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Response to health inequity: the role of social protection in reducing poverty and achieving equity

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SUMMARY

Health inequities are determined by multiple factors within the health sector and beyond. While gaps in social health protection coverage and effective access to health care are among the most prominent causes of health inequities, social and economic inequalities existing beyond the health sector contribute greatly to barriers to access affordable and acceptable health care.

Key words: social comparison; economic analysis

SOCIAL PROTECTION: A *HEALTH IN ALL POLICIES* TOOL TO ADDRESS INEQUITIES

Health inequities are determined by multiple factors within the health sector and beyond. While gaps in social health protection coverage and effective access to health care are among the most prominent causes of health inequities, social and economic inequalities existing beyond the health sector contribute greatly to barriers to access affordable and acceptable health care.

Given the dual causal relationship between poverty and health and the role of employment in generating income and accessing needed health services, a *Health in all Policies* (HiAP) approach is a key to achieve sustainable progress towards equity based on universal coverage and access. HiAP supports cohesive and thorough policy action across different levels of government and multiple sectors within the economy, especially as it relates to addressing social inequities and highlights more generally the need to address the social context (McQueen, 2013). The recent global financial and economic crises significantly impacted on millions of people. Not only was employment and income significantly reduced during this time, but these reductions were accompanied by gaps in social protection coverage, particularly in social health protection. As a result, inequality increased and many families became impoverished and unable to access adequate health care. Following the crisis, over one quarter of people in developing countries are living below the poverty line of 1.25 US$ per day (World Bank, 2010a). Highest poverty rates can be observed in countries of Africa and Asia as outlined in Figure 1.

In times of crises, inequities in access to resources are not alleviated but remain systemic: while one-fifth of the worlds' population has access to over 70% of resources and profited from the consisting increase of the world's GDP over the last 30 years, the bottom quintile of the population is left with 2% of the world's GDP (ILO, 2011).

Unfortunately, countries with populations most in need spent less on social security than others, as shown in Figure 2. It visualizes social security expenditure for health, old age and other branches by level of country vulnerability defined in terms of poverty and extent of informal

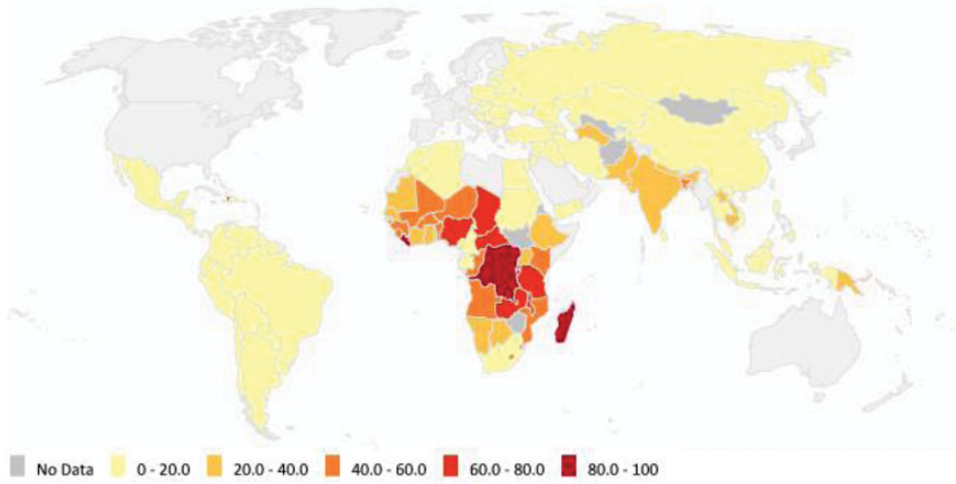

Fig. 1: Global poverty headcount ratio (in per cent), at US$1.25 per day, 2011. Source: World Bank, Poverty and Equity data, extracted on 26 October, 2012 from http://povertydata.worldbank.org/poverty/home/.

