of the highest priority (ILO, 2001).

In 1998, the International Labour Office (ILO) established the Strategies and Tools against Social Exclusion and Poverty (STEP) program to work against social exclusion. The STEP program promotes the extension of social protection in health and social inclusion. The STEP program has implemented more than forty projects in thirty-five countries in Africa, Asia, Eastern Europe and Latin America. The STEP program is part of ILO's Social Protection Sector and contributes to the ILO's global objective of ensuring appropriate social protection for all workers and their families.

This document introduces the STEP program's conceptual framework for the extension of social protection in health to those excluded. We hope this document will contribute to internal ILO technical discussions on exclusion from social protection in health. In addition, we hope this report will promote policy and social dialog between governments and social partners committed to combating exclusion from social protection in health at country and international levels. It should be noted that this document does not necessarily reflect the official position of the ILO. However, the authors believe it can contribute to the development of an operational definition of social protection in health within the context of the promotion of decent work.

This document is organized in three chapters. Chapter I presents the goals of social protection in health and the need for a socially Guaranteed Health Services Plan as a key element in combating exclusion. Chapter II examines the potential causes of exclusion from social protection in health. This includes problems of the demand and supply of health services, determinants of inclusion in health financing, and the organizational and institutional contexts, which enable well-designed systems to succeed in providing social protection in health. Finally, Chapter III briefly reviews the implications of the proposed framework for combating exclusion from social protection in health.

The first version of this framework was published in Spanish in 2001.

II. Social protection in health: Exclusion and inclusion

It is tempting to limit the definition of those excluded from social protection in health to workers not participating in a formal system of social security for their health needs. Indeed, in many countries, the lack of participation in a formal scheme of social insurance traditionally has been the main criterion used to identify workers excluded from social protection in health. However, is formal participation the most meaningful way to define inclusion? Rather, should inclusion be defined as the achievement of appropriate access to health services under financial and other societally-acceptable conditions? In other words, when examining causes of exclusion of workers from social protection in health, our concept of social protection cannot focus solely on the existence of and participation in specific organizational arrangements. Rather, the focus must be on achieving the ultimate goals of the system.

This conceptual framework proposes that the most important element in defining inclusion is the achievement of the goals of social protection in health for workers and their families through the provision of health services by financial, institutional and organizational arrangements best suited to the national and sub-national context in which they will operate. Thus, the mere fact that a worker and family participates in or is covered by a formal social security program does not necessarily ensure their inclusion in a system of social protection in health. Nor does the absence of such participation necessarily define their exclusion. The challenge for policymakers is to evaluate whether the financial, institutional and organizational arrangements for access to health services actually provide effective social protection in health and are as efficient as possible in the context of local circumstances.

Therefore, inclusion or exclusion should not be defined by the affiliation of workers and their families to a specific organization or scheme with particular financial or organizational arrangements. Social protection in health should be defined by the actual achievement of the ultimate goals of social protection in health for their population. In the light of this, it is of key importance to clearly define and agree on the goals of social protection in health.

A. The goals of social protection in health

The ILO defines social protection as "the protection which society provides for its members through a series of public measures:

- to offset the absence or substantial reduction of income from work resulting from various contingencies (notably sickness, maternity, employment injury, unemployment, invalidity, old age and death of the breadwinner);
- to provide people with health care; and
- to provide benefits for families with children".[1]

Applying this definition of social protection to the health system implies that its main goals are at least twofold. First, the goal of social protection in health is to prevent, treat, and rehabilitate the health of workers and their families by ensuring the utilization of needed and effective health services. Second, to ensure financial protection for families through a health-financing system based on the principle of solidarity.

[1] ILO: World Labour Report 2000. Income security and social protection in a changing world (Geneva, 2000).

In this conceptual framework, financial protection means that no family or household should contribute any more than a reasonable proportion of their income to finance a system of social protection in health and/or specific health services. In this sense, the definition of financial protection implies the necessity of protecting a household's income in order to prevent it from falling into or remaining in poverty, as a result of excessive contributions to the financing of their social protection in health. Although the proposed approach does not explicitly focus on the achievement of a higher level of distributive equity, the framework's focus on financial protection and solidarity may, in fact, result in greater distributive equity.

Protecting health and ensuring financial protection for workers and their families are closely related. Health status is directly related to household income because the assurance of an individual's health is a prerequisite for his or her productivity at work. Following from that, healthy workers typically enjoy longer lives and spare their households the devastating economic impact of the premature death of an income earner. At the same time, health care financing mechanisms have a direct impact not only on household income but also on access to appropriate health care services. In situations where the income earner of a household becomes disabled or dies and the family is not covered by an efficient system of social protection in health, one option the household has to maintain their economic status is for other members of the family to fill the loss by increasing their workload. The household can also reduce their consumption. In either case, the present and future welfare of the family will suffer because the family lacks social protection for their health needs and will reduce consumption of other goods and services essential for their creating and maintaining the human capital and welfare of the family. This lack of protection can lead a family into poverty and indigence (World Bank, 1997, 2001).

A long, healthy life has intrinsic value for society and is a goal of human development in itself; therefore, promoting the health of society transcends its value in contributing to economic growth. Ensuring the health of workers and their families is desirable not only on the basis that it contributes to economic growth, but it is an intrinsic objective of human development. This is reflected in the international community consensus on the importance of protecting and promoting health through mandates, agreements, conventions, and international cooperation initiatives. Also, improved health leads to economic growth. Proof of this relationship is demonstrated by the positive correlation found between health indicators and productivity as described in international comparative studies (Barro, 1997). Improving the health status of workers improves productivity through decreasing absenteeism due to illness and because workers have longer, active and more productive lives. For instance, workers suffering from anemia are twenty percent less productive than their colleagues who do not suffer from this disease. The negative impact of the HIV/AIDS epidemic on the economically active population and their productivity is another tragic example of this fact. Improvements in the health status of a population can also lead to changes in the demographic characteristics of a population. These demographic changes within a population have an important direct impact on economic development. For example, the rapid improvement in the health of the population in East Asia has led to changes in the age structure of the workforce and the dependency rate and has greatly improved this region's economic development (Bloom et al., 1998; Jamison et al., 1998).

A third dimension inherent in the goals of social protection in health is related to respecting the dignity of workers in the process of seeking and obtaining health services and ensuring financial protection. It is crucial to ensure that the way in which health services are obtained and in which financial protection is ensured do not violate the dignity of workers and their families. According to

the ILO's decent work approach, this tenet is central to the conceptual framework of the STEP program.

Of the three goals of inclusion in social protection in health care, dignity remains the least developed conceptually. This is reflected not only in this framework, but also in the debate on the evaluation of the performance of a health system. Research is currently underway within the STEP program research agenda to develop a conceptual and practical definition of what constitutes dignity within country-based systems of social protection in health.

This framework proposes that the definition of dignity, in the context of social protection in health should be done through the process of social dialog at country level. It can be inferred from the ILO's initiative on decent work that such a definition is subject to continual compliance with the global agenda on human rights and in accordance with the conventions and recommendations of the ILO and other United Nations (UN) agencies. However, a specific operational definition of dignity in the context of social protection in health which goes beyond the human rights international conventions, if not done strictly at country level, runs the risk of countries imposing predominant cultural models rather than reflecting permanent values of the international community.

Although the goal of preserving and improving the health of all workers and families is essential, financial protection and respect for human dignity are equally essential since these three objectives are key in the health system's contribution to the broader goal of human development.

For this reason, the proposed conceptual framework of social protection in health proposes that systems of social protection in health should aim to do the following: 1) preserve and improve the health of all workers and their families; 2) respect their dignity at all times; and 3) ensure financial protection so no family faces financial barriers accessing health care services, becomes impoverished, or remains trapped in poverty as a result of having to contribute to the system financing or paying for health services.

All three goals are indispensable for an adequate definition of inclusion. Achieving financial protection without real access to needed and effective health services does not fulfill the actual needs of workers and their families. By the same token, access to health services that results in a high financial burden on the family is equally unacceptable, as it may lead to or cause families to remain in poverty. Finally, financial protection and access to health services that are achieved at the cost of human dignity is also unacceptable. Therefore, exclusion occurs if any one of these three dimensions is not attained. As a consequence, this framework does not identify problems of inclusion based on whether or not an individual participates in a specific organization or scheme (ministry of health, social security institute, private health insurance or community health organizations). Rather, this framework judges inclusion by an individual's ability to effectively access health care services with financial protection and dignity. Based on this perspective, the appraisal of the efficacy and efficiency of any instrument or arrangement developed for improving social protection in health systems must be evaluated based on its capability to achieve the stated three goals:1) preservation and improvement of the health status of workers and their families; 2) the provision of financial protection; and 3) respect of the dignity of workers and their families.

This multidimensional approach to inclusion in social protection in health not only evolves from ILO definitions of social protection, but it is also enhanced by proposals from other UN system organizations such as the World Health Organization (WHO, 2000), the World Bank (World Bank, 1997, 2001) and others (Kutzin, 2000). Contributions to this conceptual framework by other UN organizations and multilateral agencies who share the ILO's goal of overcoming poverty and

exclusion lead to further coordinated efforts among these international organizations and result in an increased support to combat exclusion from social protection in health.

This framework is intended to contribute to and facilitate the policy and social dialog between governments, social partners and civil society on the causes, magnitude and possible solutions for eliminating exclusion from social protection in health. Although the evaluation of successes and failures of social protection in health is a useful exercise, this framework does not focus on assessing the performance of systems of social protection in health. The goal of this document and the presented framework, rather, is to support the dialog on this issue and assist in implementing effective action by local and national policymakers establishing and/or reforming their systems to ensure inclusion. In this context performance evaluation may be a useful tool, but it is not the main objective of the STEP program country dialog strategy.

B. A Guaranteed Health Services Plan (GHP): A key instrument against exclusion from social protection in health

1. The need for an explicit social guarantee for social protection in health

Effectively combating exclusion from social protection in health requires the existence of a social guarantee ensuring the utilization of needed and effective health services with financial protection and dignity. In many countries there is an explicit goal found as part of a social contract stated at a constitutional level. However, the absence of an explicit guarantee translated into clear operational, organizational and institutional arrangements often leaves many members of society excluded from social protection in health because they lack the necessary instruments and mechanisms to effectively demand society's compliance with such guarantees.

The framework proposes that the commitment to social protection in health take the form of a Guaranteed Health Services Plan (GHP). The richness and characteristics of the GHP in each country will differ according to its economic and social conditions and, in certain circumstances, on the international donor community's contributions. A GHP ensures inclusion in social protection in health when workers and their families:

- utilize needed and effective health care services and public health interventions in quantities and of a quality defined as adequate and in a timely manner;
- do not contribute more than a reasonable proportion of their income to finance their entry into a health system providing the interventions in the above defined conditions;
- have their dignity respected at all time within this process.

In this conceptual framework, these three dimensions are called: utilization, financial protection, and dignity. An individual or a family is excluded when any of these dimensions is missing regardless of whether or not the individual or family belongs to a specific formal scheme of social protection.

A key objective of technical cooperation in combating exclusion from social protection in health is the development of an effective policy and social dialog between local and national authorities, social partners and communities to identify specific actions and reforms to define and implement a feasible, explicit GHP. The dialog will need to address ways in which to develop instruments and mechanisms that allow national and/or sub-national actors to define and implement an agreed GHP. Too often health system reforms and the policy and social dialog accompanying them focus on the organizational arrangements, instruments, and financial issues

as if they were the objective of the reforms themselves rather than the true goal of developing an appropriate GHP. The absence of clarity of the intent of the GHP, either because it is limited geographically and/or in its content, does not allow for a rigorous evaluation of the appropriateness and effectiveness of the reforms chosen.

2. *Guaranteeing utilization or health?*

Although, as stated above, the final goal of social protection in health is to improve the health status of its participants, this framework focuses on guaranteeing utilization of appropriate and timely services rather than on guaranteeing improved health status. The final goal of improving health status, even restricted to the portion of such improvement that can be related to government policy, requires the cooperative effort of all social sectors and, particularly in developing countries, it would require reforms far beyond the traditional boundaries of the health system. Reforms aimed at improving health status need to be addressed. The current fragmentation of responsibilities for health within government is a substantial obstacle to effectively engaging in a productive policy dialog in this regard. This framework is intended to facilitate policy and social dialog between government, social partners and civil society that will result in feasible reforms in a reasonable timeframe. Therefore, recognizing the limitations of doing so, this framework focuses its efforts on facilitating dialog between actors traditionally involved in the health sector with other key actors in government, social partners and civil society. The health sector is defined as the organizations and institutions whose primary intention is to protect and improve the health of the population. Engaging in a policy dialog for guaranteeing the health status of a population with all sectors and actors required to guarantee health status, in addition to the issues of efficiency and equity involved, can no doubt easily become an insurmountable obstacle to initiating dialog and can hamper efforts to identify reforms that, although of lesser scope, are feasible and urgent, particularly for the poor.

Utilization of health services is the dimension most familiar to those working in public health or health care. Adequate utilization can be thought of as the use of an appropriate quantity of quality services provided in a timely manner to an individual or family during a certain period of time. Theoretically, in order to evaluate the utilization of health services as a goal of social protection in health, information on the quantity, timing and quality of all services included in the GHP is required. The concept of utilization, as used in this framework, refers to guaranteeing effective and needed health services for the promotion of health, prevention and treatment of illnesses, and rehabilitation of good health. Therefore, this framework employs utilization as a starting point for a policy dialog regarding the social guarantees in the health system or in other words, the GHP.