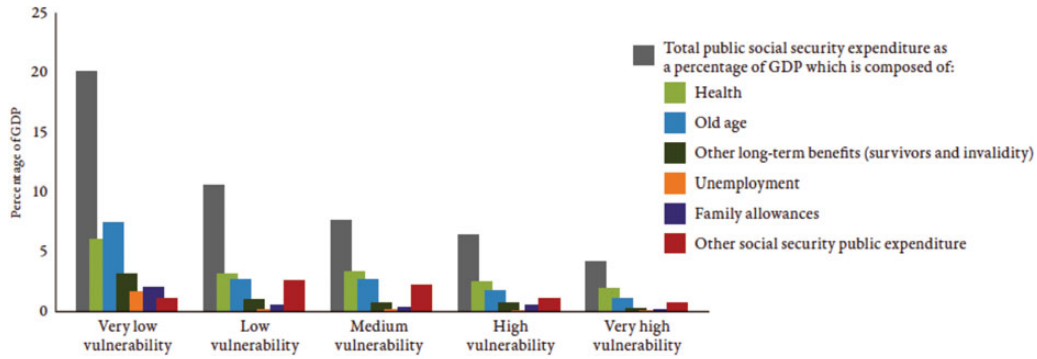

Fig. 2: Social security expenditure by vulnerability and branch, weighted by population, latest available year (per cent of GDP). Source: ILO, World Social Security Report 2010/11, page 83. A colour version of this figure is available at http://heapro.oxfordjournals.org/

economy at national level. Highest vulnerability is related to countries where more than 80% of the population live beyond the poverty line and the extent of the informal economy exceeds 80% of the work force. In these countries, least spending on social protection is observed.

Indirect effects on health of scarce or no income include bad nutrition and inaccessibility to essential services such as water, decent housing and education:

- *Education and employment*: large inequities persist in the education sector, where globally 796 million adults are illiterate (UNESCO, 2011). These inequities are directly related to the health status of individuals. For example, the educational status of the mother impacts on the mortality of her child: children born by mothers with a low education have a higher risk of dying before the age of 5 in some African countries (WHO, 2011a). Additionally, healthy people are more productive and more responsive to education. Therefore, reducing inequities in health is crucial for achieving high levels of education and employment.
- *Water, sanitation and housing*: the lack of access to water, sanitation and decent housing greatly impacts on the health status of the world's poor. However, 40% of the world's population lack basic sanitation and over 30% of the world's urban population live in slums (ILO, 2011). Furthermore, deficits in decent

housing involve unnecessary costs of health care systems: in the UK, it is estimated that every year £600 million are spent on health care due to poor housing conditions (WHO, 2011b). Access to drinking water also impacts significantly on the health status as shown in the case of Zimbabwe (Mhishi, 2013). Hence, improving housing and sanitation can decrease the burden of both individual and national health care budgets.

- *Food security*: it is estimated that globally, 1.75 billion people experience multidimensional poverty with deprivations in health, economic opportunities, education and living standards (UNDP, 2010). As a consequence of the financial crisis, the increase in food prices and climate change, more people are starving today than in 2008—one billion people overall (ILO, 2011).

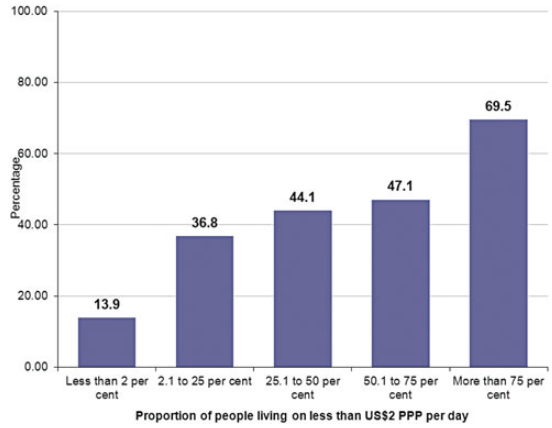

Fig. 3: Global OOP for health as percentage of total health expenditure in countries grouped by poverty incidence, 2006. Source: WHO database 2009; ILO database (2009).

Global imbalances in income and distribution jeopardize coverage and equitable access to health care and fairness of financing of social (health) protection. Thus, inequities in access to health care can be considered as a part of broader processes of social exclusion, the effects of which can only be ameliorated by taking advantage of a HiAP approach.

Following this approach, the underlying inequalities should be taken into account when defining and assessing gaps in coverage and inequities in access to health care. Accordingly, the ILO defines coverage with a view to two main components: first, as a prerequisite of coverage serves formal *affiliation* to a health system or scheme, e.g. through legislation or contracts. Second, *effective access* requiring the implementation of legislation relates to the *affordability and availability of quality health care and financial protection* in case of sickness. This definition allows for identifying and quantifying deficits towards universal health coverage by using indicators such as out-of-pocket payments (OOP) for affordability and density of the health work force for the availability of health services (Scheil-Adlung and Bonnet, 2011).

OOP are found in almost all countries to varying extents, despite the fact that OOP represent the most inequitable and unfair health financing mechanism due to their regressive nature and lack of solidarity through risk pooling. An example is Zimbabwe, where high financial barriers to access health care are resulting in increased impoverishment and worsening health status (Mhishi, 2013). On average, in low income countries, as much as 45% of total health expenditure is paid out-of-pocket (ILO, 2014).

More generally, it can be observed that OOP increase with levels of poverty: Figure 3 illustrates this relationship in countries grouped by the level of poverty. Each of the five groups consists of some 30 countries that are defined by the proportion of people living on less than US$2. In the globally richest countries where less than 2% of the population is living below the US$2-poverty line, OOP are relatively low and account for less than 15% of total health expenditure. These countries include Germany and Japan, showing 13.3, respectively, 14.7% of OOP. Sick people in countries with poverty rates between 2 and 75% have to finance roughly 40% of the total health expenditure out of pocket. This is the case, e.g. in Bulgaria, Iran and Kenya, where we find OOP rates of 39.3, 42.1 and 41.2%. The percentage of OOP is even higher in countries with poverty levels involving more than 75% of the total population: here OOP represent nearly 70% of the total health expenditure. This group includes countries such as Cameroon and India, where 68.2 and 75.6% of health expenditure is borne out-of-pocket.

Related inequities in access to health care are observed specifically for vulnerable groups, e.g. the poor, among them particularly women, the unemployed, those working in the informal economy and rural populations. They occur due to both factors within and beyond the health

sector, highlighting the need for the HiAP approach in addressing the multifaceted disparities between these groups.

Within health systems, such factors often include:

- Deficits in affiliation to public and private health protection schemes and systems based on legislation such as in national health systems or contracts, e.g. in social or national health insurances or private health insurances. Figure 4 provides an overview of the global situation indicating related coverage gaps concerning up to 90% of the population in large parts of Africa and Asia;
- Limited scope of benefits that exclude specific needs, e.g. for people with HIV/AIDS or chronic diseases;
- Imbalances and gaps in the geographical distribution of infrastructure and health workforce in rural and urban areas.

Beyond the health sector, key issues impacting on equity in access to health services most frequently concern

- The poor and socially excluded such as ethnic minorities or migrants;
- Workers and their families who lack (sufficient) income because they are not employed, underpaid, elderly etc.
- Workers in the informal economy;
- People suffering from access to needed income support through social protection.

Figure 5 shows the impact of poverty and size of informal economy on affiliation: nearly 90% of people living in countries with poverty and informal economy levels above 80% are not covered in terms of affiliation by any scheme or system (ILO, 2010).