3. *Financial protection: How much household health expenditure or contribution is too much?*

Financial protection in this framework means no household contributes or expends more than an acceptable proportion of its total income in order to gain access to an adequate health service and/or to finance the system of social protection in health. Such a proportion of household income should not lead to a family's impoverishment or the worsening of the economic situation of the members of a poor household. Aside from ethical considerations at the basis of a system of financial solidarity, there is empirical evidence that high costs can be a barrier to access and may have significant opportunity cost for other inputs to the welfare function of the household. Barriers to access to care due to cost are experienced particularly by the poorest individuals and can have a negative impact on the welfare of lower income households trying to avoid or overcome poverty. In this framework, in agreement with the WHO and IBRD proposals, household contribution is defined as the

total amount of direct and indirect expenditures spent in order to finance the system and utilize health services and goods. This includes general taxes allocated to the health system, contributions to social security, voluntary health insurance schemes or community health insurance and direct expenditures such as co-payments and other out-of-pocket expenditures. Finally, household total income is defined as the sum of the incomes of all household members.

The assurance of financial protection proposed in this framework is based on the emerging consensus that health systems should ensure that a family's ability to pay is not an obstacle to accessing a minimum level of quality health services and that excessive contributions should not lead to impoverishment. However, there is still a significant lack of clarity regarding what contribution or expenditure levels should be considered excessive.

Ideally, the contribution or expenditure level should not force a household to reduce consumption of other goods such as to damage the household's capacity for human capital accumulation. Of course, what should be considered is the net impact on human capital resulting from the increase in use of health services required for the treatment of illnesses and the reduction in consumption of other goods and services. An excessive level of household health expenditures can result from the cost of treating acute or chronic health conditions, but it can also result from the financial burden of contributing to a risk pooling scheme. In this regard, it is not only excess out-of-pocket expenditures we should be concerned about, which certainly have significant negative consequences on both utilization of services and disposable income for other inputs to human capital creation in the household. We should also consider the overall contribution that may include payments to a pooling scheme in defining an excessive contribution when it reduces other consumption. Further, an excessive contribution occurring over the short- or long-term is considered within this framework as a catastrophic event.

This definition of excessive contributions requires us to understand the actual impact of health expenditures on household consumption in general. It also requires understanding its impact on the reduction of other goods and services that affect human capital accumulation. Some evidence exists of the impact of health shocks on household consumption (Gertler and Gruber, 2001). However, no evidence exists on the short- and long-term impacts of health shocks on the reduction of consumption of other goods and services, or their negative impact on human capital creation and accumulation at the household level. Further research is needed in order to develop a rational approach to operationalizing the definition of financial protection and public subsidy policies in health, linking it to evidence of health shock effects on the consumption and human capital of the family.

In the meantime, some preliminary approaches to defining financial protection are being used. One very preliminary method is the use of specific and arbitrary limits on health expenditures for the lowest income quintiles. This method sets excessive expenditure/contribution at the level of a certain proportion of total household income equivalent to the cost of a standardized package of services (ILO-STEP, 2001), ideally the GHP for that country or population. Although this approach is compatible with the (frequently scarce) information available on household income and expenditures, it is insufficient in capturing the impact on human capital creation and accumulation. Another approach is defining a limit on health expenditures as a proportion of disposable income available to the household after subtracting household expenditures for the consumption of other goods and services. This method follows from a recent WHO publication regarding financial protection, which defines disposable income as total income minus expenditures for eligible food consumption (Knaul et al., 2001). Although superior to using the proportion of total income, this approach, in effect, defines food as the only non-health input relevant for human capital creation. It

also does not yet address the problems of measuring the impact of consumption reduction on human capital creation and accumulation. Finally, one proposed theoretical approach is to define excessive health expenditures as the level of expenditures that would reduce other household consumption to a level of consumption corresponding to households below the poverty line (ILO-STEP, IADB, 2001).

In this conceptual framework, we have chosen to assume that we are capable of empirically defining such a threshold for defining excessive health expenditures or contributions. However, it is clear that defining such a threshold to include the impact on human capital creation and poverty alleviation still is an urgent and pending issue to resolve.

C. The contents of a GHP

What is the true meaning of guaranteeing a GHP? The GHP functions as a declaration of everyone's entitlement to use a specified needed and effective package of health care services and public health interventions under acceptable conditions of financial protection and dignity. However, setting the GHP is only part of the problem. The system needs to have the capacity to monitor, verify, and enforce the access of a population to a GHP.

It is therefore important to develop a clear and explicit definition of a GHP, which should be the result of a continual policy and social dialog. The definition of a GHP should not only include specifications on the health services to be included in the package. It should also contain clear guidelines and provisions for guaranteeing the conditions in which such services are going to be provided, including those addressing financial protection and dignity. In doing so, a GHP should include the following elements:

- the package of health interventions (health care services and public health interventions);
- the acceptable level of quality (clear definitions of the interventions and the eligibility of accredited providers);
- the appropriate timing in which health care services should be delivered (maximum waiting time periods);
- "co-payments" and "co-insurance" levels;
- the specific definitions of confidentiality, accommodations, privacy, information, patients' rights and other elements essential to the preservation of dignity.

In certain cases, the portion of the GHP that can be insured (that is, the insurable interventions in the GHP) can include the maximum number of services to be covered in order to estimate the cost of the premiums and thus guarantee the financial viability of the plan. Elsewhere, we will define in more detail what constitutes an "insurable intervention in a GHP."

The specifics of a GHP can vary from country to country. Of key importance is that its elements result from a social dialog carried on throughout the processes chosen by each society to develop and achieve consensus on guarantees for social protections in health.

A GHP with too many constraints and limitations and that includes few interventions is limited in terms of its contribution to the social protection in health of workers and their families. However, any GHP is better than no guarantee at all. In countries or communities that can only afford such limited packages, the international community has a role and responsibility in assisting in the definition and financing of a GHP. This is discussed in the last chapter of this document.

D. Different forms of exclusion

This framework proposes a multidimensional definition of exclusion from social protection in health. Failure in any of the three goals discussed above results in exclusion. A population group can be considered excluded when they lack access to quality health care services and/or public health interventions in an appropriate and timely manner. Exclusion also may occur when a family or individual contributes an excess proportion of their income to finance the system or pay for services. Exclusion from social protection in health may occur when the dignity of an individual is not respected in the process of attaining appropriate health services. Another possible type of exclusion occurs among members of society whose dignity is respected while interacting with the system, but who must pay an excessive proportion of their income for social protection. "Total exclusion" is often found among the lower income groups of a society as demonstrated by our application of this conceptual framework in a pilot project in Argentina (STEP, 2000).

There exist many kinds of exclusion from social protection in health that can be identified by applying the conceptual framework of the STEP program. These types of exclusion have diverse causes and may be alleviated through an array of possible solutions.

Box 1
Types of exclusion from social protection in health

Types of Exclusion	Utilization	Financial protection	Dignity
Inclusion	+	+	+
Exclusion I	-	+	+
Exclusion II	+	-	+
Exclusion III	+	+	-
Exclusion IV	-	-	+
Exclusion V	+	-	-
Exclusion VI	-	+	-
Exclusion VII	-	-	-

Box 1 presents the different possible combinations of exclusion from social protection in health. Unfortunately, the data available at national level does not always allow for simultaneous analysis of the three dimensions of exclusion for an individual or household. Data restrictions usually permit only a partial analysis of some health interventions combined with the financial dimension. For this reason, although we emphasize the multidimensional nature of exclusion at the theoretical level, the empirical analysis of each of these dimensions will most often have to be conducted separately until better information systems are developed. Finally, we hope that as a result of the activities of the STEP program in cooperation with other organizations adequate information systems will be developed in order to study groups of the population that may suffer from more than one form of exclusion.

III. Causes of exclusion and possible solutions

In the first chapter, we defined exclusion from social protection in health as lack of access to health services, lack of financial protection or dignity as defined by each society through policy and social dialog, and as the failure to adopt social protection through a GHP. In this chapter, we will analyze possible causes of exclusion and local and national policies that may offer solutions to these problems.

A GHP aims to achieve the goals of social protection in health previously defined by assuring: 1) the use of effective health services, 2) financial protection, and 3) levels of dignity and satisfaction defined at a national level and subject to international human rights conventions.

We will now review causes and possible solutions to exclusion, but focusing exclusively on utilization of health services and financial protection. Box 2 summarizes possible problems in achieving the two goals of utilization and financial protection. At this time, we cannot analyze the assurance of dignity due to the lack of an adequate conceptual framework and sufficient data. Also, we believe the definition of dignity should be done at country level and on a country-by-country basis with each society reaching its own definitions through a process of social dialog, but subject to values delineated by the international human rights and other related conventions. The STEP program is currently conducting research on the working definition and evidence regarding dignity in the utilization of health services.

Box 2
Causes of exclusion

GHP problems	✓ *Not defined or poorly defined priorities of interventions and/or lack of enforcement of the GHP (under-coverage)* ✓ *Incongruities between the type of intervention and the financing and/or health care delivering mechanisms*
Utilization	✓ *Supply problems* ✓ *Demand problems*
Financial protection	✓ *Problems with cross-subsidization from low-risk individuals to high-risk individuals (risk pooling)* ✓ *Problems with cross-subsidization from high-income groups to low-income groups (equity subsidy)* ✓ *Problems in the relationship between the purchaser and the provider (purchasing failures)*

There are various problems related to lack of clarity when a GHP has been poorly defined. One potential problem caused by the lack of an explicit GHP is that it is impossible for a population to demand its enforcement. Unfortunately, this is frequently the case among all types of health

systems whether the system is a national health service, private insurance system or community-based health organization.

The lack of clarity of a GHP may also exclude services of proven effectiveness that families need, or include such services only under restrictive conditions (henceforth, called "under-coverage"). A GHP may also encourage perverse incentives for users and providers due to a lack of congruence between specific health services included in the GHP and the organizational arrangements available for its provision and financing. This problem will from now be called "incongruity between services and organization" or simply, "incongruity."

The lack of coverage of appropriate health services can result as a consequence of any of the previously mentioned problems of a GHP. Understanding the incongruity between health services and organizational arrangements for their provision and financing is key to understanding the incentives for actors to under-cover services. This issue requires a more in-depth analysis in the following section.

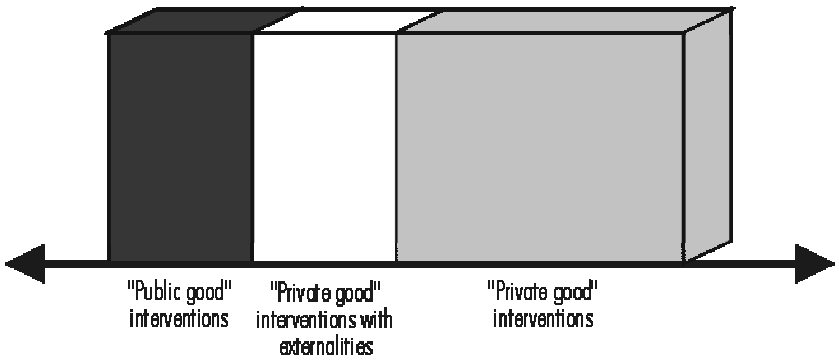
A. The need for "congruity" between health interventions and organizational arrangements for their financing and provision

It is important to make a conceptual distinction between the GHP itself and the instruments to be used for the implementation of the different services contained in it. For the implementation of a specific health intervention in a GHP, policymakers have several options for its financing and delivery. Among others, they can use:

- publicly mandated services provided by health insurance organizations under private financing;
- publicly mandated services provided by health insurance organizations with public funding;
- publicly mandated services provided through vertical or integrated public programs and organizations with public funding.

It is of key importance to identify the right organizational arrangements for the financing and delivery of each of the services included in a GHP. Which GHP health services can most efficiently be implemented through mandatory inclusion among the benefits of voluntary health insurance programs or social security organizations financed by participant contributions? Which health services need public subsidies in order to ensure appropriate levels of coverage by health insurers or social security organizations? In short, which mechanisms are most appropriate and efficient for each of the health services contained in a GHP? To implement the services mandated in a GHP and answer these questions, policymakers need to consider the economic characteristics of health services as economic goods. This is important because the economic characteristics of a health service determine the incentives that providers, insurers and users will face in responding to regulations that mandate its inclusion under a benefits package. Failure to take into account the differences in the economic characteristics of different health services may lead to problems such as contradictory incentives for insurers and provider organizations as well as for users. This may eventually lead to problems in the demand, financing and provision of services and therefore, to exclusion.

Figure 1
Types of interventions in a GHP



From an economic perspective, a basic question to consider is whether health interventions have the characteristics of a public or private good. The various types of intervention in a GHP are seen in figure 1. In order to define a health intervention as a public good, two criteria must be met. First, non-contributing individuals may not be excluded from the intervention (non-exclusive criterion) and second, the consumption of the health service by one individual should not diminish or preclude the availability of that intervention to others (non-rival criterion). For well-known economic reasons, an intervention defined as a public good should be financed publicly. Implementation through mechanisms that require private financing may lead to problems in the provision and consumption of the services. Health interventions that have the characteristics of private goods have the opposite characteristics of public goods. Private goods are those that are not available to individuals who do not pay for them and can therefore be excluded, or the consumption of which implies the reduction of the quantities available to others.

It is not always easy to distinguish between public and private goods. Some services may have the characteristics of a public good under certain conditions and of a private good under other circumstances. Furthermore, it is not always enough to confirm that an intervention has the characteristics of a public good. Its cost-effectiveness should also be considered in order to decide whether or not to include it in the GHP and finance it publicly.

However, there are some cases in which services with the characteristics of private goods may cause what economists call "externalities," when the provision of benefits has repercussions for individuals other than the consumer. These services can be privately financed but the use of these health care services might not reach the optimal levels for the public's benefit. A good example of this is treatment for tuberculosis or the use of vaccines. Higher levels of treatment of tuberculosis or vaccinations can effectively reduce the risk of contagion or epidemics for the rest of the population. In such cases, public financing is highly recommended given the fact that insufficient levels of consumption of these goods have a significant impact on the health of the whole population.

Therefore, public financing is advisable for services that have characteristics of public goods and are cost-effective as well as for cost-effective services that have characteristics of private goods, but with important externalities. Public financing is important in order to avoid the risks to the health of a population that inappropriate levels of utilization might cause. The cost of financing such services is offset by the benefit of avoiding these risks. From now on, we will refer to those services with the characteristics of a public good and those with the characteristics of a private good with positive externalities simply as "public good services" or just "public goods."

An assumption frequently made about public good services is that the consumption of these goods is necessary. A clear example of this is in the case of clean air. We can assume a result of clean air regulations is that all individuals will consume clean air when it is available. Other examples, although less obvious, include the consumption of vaccination services and preventive services monitoring the growth and development of children. A consequence of the assumption that public good services are necessary is that the inclusion of these services as part of a privately financed benefit package without public subsidies creates perverse incentives to sub-optimally finance, provide, or consume them. Ultimately, solely privately financing these goods will prove to be an inefficient alternative.

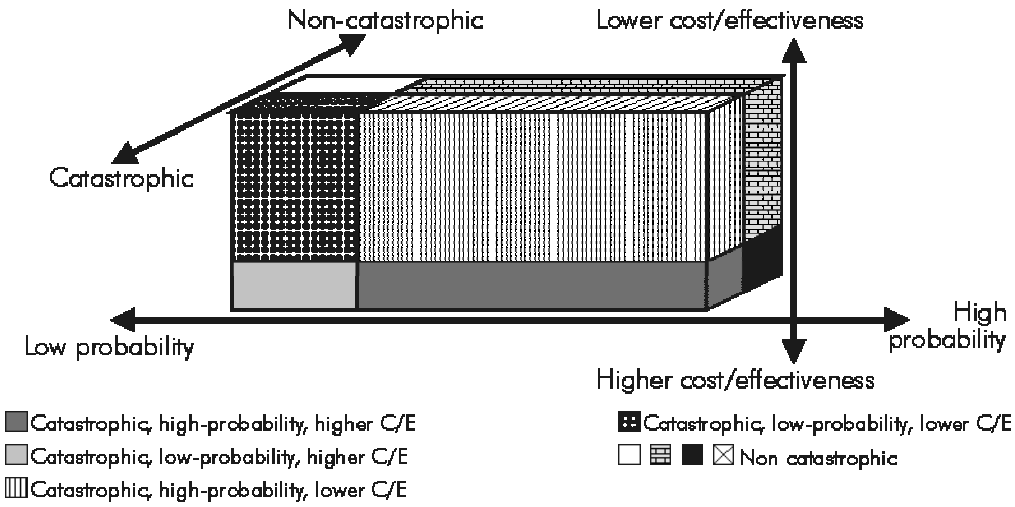
Of course a GHP does not have to be restricted exclusively to public goods. In order to comply with the multiple dimensions of social protection in health described earlier, a GHP may also include private goods. A GHP may include services with an important impact on the health of the whole population (public goods) as well as services with important effects on the health of the individual and on household expenditures (private goods). Considering the economic characteristics of health services, which guidelines should policymakers use to prioritize the specific mechanisms of financing, insurance and provision of services for the different interventions included in a GHP?

In terms of public goods, health economics theory suggests that such interventions should be directly financed with public funds in order to avoid problems in the supply and demand of such services. The inclusion of such services through privately financed insurance schemes, in particular through voluntary health insurance financed via private payments of premiums, may have negative consequences on the efficiency of the provision and demand for such services. In order to ensure adequate levels of actual demand and supply for these health services, public subsidies are necessary and, in some cases, direct public provision might be a more efficient alternative.

What is the best way to prioritize the inclusion of private goods in a GHP? Which financial mechanisms, insurance schemes and organization of the provision of services can obtain the highest impact on the levels of inclusion of a health care system? To answer these questions figure 2 presents a diagram summarizing the scope of possible services with characteristics of private goods that can be included in a GHP. Each color of the diagram represents a group of services classified according to three main criteria:

- uncertainty about the development of a health problem that would require the use of these services (usually characterized by the probability of occurrence);
- cost-effectiveness of the health care services;
- degree to which access to the service needed by a member of the family may involve a catastrophic financial burden for the household; that is, the degree to which the cost of paying for the services would represent a high proportion of the household income and/or savings (catastrophic events).

Figure 2
"Private good" interventions and GHP
Different types of interventions require different types of financing mechanisms, insurance schemes and organizational arrangements



In the case of non-catastrophic, cost-effective services with low or high probability of occurrence, no strong argument seems to exist for them to be publicly financed or to be included in the GHP. A good example of this is inadequate intake of vitamins or minerals due to lack of information on their dietary benefits. Solving this problem by mandating their inclusion in certain foods does not necessarily require public funds; rather, it requires public education and information to the population or regulations to provide them through other services (food, water, etc).

Other individual health services that do not require public intervention other than public information and educational campaigns are those that are neither cost-effective nor of a catastrophic nature. They also should not be included in a GHP. In some cases, however, public intervention such as regulation may be needed when the lack of critical health information seems to be persistent and pervasive in a large sector of the population. On the other hand, those services that are low in cost but also important for the prevention of catastrophic events should be included in the GHP, although not necessarily under insurance schemes, rather under savings schemes or direct subsidies given their high predictability.

Services related to catastrophic events that have a low probability of occurrence demonstrate the importance of risk pooling in social protection. Some examples of these services are emergency and trauma center services for victims of car accidents, organ transplantation and treatment for heart attacks, or even continuous monitoring and treatment once a chronic disease is diagnosed (diabetes, hypertension, etc). These cases are represented by dotted and light gray areas (figure 2). According to the conditions of each country, governments can play a very important role ensuring that these services are included in the GHP and implemented through insurance schemes and that adequate mechanisms for risk pooling are in place. As with the case of public goods, it seems reasonable that GHP services with these characteristics are limited to those that are cost-effective. For groups of the population that cannot afford to finance the premiums and contributions to

insurance schemes in this case, possible alternatives exist that include cross-subsidies between covered individuals within the same insurance scheme or between individuals of different coverage groups and/or pubic subsidies.

Cost-effective private goods that correspond to catastrophic events and events with high probabilities of occurrence (represented by the dark gray area in figure 2) can also be included in a GHP. However, insurance theory suggests excluding such services from insurance schemes, and instead financing them through medical savings accounts for individuals with sufficient capacity to pay and through public subsidies for lower income individuals. For private goods and services that are not cost-effective (represented by areas with lines in figure 2), no public intervention is recommended other than public information campaigns.

In summary, in order to consider the arrangements and schemes (insurance, direct public programs, private financing, public financing, etc.) to be used for a service included in a GHP, decision makers need to analyze all the characteristics of the intervention. This includes whether the service is a public good versus private good, has a high probability versus a low probability of occurrence, the catastrophic nature of the event and its low versus high cost-effectiveness. Problems in the determination of the appropriate financial and organizational schemes can generate perverse incentives leading to problems of access, utilization or financial solidarity and, therefore, exclusion.

The inappropriateness of a specific implementation arrangement and a health service characteristic constitutes what we call in this document "incongruity between services and the organizational arrangement used for its financing and provision" or, simply, "incongruity". Errors in determining the financing to be used for each intervention as well as barriers to the free flow of subsidies to counterbalance conflicting incentives derived from incongruity usually generate tensions and difficulties between regulating agencies, insurers, and organizations in charge of public finance systems. The STEP program has often found evidence of these types of problems due to incongruity in pilot projects launched under this framework.

Having reviewed the problems in the definition and enforcement of a GHP as well as problems in choosing the right implementation arrangement, the following sections review problems of utilization and financial protection as causes of exclusion from social protection in health.

B. Possible causes of exclusion due to problems in the utilization of health services

Problems in utilization occur when an individual needs health care but fails to use goods and services available through the GHP. The causes of exclusion due to problems with the access to and use of health care services can be classified in two groups: 1) problems in the supply of health services; and 2) problems in the demand for health services. The main reasons for exclusion in these two groups are summarized along with their possible solutions in box 3.

Box 3
Exclusion due to problems with access and utilization

	Problems	Possible solutions
Supply	*No providers*	*Increase "eligible" providers:* ✓ *investments* ✓ *reduction of entry barriers* ✓ *purchasing of services*
	Non-eligible providers	
	Inefficient or low-productive providers	✓ *Training and education* ✓ *Incentives*
	Providers that discriminate against particular users	*Strengthening purchasing function:* ✓ *purchasing and regulation mechanisms*
Demand	*GHP is considered unnecessary*	✓ *Educational campaigns to the population* ✓ *Increasing effectiveness of providers*
	GHP is considered necessary, but there is no willingness to pay for it.	*Ensure congruence between interventions and instruments in GHP*
	GHP is considered necessary, but there is no ability to pay	*Improving the efficiency and magnitude of the "equity subsidy"*

An accurate measure of the level of utilization faced by users of a system would require not only validated indicators (combined in some form of index), but also enough data for every intervention included in a GHP. Furthermore, an even more difficult issue is that agreement is needed on the threshold of optimal levels of utilization that would differentiate inclusion from exclusion in a health care system. Usually such instruments and agreements exist only for certain services in each country. In reality, developing countries lack data for the majority of services because of the complexity of the measurements involved. Therefore, they are limited in determining which services and the scope of their coverage to include in the GHP in order to understand whether exclusion has occurred. The rationale for including services in a GHP must be based on studies using available data on use and for which there is consensus on optimal levels. Other indicators can also eventually be included when data becomes available. This approach was used in the pilot program carried out by the STEP program with the Government of Argentina (ILO-STEP, 2000).

1. Problems in the supply of health services

There are various reasons underlying a poor supply of health services. They include: 1) a total absence of providers for the services included in the GHP, 2) a lack of supply due to the "non-eligibility" of providers available to users, 3) a lack of supply due to providers that are "eligible" but inefficient or have low productivity and 4) a lack of supply due to providers that are "eligible" and efficient but that discriminate against certain groups of the population.

A total lack of providers, whether "eligible" or "non-eligible", as a cause of exclusion is self-explanatory. A total absence of providers occurs at a national scale in the poorest countries. However, national averages can cover significant regional problems with the supply of providers that may occur in the poorest areas of middle-income countries. Therefore, one should not rule out that exclusion, due to the absence of providers, may occur in certain regions of middle-income countries despite national estimates of providers suggesting their availability.

Problems of supply due to a lack of "eligible" providers imply the availability of providers, but the inability (external to the provider, or external to the users, or both) of potential users to access or use these providers. A typical example of this occurs when available providers fail to reach an agreement with the insurers. Such is the case of military hospitals that do not provide services to non-military individuals or social security facilities that do not provide services to non-affiliated individuals. Other examples include private providers that have no agreements with the social security or the ministry of health and are located in areas where there are no public providers available. All of these examples lead to a highly fragmented and segmented provision system.

A lack of "eligible" providers that results in problems of utilization is a situation typically found in highly compartmentalized health care systems where the public sector co-exists with social security organizations and the private sector without purchasing mechanisms between the different sub-systems and/or the lack of "portability" of public subsidies. "Portability" in this context means the possibility of public funding also being allocated to non-public purchasers so that a public or a non-public purchaser can use it to purchase services from more than one type of provider available in the health care system. This is discussed in a following section on problems related to financing.

In both cases, a possible solution is the expansion of the pool of eligible providers either through promotion of public or private investments, the elimination of barriers to the entry of private providers, the development of appropriate mechanisms of public-private purchasing, and the introduction of "portability" of public subsidies. The latter two strategies are tightly related to the management of public subsidies and the separation of purchasing functions from the provision of services in the public and private sectors.