Against this background, it is important to coordinate health, social and economic policies including labour market policies, housing, sanitation, education and nutrition as well as many others which may directly or indirectly impact on equity. Thus, an approach applying HiAP by focusing on both increasing access to health care and poverty alleviation as well as coordination of related policies—such as outlined in the ILO Recommendation 202 on National Social Protection Floors—is essential for achieving

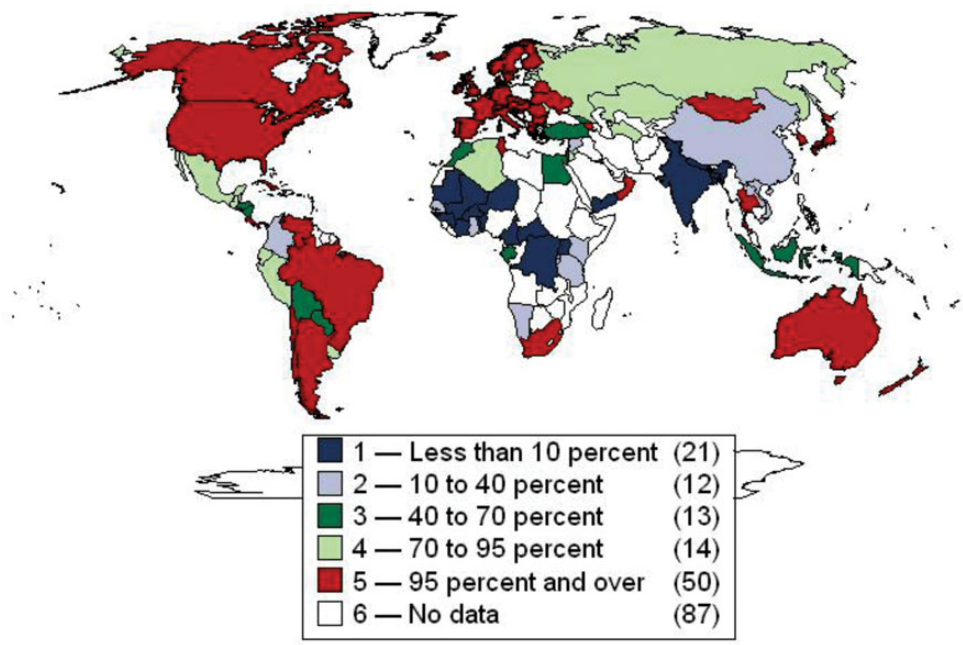

Fig. 4: Proportion of the population affiliated to public or private social health protection schemes, latest available year (in per cent), 2012. Source: ILO: http://www.socialsecurityextension.org/gimi/gess/ShowWiki.do?wid=76. A colour version of this figure is available at http://heapro.oxfordjournals.org/

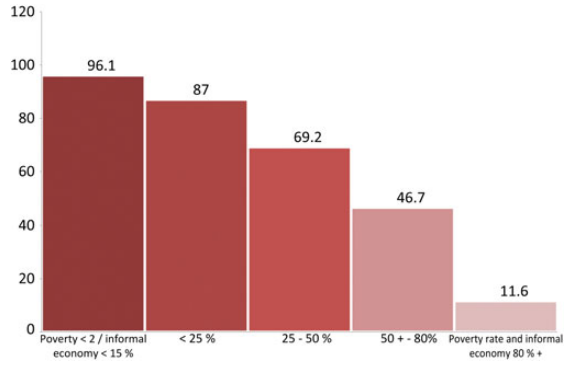

Fig. 5: Global affiliation rates to social health protection systems and schemes by poverty rate and size of informal economy Source: ILO, based on World Social Security Report 2010/11.

sustainable progress towards equity (Leppo *et al.*, 2013).

EXTENDING SOCIAL PROTECTION WITH A VIEW TO REDUCING POVERTY AND ACHIEVING EQUITABLE ACCESS TO HEALTH CARE: THE SOCIAL PROTECTION FLOOR APPROACH

Against this background, the Human Rights to health and social security demand renewed attention. [Article 22 of the Universal Declaration of Human Rights (1948) states: "*Everyone, as a member of society, has the right to social security*".] It is particularly important to

(a) Extend social health protection with a view to achieve universal health coverage resulting in effective access to health care;
(b) Develop a comprehensive policy response to address inequities in the health sector due to lack of income and poverty through social security measures, active labour market policies and others.