Problems of utilization due to lower levels of productivity and efficiency differ from the previous discussion on the existence of providers. In this case, the problem arises when the level of production of the goods and services of the available providers is considered lower than an acceptable and optimal level of production of similar providers. An example of this is comparing case-adjusted hospital discharges per bed per year for a specific acute disease among populations with comparable incidences of the disease. The majority of these types of deficiencies are due to a combination of the following characteristics of the health care system:

- a model of organization of health care services that does not meet the goals and priorities of the GHP and the demand for services of the population. Usually, this occurs due to a combination of human, technical, and physical resources in the original design of the system that is not optimal and has not been updated. Also, rigid management methods impeding the development of a process of permanent modernization and improvement in the delivery of

health care can be another cause of lower efficiency and quality in the provision of health care services. For instance: an excess supply of hospital services combined with an insufficient supply of ambulatory services of low, medium and high complexity; primary health care services with low problem-solving capacities due to lack of skills; and lack of a diagnostic and therapeutic infrastructure and supplies;

- lack of appropriate funding and training negatively affecting the efficacy and efficiency of providers;
- a system of perverse incentives, in particular those related to payment mechanisms that perpetuate non-efficient clinical procedures and conduct.

Solutions to these problems must reflect changes in the design of the health care systems, changes in the management models of providers, changes in the system of incentives created by the different types of purchasing and payment mechanisms, and the permanent training of providers. Total quality programs are among the approaches used in recent decades by various health care systems to address these types of problems.

Governments have placed significant emphasis on solving problems related to low productivity and efficiency in the health care systems of their countries. This is reflected in changes to the design of health care systems, regulations introduced by ministries of health affecting both the public and private sectors, and the use of loans and technical assistance from multilateral and bilateral agencies for the improvement of primary health care programs, hospital management and the separation of purchasers of health care services from the delivery of these services. Nevertheless, actual improvement in the performance of health care systems cannot be attained by focusing only on the system of incentives through price signals and financing mechanisms and the consideration of providers merely as "black boxes" (Baeza, 1996). Changes are important not only to the external incentives to the providers (purchasing and payment mechanisms), but also to internal administrative and clinical structures and practices.

The final cause of exclusion related to problems in the supply of health services follows from discriminatory practices by providers against certain groups of the population. This occurs when an individual fails to receive required care from an existing eligible provider. The main cause of such discriminatory behavior from providers often is due to the individual's inability to pay for the service at the moment of delivery regardless of whether a purchaser exists who will eventually pay for the service. There are various origins of this problem. One of which may be the relationship between the "purchaser" and the "provider". This will be examined in greater detail in the section on problems in the financing of health services.

The STEP program focuses mainly on the demand-side problems in health care utilization. These include the financing, insurance and purchasing of health services. For this reason, the STEP program's efforts in alleviating supply-side problems will center on working in conjunction with WHO, multilateral development banks and other cooperation agencies to address exclusion due to problems in the supply of services. In cases where problems of supply have an impact on demand, such as in the case of problems of the quality of provided services, the STEP program maintains a more active role.

2. *Problems in the demand for health services*

A problem in demand arises when, for various reasons, users do not use health services they need. Reasons for a demand problem may include: 1) the GHP intervention is not considered

necessary; 2) the intervention is considered necessary, but there is no willingness to pay for the service; and 3) the intervention is considered necessary, but there is no capacity to pay.

Demand problems arising from a service deemed unnecessary are typical of services that have long-term benefits (i.e. secondary prevention of hypertension). A similar problem results when the individual who demands the service is not the same person who ultimately benefits, such as the treatment of children, or when, during pregnancy, the mother is the "economic agent" demanding services on behalf of her child. These types of problems are called problems of agency and are treated in this framework in the same way as public goods. Lack of demand due to problems of perception (which differs from the above mentioned problems of agency) should be addressed mainly through educational and information campaigns directed at the population at risk. Educational campaigns targeted at providers may also effectively induce demand for specific services when users visit providers for other reasons. The whole system must change in order to identify health problems at an early stage and promote the demand for therapeutic services even when the population is not fully aware of the long-term consequences.

These types of educational campaigns are often public goods or private goods with positive externalities. This is especially relevant in developing countries where the population is covered by multiple social protection schemes that are explicitly or implicitly in competition and offer short periods of coverage. In any case, both broad-range and targeted educational campaigns can be included as part of a GHP, but the specific mechanisms of financing and organization may differ in order to avoid the previously-mentioned problems of "incongruity." In addition, incentives for the purchaser and the financing organizations should be logically aligned with the rest of the system in order to encourage the use of certain services that prevent further complications and, therefore, the use of more costly health services.

Dealing with problems of exclusion resulting from lack of demand is a growing challenge for health care systems around the world, in particular with the increasing incidence of chronic conditions and the aging of the population. A system that does not account for these factors and responds only to spontaneous demand will most likely fail to reduce exclusion. Health care systems should be able to induce and generate demand in those cases where there is no spontaneous demand for certain services by the population. Both purchasers and providers should launch coordinated efforts to tackle this problem effectively.

The demand for certain services is also related to an individual's assessment of the trade-off between the value of the services and the difficulty of actually obtaining them. Economic models suggest that individuals take into account such factors as time spent and out-of-pocket expenditures; therefore, demand-side problems in the use of health services should be understood within the framework of a household's economic and financial context. Another possible explanation for lack of demand for certain services is an unwillingness to pay. This problem has been analyzed within the context of incongruity between services and instruments of GHP. Finally, another explanation is related to an individual's inability to pay. The individual may believe in the usefulness of the intervention, but he or she may not be able to afford payments needed at the moment the service is delivered. Individuals, despite the perceived value of the intervention, also may not be able to afford the indirect costs of obtaining the intervention such as traveling times and other types of costs not directly related to the provision of services but relevant to the individual's financial situation. Within this conceptual framework, this final situation arises from a problem related to the design of the financial system, either because the individual does not belong to an insurance scheme or because the cross-subsidies fail to work appropriately. This problem is discussed further in the following section.

C. Possible causes of exclusion due to problems with financial protection

Exclusion due to a lack of financial protection may occur when an individual or household has to spend an excessive proportion of their income on health care expenditures. Expenditures may include contributions to voluntary or mandatory insurance schemes, contributions to general taxes earmarked for health care services, or out-of-pocket expenditures.

Excessive contributions for health expenditures reflect problems faced by a lack of financial protection which may result in reductions in consumption of other goods and services that acutely damage a household's capacity for the formation and accumulation of human capital either in the short- or long-term. Of course, what should be considered is the net impact on human capital resulting from the increase of expenditures for health services required for an acute or chronic health event and the reduction of expenditures for the consumption of other goods. The excess level of household contribution or health expenditures can either be a result of an acute health shock or the result of a chronic health condition leading to excess expenditures or excess contribution to a pooling scheme. Any of these two types of health conditions leads to a disproportionate level of household health expenditures (acute shock determining excess contribution or chronic condition determining the same) and is considered under in this framework to be a catastrophic event.

Conceptually this definition of excess health expenditure or contribution captures the long-term impact on the household creation of human capital. It necessitates the need to define the level of health expenditures that results in consumption reduction at household level, and also the impact of the reduction of household consumption affecting human capital creation such as adequate nutrition, schooling, food or other goods or services. Although some evidence exists on the impact of health shocks on household consumption due to excessive health expenditures (Gertler and Gruber, 2001), there is no evidence on the impact of such consumption reduction on short- and long-term household formation and accumulation of human capital. This is a research area that currently needs to be developed in order to have a rational approach in operationalizing the definitions of financial protection and public subsidy policy in health. Defining such a threshold on the basis of the impact on human capital creation and poverty alleviation is a pending but urgent issue. Although the discussion in the next sections implicitly assumes that we are able to set such a threshold, we continue to be technologically far from able to do so. The STEP program is currently conducting research to contribute to the empirical evidence on both the threshold and the impact of excess health expenditures or contributions on human capital creation at household level.

Before analyzing the problems related to financial mechanisms that may cause exclusion due to a lack of financial protection, we must first review some important concepts related to the financing of health care systems.

1. The financing function in a health care system

In this section, we examine the main objectives of health systems financing using a similar typology as the one proposed by the World Health Organization (WHO) in the World Health Report 2000 (WHO, 2000).

In order to reach the goal of inclusion through the achievement of financial protection resulting from financial solidarity, a system of social protection in health should do the following:

- aim for the highest possible level of contribution for health services to be made before having to demand them (prepayment). This should help decrease the amount of the contribution at the moment when services are needed and demanded;

- aim for the largest pooling of risks possible within a population. This should ensure an actual transfer of subsidies from individuals with lower risks to those with higher risks;
- aim for an adequate degree of equity within the system to promote a reasonable flow of subsidies from higher income groups to lower income groups;
- develop a purchasing and payment system that creates adequate incentives for providers to promote the delivery of quality health services in a timely manner (strategic purchasing).

The system achieves these objectives (or not) as a result of the specific arrangements it adopts for its three main health financing functions: 1) revenue collection; 2) risk pooling and 3) purchasing.

The revenue collection function is a set of procedures by which the system or parts of the system collect financial resources that later will be pooled for the financing of health care services. Typical revenue collection mechanisms are general taxation, mandatory payroll contributions, mandatory or voluntary contributions (premiums) based upon risk, direct out-of-pocket expenditures and personal savings. Traditionally, each of these methods of revenue collection is associated with a specific way of organizing funds, pooling, and the purchasing of services. General taxation is typically associated with national health systems. Payroll contributions are typically associated with social security organizations, while premiums based on risk status are typically associated with voluntary health insurance systems. However, reforms introduced in recent years are changing these typical associations. For example, in Costa Rica the social security system is financed by the allocation of funds from general tax revenue in addition to payroll contributions. This is similar to the way in which the national health care systems of Chile (FONASA) and Colombia are financed.

The specific mechanisms used for the collection of resources determine the level of contribution for the health intervention needed at the time the services are used. From now on, the framework will refer to this as prepayment. Low prepayment levels translate into high levels of out-of-pocket expenditures for workers and their families. This, in turn, results in exclusion due to a lack of financial protection. This is especially burdensome for the poor and indigent. Financing by general taxation achieves the greatest level of prepayment while out-of-pocket expenditures represent the lowest.

The pooling function refers to the collection and management of financial resources that spreads the financial risks among all members of the group. Pooling of financial risks is at the core of traditional insurance mechanisms.

Each society chooses a different way in which to pool the financial risk of a population in order to finance its health care system. Social security is one of the most frequently used mechanisms for risk pooling at a national level. Private health insurance and national health services and/or ministries of health are other ways of organizing this function. There are other less frequently used risk pooling schemes including community organizations such as mutual aid organizations or microinsurance programs. All these organizational forms for the pooling of financial resources usually coexist in developing countries.

Figure 3
The need for cross-subsidization

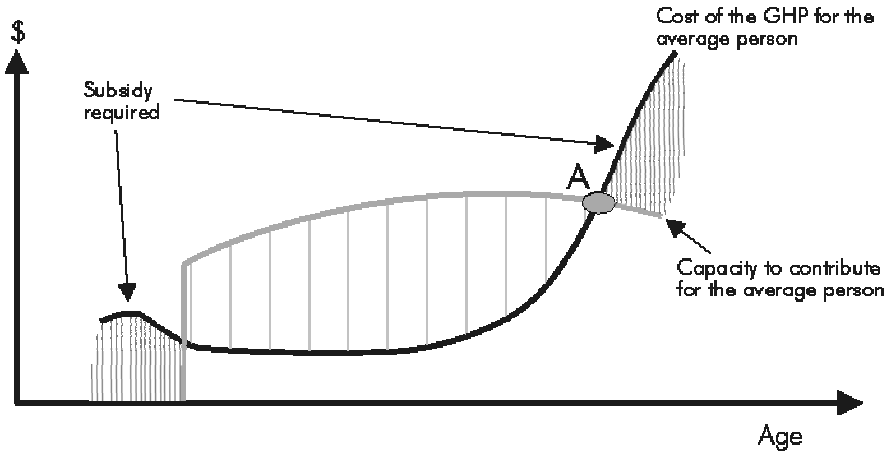


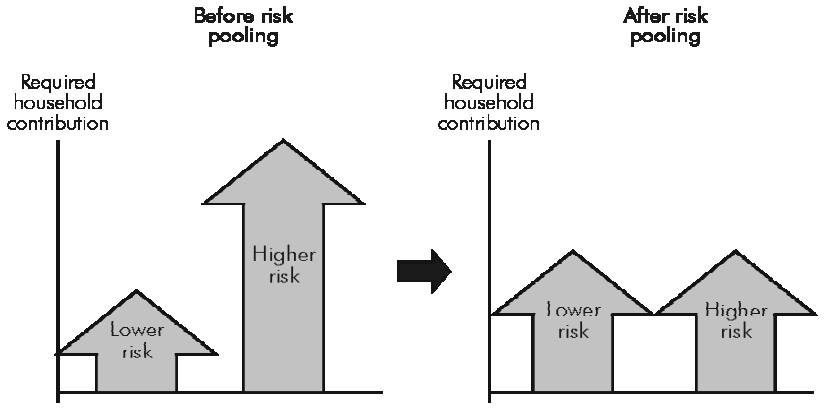
Figure 3 represents the evolution of the cost of financing the GHP during the lifetime of an average individual, his or her ability to pay, and his or her need for subsidies. The black line shows the relationship between actual cost and age. The gray line represents the relationship between the ability of an individual to pay for the services and the individual's age. In this document, we refer to this ability as the maximum level of health expenditures which a family or individual can contribute to the financing of the system and services without incurring an excessive contribution as defined above. As the risk of requiring services increases with time, the ability to contribute becomes a smaller proportion of the total actual cost of financing the system and paying for services. The point labeled "A" in the figure represents the starting point for the need of a subsidy. To the right of this point, the individual or family needs a subsidy in order to be able to finance and gain access to the services they require without incurring an excess expenditure or contribution. It is possible for households or individuals with higher incomes to never achieve this point. It is also possible that lower income households or individuals may need a subsidy from the beginning of their lives in order to access health care services at the levels and in the conditions specified by the GHP. In this situation, a combination of financing schemes and mechanisms for allocating subsidies, financial protection can be offered. In addition, as along as a GHP is considered efficient and equitable, meaning the interventions included have been defined and enforced for the entire population, then no one is left out of it at any point of his or her life.

The pooling function is central to the creation of cross-subsidies between high-risk and low-risk individuals. These cross-subsidies are the essence of health insurance. The effects of cross-subsidization are shown in figure 4. If the pool is large, then the smaller the average contribution necessary per person. This follows the law of large numbers and economies of scale and savings in financial cost of technical reserves. As the pool becomes larger, it is more likely that the proportion of the financial resources devoted to the purchase of needed services becomes larger than the proportions assigned to contingency reserves or administrative costs. Additionally,

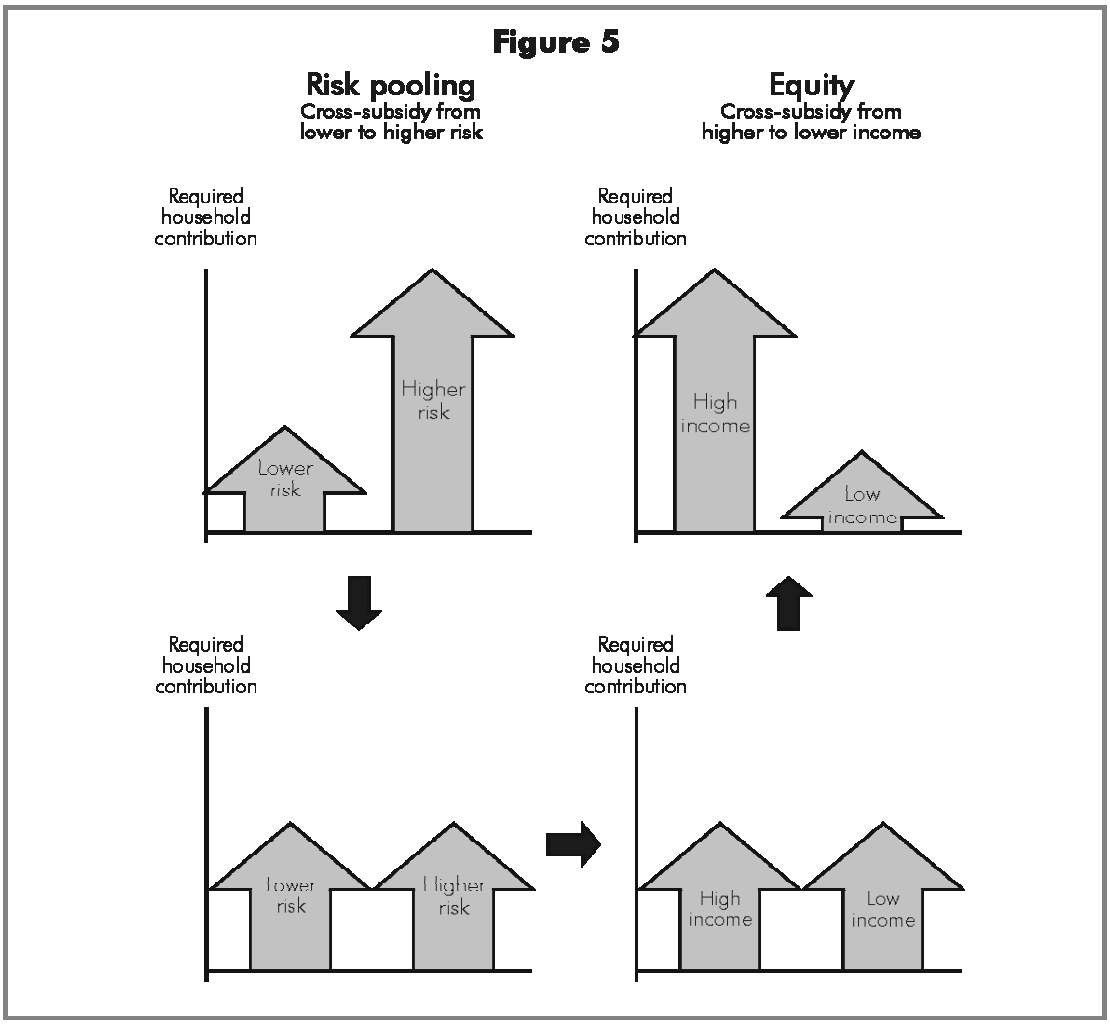
larger pools of financial resources generate stable sources of financing for providers, which in some cases can lead to an adequate supply of health care services.

The absence of a system for spreading risks and one that does not benefit from economies of scale by allowing the creation of cross-subsidies results in high and unexpected out-of-pocket expenditures for the individual who needs health care services. Upfront out-of-pocket payments are a significant barrier to adequate utilization of health care services and have negative consequences for the budgets of poor and indigent families forced to divert money from other important basic needs. It is generally agreed that a high level of out-of-pocket expenditures is a sign of a health care system with an inefficient pooling function.

Figure 4
Effects of risk pooling
Cross-subsidization from low- to high-risk individuals



Nevertheless, spreading risks through insurance schemes could also result in low-risk, low-income individuals subsidizing high-income, high-risk members. Furthermore, there may be important groups of the population that cannot afford to pay the premiums for the GHP or groups for whom premium costs are burdensome and, potentially, may result in perpetuating or worsening their poverty level. For this reason, most health care systems aim to develop financing systems both with the goal of spreading risks and of promoting equity in the financing of health care services. Thus, ensuring the availability of subsidies from high- to low-income households guarantees that no individual is left out because of their income. In this framework, we distinguish the low-risk to high-risk subsidy from the subsidy that shifts costs from high- to low-income households. Both are illustrated in figure 5. The subsidy from high- to low-income individuals or households is the "equity subsidy."



The purchasing function is the way in which systems utilize collected and pooled financial resources in order to buy needed health care services for the population. Within this framework, we also include traditional mechanisms of financing services such as financing by "budgets."

In the practical day-to-day interaction between purchasers and providers, it is the purchaser, within a regulatory framework, who plays a key role in defining the external incentives for providers to develop the appropriate provider-user interaction and health service delivery models. It is also a purchaser's responsibility to continually monitor and evaluate the quality and timing of the services provided for its population. However, there is a difference between "strategic" purchasers and "passive" purchasers. A strategic purchaser develops a strategic purchasing plan by responding to the following questions: How should health services be purchased for the population in the most efficient manner? What level of quality of services must be assured? From whom should these services be purchased? How should these services be paid for? How should the delivery of health care services be monitored and supervised in order to guarantee they meet specified conditions?

A strategic purchaser has the freedom and a flexible management and regulatory framework in order to answer these questions, mainly focusing on the interests of the population it serves. A strategic purchaser can selectively choose the services and providers that best suit the implementation of the GHP for its members and can therefore choose the specific conditions of a virtual or actual contract with providers regarding the payment mechanisms and negotiation of prices. In contrast, a passive purchaser does not have this freedom and can only develop a budget, which is often based on a historic trend and/or implemented as line item budgets. Passive purchasers may only develop a budget for the purchase of certain services with minimal selectivity.

2. *Alternatives for financing an equity subsidy*

There are at least four alternatives, which often coexist within the same health care system, to financing an equity subsidy. They are personal savings, subsidies within a risk pool, subsidies across different risk pools, and public subsidies. An in-depth analysis of these alternatives is beyond the scope of this document. However, a brief review of the alternatives is necessary in order to understand the complexity of offering an equity subsidy, an essential component in the prevention of exclusion, as part of a program for social protection in health.

Personal savings refers to the voluntary or mandatory accumulation of part of the worker or family income in order to finance additional contributions and/or health care services in the future. A variation of this mechanism is the purchase of a reinsurance contract. These financing mechanisms may help those with a capacity to generate savings and in certain cases they may significantly moderate the impact of health shocks on household overall consumption. But most likely there will always be groups of the population that will require subsidies at some point of their lives because their level of generated savings will not be sufficient to finance needed health care services.

Subsidies within the same insurance schemes are found at the core of traditional systems of social security financed by a payroll tax. The goal of collecting revenues through an income-related contribution (in contrast to a risk-related contribution) is to generate cross-subsidies from high- to low-income individuals and assist individuals who are above the income threshold for subsidy. This system is optimal when the whole population belongs to the same risk pool. In a system where there are multiple, competing insurers and a fragmented risk pool, risk-related contributions increase the incentives for selective coverage (cherry-picking). In addition, the financial resources might not be sufficient either for spreading the financial risks or for the creation of an equity subsidy. Under income-related contributions, there are also strong incentives to match the contribution of the participant with the benefits, particularly when either no GHP is in place or regulation allows for additional benefits to the GHP to be purchased by the member from the same insurer providing the GHP. This results in a reduction of the available resources for cross-subsidization.

The third alternative is the creation of a subsidy system among the populations that belong to different risk pools. It involves the creation of funds, often a single solidarity fund, financed by a portion of the contributions to each risk pool. This mechanism is a characteristic of systems with multiple insurers often covering only formal workers and their families. Examples of this are found in the health systems of Germany, Argentina, Colombia, the Netherlands and other countries. A key element of the success of this mechanism is the implementation of adequate systems of compensation among different risk and income groups.

Finally, another alternative for financing equity subsidy is public financing with funds generated via general taxation. This system is widely used in OECD countries to subsidize health care for groups or for all of the population. It is also used in developing countries where a large

portion of the population does not belong to the formal economy and/or requires subsidies in order to access health care services as required by the GHP. It also occurs when social security organizations receive public subsidies either to cover their operational deficits and/or to explicitly include the poor and the informal workers in their schemes.

As a transition strategy, given the fragmentation of risk pools in developing countries and the difficulties in tax collecting capacity, ensuring cross-subsidies between different health insurance schemes (risk pools) are probably the most feasible way to increase equity subsidies for people participating in such schemes. Public subsidies are essential, however, for all the population outside pooling schemes and for the poor, but tax generating and collecting capacity limits its use as a source of financing equity subsidy in developing countries. Although subsidization across risk pools is the most feasible alternative so far in developing countries, this does not mean its implementation is simple. There are important transaction costs associated with this alternative and a growing population left out of the formal sector limits the use of these mechanisms to overcome exclusion.

On the other hand, a large amount of subsidies might be available from general taxation (usually in middle-income developing countries), but the lack of portability of such subsidies restricts its use as a source for subsidization across risk pools. This lack of portability might be a significant obstacle to combating exclusion given the constant movement of workers and their families from formal to informal schemes of social protection in health and vice versa.

3. *Problems in the financing of health care and its implications for exclusion*

One of the key causes of exclusion due to financing is the lack of resources in poorer countries; therefore, lower levels of resources for the health system. This is certainly an important problem in many developing countries. However, this problem is beyond the scope of this framework for social protection in health. The problem of low resources that some countries face constitutes an obstacle often beyond the health system capacity and needs to be addressed in the context of economic growth and international cooperation and aid.

In addition to the problem of low available levels of resources in a country, exclusion occurs due to problems in ensuring financial protection even in the presence of significant resources at country level. Box 4 presents causes of exclusion due to problems in the financing of health services. This is demonstrated in the following cases:

- GHP problems: problems from the lack of, or poor definition, of the interventions to be included in the GHP;
- pooling problems: problems with the risk pooling mechanisms available or chosen. This includes the absence of cross-subsidies between low- and high-risk groups;
- equity subsidy problems: problems in the equity subsidy mechanisms available or chosen. This also includes the absence of cross-subsidies between high- and low-income groups and the lack of progressiveness of the general taxation system earmarked to finance the health care system;
- purchasing problems: barriers to access, or discrimination by providers, due to perverse incentives resulting from a flawed purchaser-provider relationship, but also from an imperfect regulatory and managerial framework for providers. We referred to this problem earlier as "under-provision."

Box 4
Causes of exclusion due to problems in the finance function

Lack of financial protection	✓ *GHP problems (under-coverage)* ✓ *Problems in cross-subsidies from high- to low-income groups* ✓ *Problems in cross subsidies from low- to high-risk* ✓ *Problems in purchasing function (under-provision)*

a) GHP problems (under-coverage)

Under-coverage problems occur when a GHP is inappropriately defined. Some examples are excessive co-payment levels, ill-defined interventions, and absence of maximum waiting time definitions. In the case of excessive levels of co-payment, the end result is individuals face high out-of-pocket expenditures. This constitutes exclusion due to lack of financial protection and will most likely lead to barriers in utilization for individuals who cannot afford high co-payments. Other causes of inappropriate definition of the GHP are discussed in earlier sections.

b) Risk pooling problems

Box 5 summarizes problems related to risk pooling and suggests possible solutions. The first cause of exclusion due to the lack of financial protection is an absence of risk pooling systems to include the entire population. This problem occurs frequently in low-income countries where only a minority of the population belongs to the formal sector and a very low proportion of the population participates in effective pooling systems. This situation also exists among smaller population groups in some higher income countries. In many of these situations, the population not participating in large formal pooling schemes theoretically is covered by public subsidies implemented through public programs. However, in actuality, the public sector scheme is often ineffective and the population seeks alternatives that may include self-organization at community level. Evidence of this has been revealed by research conducted by the STEP program (ILO-STEP, 2000). However, due to many factors, often these community organizations do not provide an effective or efficient system of risk pooling (ILO-STEP, 2001). Thus, the affected population still faces severe financial burdens.