This includes developing efficient, effective and well-coordinated social health protection systems and schemes as well as setting policy priorities on employment, income support, skills development and enforcement of the right to equality and non-discrimination with a view towards the objectives of HiAP. In order to be successful, income support measures for the working age population should be combined with labour market policies which support existing jobs or create new ones, increasing the employability of people through training and other measures as well as facilitating the transition from informal to formal labour markets. This approach is confirmed by recent findings that work is a key determinant of health and a determinant of inequalities in health (Bambra, 2011).

The concept of national social protection floors (SPF) addresses all of these issues in a comprehensive manner (ILO, 2012). In line with the HiAP approach, the SPF intends to positively impact on equity and health outcomes through coordinated policies, particularly social (health) protection policies aimed at improving access to health care, alleviating poverty and developing coherent socio-economic policies. It is based on new paradigms, particularly that:

- Essential social (health) protection is feasible at any level of GDP;
- SPF are not just about protecting against ill health and impoverishment but about prevention;
- SPF are an investment in people rather than a tool to redistribute income;
- Social (health) protection is not just a national issue but impacts at the global level.

The SPF concept provides a coherent framework addressing essential social rights. It aims at a basic set of social guarantees such as access to health care and income security for all. National SPF should consist of essential social transfers, rights and entitlements providing access to health care and income to all in need (Figure 6).

The concept is based on the fact that social (health) protection is a tool to prevent and address efficiently and effectively poverty and inequities in access to health care. If based on social security policies that are aligned with economic and labour market policies, social protection also acts as an automatic social and economic

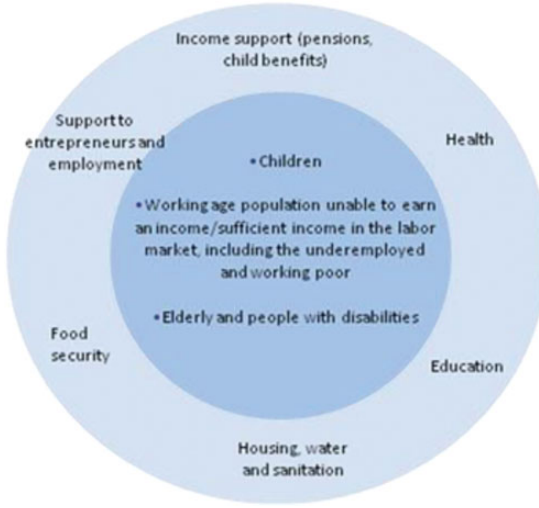

Fig. 6: Policy coherence based on the Social Protection Floor Approach.

stabilizer, allowing countries to cope with the fall-out of crises. By providing at least essential benefits in kind or in cash to those in need, this tool secures prevention of and protection in case of ill health, insufficient income, disability, old age, unemployment and addresses generally poverty and social exclusion. Such as the HiAP approach, the SPF framework encourages coherent multisectoral policies and recognizes a multidimensional definition of poverty and needs. The SPF includes guarantees of:

- *Universal access to essential and affordable social services* in the areas of health, water and sanitation, education, food security, housing and others defined according to national priorities;
- *Basic income security*, in the form of various social transfers (in cash or in kind), such as pensions for the elderly and persons with disabilities, child benefits, income support benefits and/or employment guarantees and services for the unemployed and working poor.

When striving towards universal health coverage, related legislation should be in line with national and internationally agreed upon objectives such as the MDGs and relevant ILO Conventions and Recommendations, e.g. ILO Convention No. 102 on Social Security (Minimum Standards) and ILO Recommendation No. 202 Concerning National Floors of Social Protection. However, coverage should not be limited to affiliation or legislation but be defined as effective access to at least essential, affordable and available health care of adequate quality and financial protection in case of sickness. At the national level, basic benefit packages should be gradually built up towards higher levels of social protection.

Objectives of related social protection policies should aim at universal coverage and be based on social solidarity. When addressing nationally defined goals, some key principles should be applied, particularly:

- Entitlements based on legislation;
- Non-discrimination, gender equality and responsiveness to special needs;
- Adequacy of benefits;
- Fair and sustainable financing;
- Coherence with social, health, economic and employment policies;
- Extension to all workers, including those in the formal economy;
- Efficiency and effectiveness including involvement of organizations of employers, workers and others concerned.