Box 5
Exclusion due to problems in the pooling mechanism
Households must contribute more than a reasonable proportion of their income to finance a GHP due to problems in the chosen risk spreading mechanism

	Problems	Possible solutions
"Pooling" problems *(Problems with cross-subsidization from low to high risk groups)*	*There are no pooling arrangements or those existing are inefficient*	*Development and promotion of pooling schemes*
	There are pooling schemes but users are not eligible	*Elimination of eligibility barriers for the self-employed and small business owners, modification of legislation, community rating, and equity subsidies*
	There are pooling schemes but users do not consider them necessary	✓ *Educational campaigns* ✓ *Mandatory affiliation to insurance schemes (avoid free riders)*
	There are pooling schemes but users are not able to pay	*Expand risk pools and development of equity subsidies*

Exclusion due to a lack of risk pooling is less frequent in middle-income countries. In these cases, the problem is more frequently a low level of efficiency based on fragmentation of the risk pool (the population) into groups that are too small. As discussed earlier, what may be especially problematic is the lack of portability or inability of individuals to carry subsidies with them when they move from one risk pool to another or, in other words, the lack of a "money follows the patient scheme" for public subsidies to pay for various providers in or outside the public sector when required. Additionally, the ineffective purchasing of services within each insurance scheme or public health organization is normally found in these cases.

There is some evidence that risk pooling problems are becoming more important for particular groups of the population in middle- and higher-income countries (ILO-STEP and PAHO, 1999). Self-employed workers and those in the informal sector are "trapped" between barriers to join social security organizations and non-eligibility for subsidized public services. Often, voluntary private insurance is the only option available for those who can afford to pay the premiums. However, voluntary private insurance in many cases has serious limitations. Governments may not have created an adequate regulatory environment for the voluntary insurance market and no portability of subsidies may exist between these types of insurance. These groups could benefit from modifications to the regulatory environment of social security and voluntary health insurance, making premium costs relative to incomes and encouraging the portability of subsidies.

For instance, data from Argentina suggests 10 percent of individuals in the highest income quintile use public health care services (SIEMPRO, 1997). This group of high-income users is estimated to represent more than 3 percent of the total population covered by a public sector health care system serving an estimated 500,000 individuals. It is possible that these individuals are free riders who benefit from a public service without contributing to the system. However, it is also possible that these individuals confront important barriers in joining social security schemes or voluntary insurance schemes such as in the case of self-employed individuals and owners of small businesses. Finally, even effective risk pooling mechanisms will not solve problems of exclusion if potential members cannot afford to pay the premiums or contributions to formal insurance schemes. In this framework, this constitutes a problem related to the availability of equity subsidies and will be analyzed in the following section.

c) Lack of and/or inefficient equity subsidy problems

Exclusion due to lack of equity subsidies occurs when there are functioning health insurance schemes, but individuals and households cannot afford the level of contribution demanded by the scheme or when these payments represent an excessive proportion of their income. Exclusion problems related to equity subsidies and possible solutions are presented in box 6.

Box 6
Exclusion due to problems related to equity subsidies
Individuals or households contribute more than a reasonable proportion of their income to finance a GHP

	Problems	Possible solutions
Problems with the equity subsidy	*Users do not participate in existing pooling schemes because they cannot pay the premiums (insufficient equity subsidy)*	*Ensure an adequate level of equity subsidies:* ✓ *within pooling schemes* ✓ *among pooling schemes (solidarity funds)* ✓ *from public sources (general taxes)*
	Users participate in existing pooling schemes but pay in excess due to insufficient equity subsidies	
	Pooling schemes with sufficient equity subsidies available but with no "portability of subsidies"	*Develop "portability" of subsidies among public subsidies or insurance schemes*
	Pooling schemes where users pay too much due to the inefficient "portability of subsidies"	✓ *Improve risk adjustments according to the number of members of the household* ✓ *Improve purchasing efficiency in private and public sectors*

One possible cause for this type of problem is an insufficient equity subsidy. The determination of whether a subsidy is sufficient is an empirical question that requires cost estimates of the GHP and the contribution levels and income of the participants in the risk pool. Insufficient equity subsidies are an evident problem in low-income countries. Lack of resources explains most of the problem, but inefficient management of collected funds also contributes to it. It is an urgent but complex task to solve the problem of protection for populations of low-income countries, particularly the poor and indigent. These problems arise in a context of poverty and institutional and organizational instability that impedes an adequate generation of funds and its collection for an equity subsidy.

But even in many middle-income countries with significant levels of equity subsidy, mostly achieved through substantial public expenditures on health, the inequity in the allocation of such subsidies determines exclusion. This is the case in systems that do not provide for sufficient and effective cross-subsidization mechanisms from high- to low-income populations among the existing different risk pooling mechanisms or organizations. It is also the case in many middle-income countries in which the sub-national allocation of public subsidies is significantly inequitable. In countries with a weak federal government or strong regional governments, the fragmentation of social protection in health might also occur. Such is the case in countries in which the decentralization of the federal structure has resulted in the fragmentation of the risk pool, which eventually leads to inequalities in the allocation of equity subsidies to regions. Historical budgets tend to perpetuate these regional differences. This problem should be of utmost concern for policymakers not only because of the consequence of an inequitable allocation of fiscal resources, but also because such a situation is the result of public policies.

The other two causes of exclusion related to equity subsidy problems are related to inefficiencies in the management or allocation mechanisms of the subsidy. A major distortion in the efficiency of allocation of an equity subsidy is its lack of "portability", which occurs when equity subsidies do not follow individuals changing from one risk pool to another (Baeza and Copetta, 1999). There is no mechanism for compensation in this case, which may result in the loss of subsidy for the person or family in question. The need for demand-side subsidization is often mentioned as a solution for this problem. However, we use the term "portability" to denote that this framework does not argue for demand-side subsidization in general as a solution, but rather for a particular form of demand-side subsidization in which the subsidy is directly linked to a specific GHP. This would be an accreditation process to determine eligible pooling organizations and other conditions as defined by a GHP for both insurers and providers.

Restricting cross-subsidies exclusively within each insurance scheme does not ensure that workers will continue receiving the necessary level of subsidy when changing from one risk pool to another. This might represent a problem for workers in general because the new insurer might not accept the worker if the required subsidy represents a significant financial burden or they might have the incentive to discriminate against him or her for the same reason. If appropriate regulations are not in place, pre-existing conditions and other similar types of limitations may eventually decrease the level of protection for workers. Portability is of particular importance in the context of changing working conditions and increasing growth of the informal sector. In practice, multiple jobs and increasing informalization often determine the high mobility of workers from one risk pooling scheme to another in developing countries. In that context, social protection in health for the poor and workers in the informal sector is potentially negatively affected by the lack of portability of public subsidies.

If the trend of a growing informal sector in developing countries continues, the lack of "portability" of the subsidy will become an increasingly important impediment to overcoming exclusion. Even if there are several subsidies available in the system, a process of segmentation of the mechanisms of social protection impedes workers from moving between risk pools or choosing the insurance schemes that best serve their needs. If a country possesses the required institutional capacity (particularly tax collecting and regulatory capacity), the replacement of multiple subsidies in separate insurance schemes with a single portable subsidy financed from general taxation can be an important solution to the problem of exclusion.

Figure 6

Fragmentation of the system of social protection in health

Argentina: population breakdown by income quintiles and by coverage of health systems (1997)

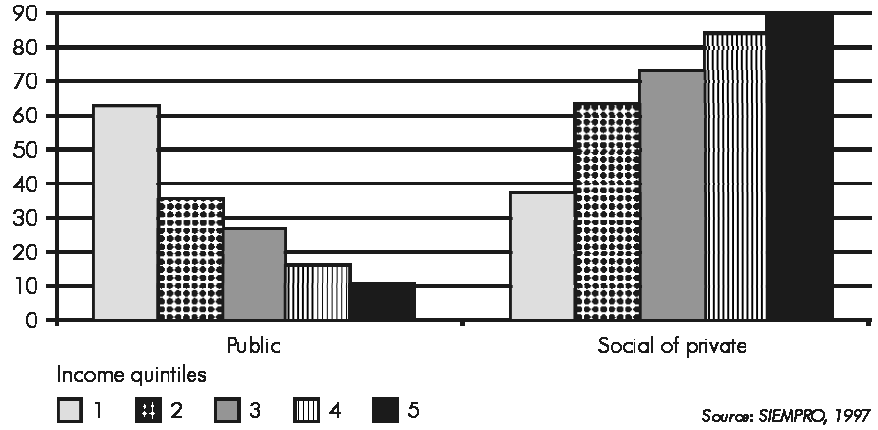


Figure 6 shows the case of Argentina where the social protection system is segmented by income due to the lack of "portability" of the equity subsidy between the public sector and social security. Most individuals in need of significant equity subsidy are covered by the ministry of health at the national or provincial level and do not participate in social security or private voluntary insurance schemes. The Argentine experience is similar to that of other countries in Latin America which share the same regulatory environment and also lack "portability" of the public subsidy. This arrangement would not necessarily be a problem to the extent that low- income workers that maintain the same level of income and move from the informal to the formal economy would still retain their equity subsidy. However, the lack of portability between the public sector and social security does not guarantee the availability of such a subsidy. In this case, the mere change in an individual's labour status would condemn the worker to exclusion because of a lack of financial protection. A change in labour status may also force the worker in his or her new pooling scheme to provide for their subsidy when previously it was provided for by the public sector and financed via a progressive general tax. This situation may provide a possible disincentive for low-income workers to enter the formal economy.

Figure 7
Fragmentation of the system of social protection in health
Chile: Population breakdown by monthly income and by coverage of health systems

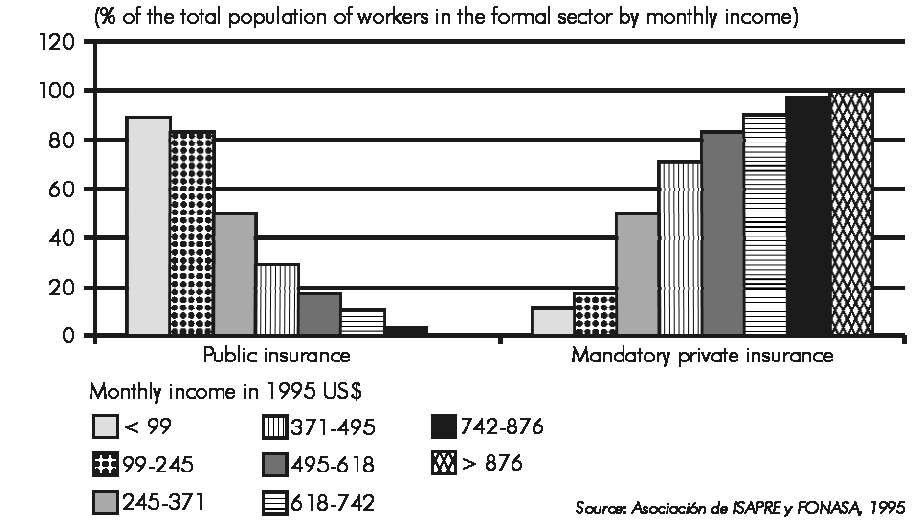


Figure 7 shows a similar case of segmentation of social protection in health in Chile. This type of segmentation occurs in the majority of developing countries where separate systems of social protection coexist for the formal and informal sectors and for the poor. Segmentation seems to be the rule and not the exception in developing countries.

Other causes of inefficiencies related to equity subsidies are flawed design and/or poor management of the subsidy funds and allocation mechanisms. In countries with "portability" of equity subsidies, the challenge is in appropriately estimating the adequate amount of subsidies, particularly because of the extreme technical, organizational and institutional complexity involved in the calculation. This is the case of the social security schemes in countries like Argentina, Colombia and the Netherlands.

A key aspect of the efficient allocation of equity subsidies is the accurate estimation of differences in the needs for subsidies of different groups of a population. Even where "portability" of equity subsidies exists, if the amount of the subsidy is not close to the actual subsidy needs of particular groups of workers and their families then the efforts to overcome exclusion will be inefficient. Underestimation of an adequate level of subsidy leaves families without adequate protection while an overestimation reduces the resources available for others.

Historical budgets or the allocation of resources exclusively based on production factors (e.g. labour, investments, and supplies) makes it difficult to identify the actual groups of a population that benefit from public subsidies. It is also an obstacle for governments and society to clearly understand who and what is actually being subsidized and what can be expected and required from the organizations and actors providing services and managing equity subsidies in social protection in health.

In the case of countries in which some kind of subsidy and "portability" already exists, the key challenge for policymakers is to ensure the correct incentives for all actors to avoid risk selection behavior in an increasingly competitive health insurance environment.

d) Purchasing function problems

Problems in the purchasing function refer to a failure to be a "strategic" purchaser and rather, be a "passive" purchaser. Strategic purchasing refers to the capacity of the purchaser to be selective in choosing providers, payment, and contracting mechanisms. They may take advantage of the wide range of available prices and quality to create the external incentives for providers to improve their efficiency in providing the services under the conditions of dignity and quality that the purchaser wishes for its population. We argue, in general, that provider competition and market exposure under a "correct" purchasing incentive environment (price signals and hierarchical control in different combinations) increases efficiency.

In contrast, "passive" purchasers are those not able or focused on creating such incentives and are more focused on the financing of providers than in creating the conditions for providers to deliver health care services under the required conditions stipulated in the GHP for all the three dimensions of utilization, financing and dignity. Failing to create the appropriate incentives for providers may result in purchasing models that inappropriately reduce utilization because of providers setting barriers to access to services for certain groups. This is what we refer to in this document as the "under-provision" of health care services. "Under-provision" is facilitated in the absence of "strategic" purchasing. Such discriminatory practices may also include lower levels of quality (objective or subjective), longer waiting times, and/or inappropriate charges to users. These discriminatory practices can lead individuals to seek and pay for health care services which should theoretically be provided under the auspices of the GHP.

D. Exclusion due to problems in organizational and institutional incentives

1. Organizational and institutional incentives and their impact on inclusion

So far this framework has reviewed the technical design problems that might determine exclusion (insufficient level of prepayment, risk pooling, equity subsidization, and/or strategic purchasing). Good technical design does not, however, ensure effective implementation of policy and actions against exclusion from social protection in health. Policymakers often learn that non-technical design determinants become a major obstacle in implementation. This section examines organizational and institutional incentives as essential components of a successful effort to combat exclusion from social protection in health.

For example, general tax revenue is generally considered as potentially the most efficient financing mechanism for collecting resources to ensure the highest level of prepayment and, depending on the progressiveness of the taxation scheme, it may ensure equity subsidization. Why then are out-of-pocket expenditures the predominant form of collection of funds in low- income developing countries? The use of general taxation as the main source of financing for health requires highly complex organizational systems and institutional capacities. This is often exactly what is lacking in developing countries. Creating adequate external and internal incentives for participants, insurers, and providers to collect and manage funds is organizationally and institutionally very demanding. The following sections review the main elements determining the

successful implementation of a technically sound design of social protection system in the health sector.

In the absence of a proper organizational and institutional environment, the recommendations and possible solutions to the problems of exclusion previously analyzed might not only be ineffective but may also have a negative impact on combating exclusion from social protection in health in developing countries. Policies that promote an inclusive system of social protection need not only consider the best possible technical design. They must also evaluate it according to the organizational and institutional characteristics of the settings in which such designs will be implemented and simultaneously introduce the required organizational and institutional reforms. For example, the segmentation of risk pools has been observed in the last two decades in Latin America as a result of the introduction of reforms aimed at creating a more competitive environment and expanding the role of the private sector in pooling. However, there was an absence of simultaneous organizational and institutional reforms in the health system as a whole resulting in some cases in increased inequity and exclusion (Baeza, 1998).

2. *Organizational arrangements*

Different societies define various organizational arrangements for their systems of social protection in health. These, in turn, are usually linked to distinctive instruments for collecting, risk pooling, and purchasing health services. The most common organizational arrangements are:

- ministries of health, which frequently have large networks of public providers. Usually this organizational arrangement in developing countries provides services for workers in the informal sector and is funded by general taxes collected by the central government;
- social security organizations, which can be a single national organization or several institutions (competing or non-competing). The private sector may or may not participate in the management or ownership of these organizations. Social security organizations traditionally provide services for workers in the formal sector and either have their own networks of providers, buy services from other providers, or both. Usually these organizations are funded via payroll taxes;
- voluntary insurance (usually private insurance schemes) with a formal or informal structure. Usually these organizations are financed by voluntary risk-based premiums;
- community financing organizations or informal insurance schemes organized by members of the community established by small groups of individuals or by provider organizations to pool risks. These organizations are usually financed by different types of voluntary contributions and often by variable amounts of subsidization. Some forms of these organizations are also known as microinsurance (Dror and Jacquier, 1999; ILO-STEP, 2001).

Providers can also play a role in pooling arrangements when they collect capitated contributions that are not risk-adjusted. Another form of provider-based insurance scheme is prepaid medicine, a model that is becoming increasingly popular among private corporations and businesses in Latin America (ILO-STEP, 2001).

Each type of organizational arrangement is often associated with specific technical designs for the financing function. For instance, social security organizations spread risks across their members, usually from the formal sector, and collect revenues through salary related contributions. This potentially may lead to substantial cross-subsidization if the benefit package is similar regardless of the salary level. In contrast, private voluntary insurance collects through risk related

contributions, with contributions varying according to risk, although some cross-subsidization occurs between individuals belonging to the same risk category as defined under actuarial calculations. These two arrangements present fundamental differences in the collecting of revenues and also determine fundamental differences in their pooling characteristics. Contributions to social security organizations are proportional to the individual's salary, while contributions for private and voluntary insurance are proportional to the individual's risk. Since these are two distinct models of collecting and determine two different pooling characteristics of the scheme, the coexistence and competition between these two different organizational arrangements within the same health care system creates external and internal incentives that will lead to segmentation of the risk pools. The case of Chile demonstrates the negative effects of this situation. The technical design changes introduced in Chile during the early 80's failed to ensure the "portability" of public subsidies because there was no restructuring of the institutional and organizational incentives of the system (Baeza and Copetta, 1999).

Usually under these alternative arrangements all system functions are integrated within the same organizational structure. However, there are important exceptions. In the case of ministries of health or in the case of national health care systems, the collection of funds is carried out by the ministries of finance and a significant part of the pooling is done at that level. Some social security systems with multiple insurers have created centralized structures for the collection of funds and the management of risk and equity subsidies (solidarity funds) as in the case of Colombia and the Netherlands, which also means a significant part of the risk pooling is also done at that level. Finally, the United States has made some attempts to separate the pooling and purchasing functions in different organizations (Weiner et al, 1994).

The separation of financing functions (collecting, pooling and purchasing) to create incentives for insurers is still being developed and is not yet frequently used. This is in contrast to policy reforms such as "managed competition" and "internal market reform" under which purchasing and provision of services encouraged the purchaser to create positive incentives for providers (Enthoven, 1985, 1988, 1993; Ovretveit, 1995). However, the separation of pooling and purchasing functions may play an important role in the near future by helping to promote the unification of risk pools without losing the possibility of consumers choosing their preferred purchasing agency. In addition to encouraging competition in purchasing rather than in pooling, the separation of these functions can lead to a reduction of the inequalities between groups created by highly segmented risk pools. It might also facilitate the political economy of aggregating pools through reducing the threats of disappearance to existing insurance organizations within a health system with multiple competing insurance organizations.

Fragmentation of the risk pools (too many small risk pools) leads to distortions in the financing mechanisms resulting in severely negative consequences for inclusion. Numerous small risk groups are less financially viable and reduce purchasers' negotiating capacity with providers. Large risk pools have the advantage of economies of scale and reductions in the financial uncertainty of the pool. They also have the advantage of significant implications for the solvency margins and technical reserves required for ensuring financial sustainability. Large purchasers also have more bargaining power in negotiating (particularly in purchasing services of medium and high complexity) with providers who tend to behave as natural monopolies. This greater capacity for negotiation gives large purchasers advantages in terms of price but also in quality and timing of health care services.

It can be argued that a similar problem of risk pool fragmentation takes place in low-income countries where health microinsurance has been developed. However, here the problem is that no

insurance schemes with large risk pools are in place as alternatives. In that sense, if health microinsurance schemes are beneficial for those who join them, then it might be better to have these small schemes with fragmented risk pools than not to have any pooling at all (ILO-STEP, 2001). Another way to look at this issue is to consider that not having any insurance scheme is a radical form of fragmentation of the risk pool that has reached the smallest group possible-the individual. Introducing effective microinsurance schemes where there was no insurance coverage at all seems reasonable because it does not represent fragmentation. Rather, it may be a potential beginning to the process of pooling risks. Microinsurance can be considered a first step towards a more comprehensive system with larger risk pools. Ideally, as soon as microinsurance schemes are developed, strategies for merging risk pools should also be considered. This process could also allow early detection of problems that could arise in the context of less fragmented insurance schemes covering larger groups of the population.

In the majority of cases, the inexistence of efficient public services or insurance schemes covering large groups of the population makes community insurance an alternative for the uncovered population, in particular those with some ability to pay. Community health financing organizations can potentially open the possibility of increasing the level of prepayment in the collection of funds. It also might allow the population to take advantage of risk pooling by facilitating risk pooling and the allocation of resources for equity subsidies among members. However, preliminary reviews by the STEP program (ILO-STEP, 2001) suggest that there is very little evidence so far demonstrating the actual effectiveness of such schemes in increasing inclusion to social protection in health as defined in this framework. Therefore, this framework emphasizes the priority of achieving large regional or national insurance schemes when feasible and advocates large risk pools as a better alternative than microinsurance to ensure inclusion. The assessment of whether it is more feasible to initiate a national or regional insurance scheme system or to start with microinsurance schemes should be done on a case-by-case basis and should largely depend on the organizational and institutional characteristics of the country.

3. *Organizational or internal incentives for achieving inclusion*

A key element for achieving the maximum potential of adequate technical designs (prepayment, risk pooling, equity subsidy and strategic purchasing) to avoid (or combat) exclusion is an adequate incentives framework for all the organizations involved in social protection in health. External and internal incentives must be in line with the technical design chosen so that all actors involved will have clear incentives to effectively promote the ultimate goal of inclusion. The main internal incentives of key importance in this respect are the following:

- **degree of autonomy**. The capacity of an organization to make certain important decisions independently of its owners or of central government in the case of public organizations. For example, determination of premiums, decisions regarding the level of co-payments, strategies for selecting, contracting and payment to providers, establishment of priorities on the services to be purchased, and decision regarding the financial surplus. These examples have potential significant impact on the utilization of services, and the financial protection and dignity of its members;
- **accountability**. The organization, particularly its top management, has to answer for its actions and results to the owners or others to whom their authority has been delegated. The enforcement of accountability usually requires regulations, vertical monitoring systems that enable transparency, and clear rules of accountability for the results;

- **market exposure.** This incentive refers to the proportion of the budget that comes from the contributions of individuals (consumers) who choose the organization and the proportion of funds that come from public funds or other fixed income sources. It is important to determine whether the government will subsidize budget gaps if the organization does not attract sufficient contributing members. High proportions of revenues from consumers who choose the organization mean high market exposure;
- **financial responsibility.** The degree to which the management of the organization is held responsible for its financial performance. Also, the share of the profits or capital gains that the organization is authorized to retain;
- **unfunded mandates.** The interventions, individuals or groups that the organization is required to cover free of charge even when no subsidy is in place. Such cases may include insurance coverage for the indigent or coverage for individuals with known high risks.

From the above-described internal incentives, it is clear that optimal technical designs (prepayment, risk pooling, equity subsidy and strategic purchasing) might work differently in organizations subject to radically different organizational incentives. For example, the incentives influencing strategic purchasing are significantly different for ministries of health and voluntary private insurance schemes. Ministries of health are subject to low market exposure and low financial responsibility and are accountable to central government, while voluntary schemes are subject to high market exposure, high financial responsibility and are accountable to the owners. Also, significant differences in market exposure may mean different incentives for the customer orientation of the organization. These differential exposures to organizational incentives need to be closely considered when deciding on optimal technical design and also need to be balanced by external incentives in order to achieve societally desired behavior by the organization.

Another example is related to "national priorities" in health. Voluntary, private insurance and community insurance are accountable mainly to the owners and to the insured given their high market exposure. These organizations are less prone to include in the insurance benefit package services that might be of national priority for the health authorities of the country but are not demanded by the population even if they are allowed to charge for them in the premium (e.g. public goods, preventive services). In this case, external incentives (e.g. stewardship intervention through regulation) have to be in place to ensure that these organizations also respond to the priorities of governments (national priorities) and are accountable to the government for them. Frequently, voluntary insurance systems focus on the short-term and prioritizing low-cost health problems with high incidence and leave the insured without coverage for interventions of high financial risk. Implicitly in these cases, the public sector becomes the default insurance scheme that will cover those interventions. This problem has to be taken into consideration in the design of a GHP in order to provide not only for the best technical design but also for regulation to compensate for potentially counteracting internal incentives.

Differential exposure to unfunded mandates is another example. Ministries of health or national health services adapt relatively easily to unfunded mandates. The impact on the provision of services and adaptive managerial policies to unfunded mandates is quite different and far larger than the capacity to adapt to such mandates by private insurance. Ministries of health traditionally adapt to these mandates by decreasing the quality of services and increasing the waiting times or, sometimes, generating budget deficits that have to be provided by the government. Private insurance schemes respond to unfunded mandates by "cherry picking" or developing policies that lead to "under-coverage" and "under-provision" as we have previously discussed. For this reason,

while the government can ensure compliance with unfunded mandates by ministries of health through vertical command and control structures, this strategy is ineffective in the case of private insurance and requires regulation or other external incentives to ensure compliance.