Strategic approaches to achieve sustainable progress in social (health) protection should focus on four essential guarantees:

(1) All residents in a country should have access to a nationally defined set of essential health care services;
(2) Income security should be focused on children aimed at facilitating access to nutrition, education and health care;
(3) The working age population in need of income support should enjoy a minimum security through social assistance benefits;
(4) All residents in old age and with disability should have income security through pensions.

Essential health care benefits to be provided should be in line with national and internationally agreed objectives such as the MDGs and ILO Conventions and Recommendations that provide a list of health care items and overall objectives. [Besides ILO Convention 102 (Minimum Standards, Social Security) and Recommendation 202 further ILO Recommendations focusing on Medical Care (e.g. 130) and provide related guidance.] They should address the needs of the population and be of adequate quality meeting the criteria of affordability, availability, accessibility and quality. Two components—health care benefits including curative, preventive and maternal

care—as well as cash benefits providing financial protection, e.g. transport costs or income replacement should be considered.

Various *policy instruments and financing tools* are available to design social protection schemes, related benefits as well as coordinate them based on national circumstances. An overview is provided in Figure 7.

Social security schemes can be either contributory such as social insurance schemes or non-contributory, e.g. tax-funded social assistance schemes:

- *Contributory schemes* are usually not-for-profit social insurance schemes, e.g. social health insurance or old age pension insurance. Key sources of funds include contributions/payroll taxes from employers and employees and are collected by social security institutions or public bodies. Frequently, subsidies are provided to cover the poor. Benefits of contributory social insurance schemes are usually defined and provided either in kind such as health care or in cash such as paid sick leave or unemployment benefits. Private insurance schemes such as community-based or occupational schemes exist both in the form of for-profit and not-for-profit. For private schemes, premiums from households are collected by insurance funds.
- *Non-contributory schemes* are tax-funded schemes. These might be direct or indirect taxes paid by citizens and collected by government institutions. Benefits provided might be designed for everybody such as universal health care services of National Health Systems or targeted, e.g. to the poor such as means-tested income support in social assistance schemes. Further, benefits can be conditional cash transfers requiring, e.g. school attendance or taking up preventive services.

The revenue raising potential of the various financing mechanisms depends on the overall institutional and legal environment and the socio-economic context. In both contributory and non-contributory health insurance schemes, additional out-of-pocket payments are usually raised directly by the provider.

Most frequently, all these schemes co-exist in countries given their specific advantages and disadvantages. Advantages range from large risk pools that ensure burden sharing such as in tax funded schemes, generation of stable income in social insurance schemes and reaching out to the informal economy, e.g. through micro insurance schemes. Disadvantages include the risk of underfunding due to competing public funding in tax-based systems, exclusion of informal economy workers in social insurance schemes and small risk pools and coverage as well as impoverishing effects in micro and private insurance schemes. Thus, it is important that the various schemes existing in a country be coordinated with a view to close coverage and access gaps. Reforms should aim at progressively improving the overall levels of population coverage and benefits. Regarding the development of all social protection schemes, e.g. health, old age and unemployment, an integrated approach should be aimed at in order to create synergies, particularly at the household level.

Monitoring progress of equitable access to health care and other benefits and if needed revisions of concepts and methods used to provide social protection is an important feedback to policy makers. For this purpose, social security data, statistics and indicators should be developed and exchange of information and experiences on

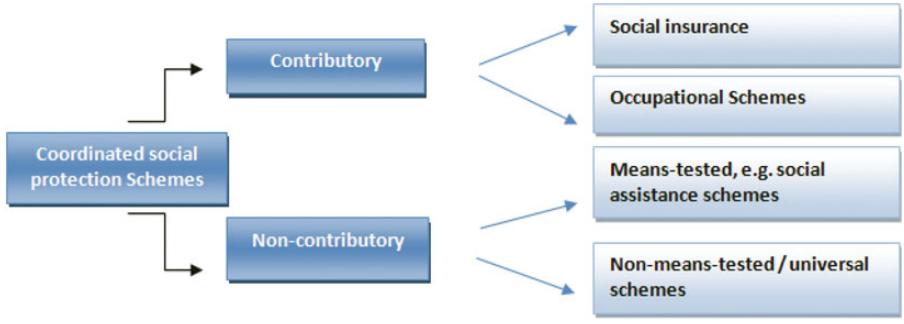

Fig. 7: Typology of social protection schemes.