Unfortunately these differences in exposure to internal incentives are not frequently taken into account when expanding the role of the private sector and/or community insurance schemes that may lead to exclusion instead of inclusion. In those cases, authorities from the ministries of health frequently complain about the difficulty of enforcing compliance with unfunded mandates (health interventions) which were easier to enforce on public providers before the provision or the insurance role was transferred to the private sector. Policymakers must bear in mind that these types of reforms require redefinition of the stewardship role that government plays in the system by determining correct external incentives for all actors in the system.

Box 7 shows a matrix with the different organizational arrangements and their exposure to different internal incentives.

Box 7
Different levels of exposure of various organizational arrangements to internal incentives

Organizational models / Internal incentives	Ministry of health	Social security	Community organizations	Voluntary private insurance
Autonomy	Limited	Variable, but usually high	High	High
Accountability	Government	Board members / users	Owners and users	Owners and users
Market exposure	None	Variable, but usually high in high competing systems	Variable but usually low	High
Financial responsibility	None or limited	Low	High	High
Unfunded mandates	High	Low	None or limited	None or limited

4. Institutional or external incentives

Institutional or external incentives refer to the explicit and implicit rules and practices that define how different organizations interact in a system. As is the case with organizational incentives, institutional incentives are also a key element for achieving the maximum potential of adequate technical designs (prepayment, risk pooling, equity subsidy and strategic purchasing) and for avoiding (or combating) exclusion in social protection in health. The main external incentives of key importance in this respect are:

- **rules and practices related to the governance and management of organization.** These rules and practices shape the relationship between the organization and its owners, most likely between the top management of the organization and the owners. It defines how owners participate in decision-making, how accountability will be exercised, and all rules for such interaction. The ownership of the organization, public or private, entitles its owners to make decisions regarding its assets and surplus;
- **rules and practices related to financing for public policy objectives.** These rules and practices shape the relationship between the organizations managing health financing and the public funds available for health (if any). They include guidelines for the implementation of public budgets, eligibility for public subsidies, auditing, taxes, etc.;
- **rules and practices related to the role of stewardship.** The rules and practices that shape the relationship between the health system organizations and the authorities (usually government) with mandates in public policy in health and in social protection in health and the enforcement of laws and regulations regarding the relationship between consumers and insurers or providers, etc. Stewardship is carried out through a diversity of instruments (laws, auditing, education, monitoring, regulations and other). Examples of key important regulatory aspects included under these possible rules are the length of contracts, mandatory benefits package or GHP, rules about the mechanisms for calculating premiums (e.g. community rating or other), regulations on the level of worker's contributions, barriers to the entry of insurers or providers, financial reserves and solvency rules, marketing, and sales regulation.

Box 8 shows a matrix with the different organizational arrangements and their exposure to different external incentives.

Box 8
Levels of exposure of different organizational arrangements to external incentives

Organizational models / External Incentives	Ministry of health	Social security	Community organizations	Voluntary private insurance
Governance	Public, low level of decision rights	Public or "quasi-public", low level of decision rights	Private, high level of decision power	Private, high level of decision power
Public financing	High	Variable, usually low level	None, except when there are public subsidies	None, except when there are public subsidies
Stewardship	Hierarchical control	Variable degrees of hierarchical control, regulation and incentives	Regulation and financial incentives	Regulation and financial incentives

Extending social protection in health to those excluded requires the cooperation and participation of many organizational arrangements beyond those traditionally used for the formal sector. However, shifting from one organizational arrangement to another, particularly extending it through private and community arrangements and its coexistence with traditional formal sector and public sector models, is extremely demanding organizationally and institutionally both for the actors and for the stewardship role of the government. This complexity may need to be considered before the introduction of reforms and adjustments to the implementation schedule in order to avoid problems of exclusion resulting from incompatibility between the technical design and the organizational and institutional context prevailing in the specific context of a country.

Careful consideration of organizational and institutional incentives both at organizational and institutional levels should be seen as crucial elements in extending social protection in health. Such incentives can make the difference between success and failure and have too often been ignored in health sector reform processes. This problem is evident in the troubled health sector financing reform efforts carried out in Eastern Europe and Latin America during the 80's and 90's (World Bank, 1997; Baeza, 1999).

IV. Implications for combating exclusion from social protection in health

The conceptual framework for social protection presented in this document has concrete implications for the strategy of combating exclusion from social protection in health.

The discussion in this framework points out the complexity and multi-dimensionality of exclusion from social protection in health and its causes. Combating exclusion requires establishing trust and effective social and policy dialog between government, social partners and communities in order to identify the causes and magnitude of exclusion as well as its possible solutions. It requires establishing the technical and political capacity to identify the technical design and the organizational and institutional determinants of exclusion.

The framework emphasizes the need to establish a clear distinction between the objectives of inclusion and the possible instruments for achieving it. Too often the discussion and efforts are focused on implementing specific instruments (health microinsurance, formal social security, private sector participation in health insurance, or others). Too often inclusion is judged on the basis of people's participation in such instruments rather than on achieving access to effective health services that improves the health status of its members, financial protection and/or assuring the dignity of individuals. Combating exclusion is not about one instrument or another, it is about achieving the objectives of social protection in health using any and all instruments proven to be effective in specific organizational and institutional contexts. Therefore, the objective in combating exclusion from social protection in health is not to establish programs for advocacy and implementation of microinsurance, re-insurance of microinsurance, implementation of formal social security in health, increased participation of the private sector in social security in health, a national health service or any other specific instrument. The objective is to support country and sub-national efforts to establish effective policy and social dialog for identifying the determinants of exclusion and how those instruments (or others) can better serve the objective of inclusion in the specific organizational and institutional context at national or sub-national levels.

In developing countries, the strategy for combating exclusion aims to address the inexistence, lack of effectiveness, or lack of efficiency that may characterize systems of social protection in health by focusing on solving its multidimensional causes. They may include the inexistence of pooling arrangements, low levels of resource collection capacity, inefficiencies of existing systems of social protection in health, including problems in collection, pooling, and strategic purchasing, and a low stewardship capacity of the state to prevent and overcome exclusion in health.

Two distinct country contexts must be considered when developing and implementing strategies to overcome exclusion. First, low-income developing countries often face low institutional and organizational capacity. Second, medium-income countries often have growing levels of capacity. Combating exclusion in health requires efforts in both settings, but the strategies are often significantly different. In the context of a country with low-income and low-institutional capacity, the main characteristic is the lack of effective pooling arrangements and the fragmentation of the few existing pooling arrangements into multiple small schemes. In this context, communities often organize pooling and purchasing arrangements or so called health microinsurance (Dror and Jacquier, 1999) or community health organizations (ILO-STEP, 2001). The challenge in this context is to increase pooling through implementing instruments appropriate

for the organizational and institutional context of the country and the community and to do so in a manner that would facilitate in the future (when conditions allow) the aggregation of pools to an efficient size. In this context, we believe that having some pooling is better than not having any and that community health organizations might have a positive impact not only in pooling but also in purchasing and as an entry point to larger pooling schemes (ILO-STEP, 2001). However, the international community is still a long way from having hard evidence that these organizations actually are sustainable in the long run and have a positive impact on social protection in health by improving health, utilization, financial protection and/or the dignity of its members. There is also some skepticism that it is actually possible for countries to steer these arrangements to more aggregate pooling later on (ILO-STEP, 2001; Bennett et al., 1998; ILO-STEP and PAHO, 1999).

The STEP program has devoted significant attention to supporting the development of pooling mechanisms within the context of microinsurance for low-income countries. Joint ILO-World Bank initiatives also focus on these efforts in countries where community insurance programs face important challenges, among others due to problems with reinsurance mechanisms.

In a low income country context, it is necessary to distinguish between two population groups:

- those that have the capability to contribute to financing the GHP, but for whatever reason suffer exclusion; and
- those who would have to contribute in excess or are not able to contribute at all to financing the GHP.

In the case of a population with capacity to contribute, the main challenge is to create or increase effective pooling arrangements. This can be achieved through the elimination of barriers for participation in existing pooling arrangements. In the absence of any other more aggregate pooling arrangements, community health organizations can be an alternative, subject to the issues discussed above in this framework. However, it should be considered only as a preliminary stage in a process of further developing more efficient models of risk pooling. Otherwise, its limitations in allowing for equity subsidies would confine poor communities to pooling their scarce resources. For community health organizations to be effective, a significant technical assistance effort is required. This includes support for the management of risk-spreading mechanisms, definition of the set of covered health care services ideally in line with the defined GHP when feasible, managing the process of affiliation to the system, managing financial resources and the purchase of services. According to the experience of the STEP program, weakness in any of these aspects frequently leads to important problems that compromise the viability of the scheme. Another important cause that may lead to important system problems is the absence of reinsurance mechanisms for the few schemes for which an unpredictable revenue-expenditure variation threatens the scheme's financial viability even when the management and contribution capability of the community are in place.

In the case of a population with no capacity to contribute, the main challenge is the lack of sufficient equity subsidies in addition to the lack of pooling arrangements. In the setting of low-income and low-institutional capacity, it is extremely hard for the existence of an equity subsidy at country level (from government revenues or other sources). This suggests that possibly the only viable alternative is for the international donor community to take a proactive role and explicitly assume the financing of the required subsidies.

Even in the presence of a clear intention of the international donor community to contribute with substantial equity subsidization, which of the coexisting models of organization should be subsidized? Should international donors support the ministries of health, the social security organizations, or community health organizations as key instruments for extending social protection in health? Given the important restrictions of low-income countries in terms of organizational and institutional capacity, this topic is still being debated. Experience with each of these alternatives and analysis of the results is still insufficient and a much more rigorous evaluation of the potential of these alternatives in low-income and low-institutional capacity settings is needed. The STEP program is actively working on contributing to the creation of such evidence through undergoing research and by promoting policy dialog around this question. In the meantime, we believe that there is a need to experiment and document rigorous evaluations of these three strategies.

Strategies such as the sector-wide approach (SWAP) constitute, an opportunity for multilateral agencies to support governments willing to explore these three strategies. The development of pilot projects that establish subsidies for insurance premiums as a way to allocate the equity subsidy for the poorest groups of a population could also be useful to advance in that direction.

In middle-income countries with greater organizational and institutional capacities, the focus is different. In these countries, the combination of public and private insurance schemes and the existence of equity subsidies funded mainly from public resources, but also from cross-subsidization within each health insurance organization, requires the focus to be on the policy and social dialog between the government and social partners. The goal of this national dialog should be the identification of the causes of exclusion and exploring potential solutions that take advantage of the vast resources already mobilized by existing organizations such as ministries of health, public and private insurance schemes, social security, etc. In these cases the effort should aim to improve the efficiency of equity subsidy allocation through, inter alia, the virtual or actual aggregation of risk pools, portability of public subsidies and public sector reforms. More specifically, in this context, the strategy for combating exclusion in health should mainly be focused on:

- improving the efficiency of equity subsidy management (both in the public sector and in the health insurance system including social security);
- reducing the fragmentation of risk pooling arrangements, either merging organizations or through a virtual merging process by the creation of a new institutional framework that allows for better management and redistribution of equity subsidization. This is particularly important in the case of countries with a tradition of having multiple insurance schemes, explicitly or implicitly competing among themselves and for which a single pool is not a national option. The introduction of a GHP in such a context will make it more urgent to improve all the management mechanisms for equity subsidy. The new institutional framework will most likely include requiring the introduction of the "portability" of subsidies, improving the efficiency of subsidy management and strengthening the regulation that protects users.

The STEP global program aims to strengthen its role for extending social protection in health to the excluded in the world. The main focus of its efforts is on combating exclusion and the advancement of social protection. The program uses a synergistic combination of empirical and conceptual research and country and community projects that are deeply rooted in a process of policy and social dialog at local and national levels. In order to develop these goals, the STEP program aims to:

- develop new knowledge on what works and what doesn't in extending social protection in health through conceptual and empirical research and in partnership with other bilateral and multilateral agencies working in the field;
- disseminate knowledge and decision-making-oriented information to enhance social protection in health, and support country and sub-national efforts in policy and social dialog aiming to increase inclusion in social protection in health;
- advocate for effective policy and social dialog between bilateral and multilateral agencies in order to identify the causes of exclusion from social protection and possible solutions at local and national levels and support efforts to combat it;
- Implement, in partnership with international and national actors, pilot projects "in-the-field" in order to explore new mechanisms and alternatives for the expansion of social protection in health; and
- provide technical assistance through projects with governments and social partners to identify, determine the magnitude, and propose solutions to exclusion from social protection in health and its multiple causes. These projects aim to identify solutions for the problem of exclusion through emphasizing the need for technical design appropriate for the organizational and institutional contexts in each region and country.

At the core of this framework is the concept of a social guarantee of a health benefits package. The specific content and complexity of such a social guarantee depends on the country's definition through effective policy and social dialog and on the capacity of the country and the international community to allocate sufficient financial resources to provide for equity subsidies. The mission of the STEP program is to contribute to the efforts of governments and social partners to implement a viable transition to their own social guarantee of social protection in health as embodied in the GHP. This effort needs to always remain focused on the permanent objective of inclusion but be innovative and open to using every different effective instrument, which will necessarily evolve and change in time as a result of experience and knowledge.

The STEP program is committed to inclusion in health based on the permanent goals and values of social protection and using evolving instruments to meet the contemporary challenges.

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