strategies, policies and practices between countries facilitated. In the area of health care, a set of indicators capturing effective access to health care is suggested so as to allow mapping progress over time (Scheil-Adlung *et al.*, 2010). The key elements reflected in indicators relate to:

- *Population coverage* defined as the proportion of the population affiliated to a scheme or system such as national health systems or social insurance schemes;
- *Availability* of services based on the existence of health work force, infrastructure, goods and products, e.g. measured by the ILO Access Deficit Indicator focusing on the density of the health work force per population;
- *Affordability* and *financial protection*, defined by the absence of financial barriers to access services (such as OOP, particularly catastrophic payments);
- *Quality* that is strongly linked to the availability of sufficient resources, particularly public funding.

In this context, "monitoring progress" also includes measuring impacts of policies outside the health sector. Following the HiAP approach, policies to alleviate poverty such as labour market policies must be analyzed before, during and after implementation for impacts on health outcomes and accessibility of health care.

SUGGESTED SEQUENCING OF IMPLEMENTATION

The implementation of national SPF should be embedded in development planning processes and based on existing elements of social protection using the institutional and administrative infrastructure. Thus, policies should be country-defined and led. However, a sequence of key activities should be followed: starting with assessing coverage and access deficits and stocktaking of existing schemes, developing national coverage plans including policy /reform options, cost and fiscal space evaluation and finally strengthening institutional capacities for implementation and monitoring.

Related assessments should be used to identify viable reform options for country-specific social protection policies. Data development should allow for the evaluation of the financial sustainability of options and reflect needs of the population. Further, it should be kept in mind that the size of social protection investments is a matter of political priorities given the fact that countries at similar levels of per capita GDP differ significantly as regards social protection expenditure. When developing social protection options in health and beyond, the range and level of benefits set out in the ILO Conventions and Recommendations might serve as guidance.

National coverage plans should consist of a coherent design of coordinated social protection schemes in health, income support, measures addressing unemployment, etc. Given the broad approach and country-wide consensus needed, it is recommended to establish a national SPF task force composed of experts and decision makers from different ministries. The national consensus to be achieved should also involve representatives of the social partners such as trade unions and employers in order to ensure compliance with reforms and sustainability. The UN manual and strategic framework for joint SPF/UN country operations might be consulted for guidance.

CONCLUSIONS

The key issues of health inequity and inequitable access to health care relate to gaps in legislation, design and financing of social health protection schemes and systems as well as the social and economic status of the vulnerable.

Thus, health systems must be concerned with population coverage and effective access to health care characterized by the availability, affordability and quality of services as well as financial protection. As far as issues beyond the health sector are concerned, specifically poverty and labour market matters should be addressed with a view towards their impact on accessibility of needed health care in accordance with the HiAP and SPF approaches. ILO Recommendation 202 Concerning National Floors of Social Protection tackles these issues in a comprehensive approach focusing on:

(a) Extending coverage and providing universal and effective access in social health protection;
(b) Reducing poverty and social exclusion;
(c) Increasing policy coherence across sectors.

Extending related coverage requires guaranteeing universality through a rights-based approach covering the total population in well-coordinated social protection schemes providing for health care and income support. This includes making prevention and curative care affordable and

available and developing the necessary fiscal space and administrative capacities. Reducing poverty and social exclusion requires providing at least an essential level of health care benefits in kind and in cash, basic income support and increasing formal labour market participation of the vulnerable. Further, developing coherent social, economic and labour market policies is key for equitable access to health care and thus equity in health.

CONFLICT OF INTEREST

None to declare.

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