

Although a larger percentage of the world's population has access to health-care services than to various cash benefits, nearly one-third has no access to any health facilities or services at all. For many more, necessary expenditure on health care may cause financial catastrophe for their household, because they have no adequate social health protection which would cover or refund such expenditure (ILO, 2008b).

Health care is certainly the most complex of social security branches. From the point of view of the beneficiary it encompasses multiple benefits and measures, while on the supply side it is connected to an important sector of the economy involving interrelated financial mechanisms and economic interests.

3.1 Definition and measurement of social health protection

Social health protection is defined by the ILO as a series of public or publicly organized and mandated private measures against social distress and economic loss caused by the reduction of productivity, stoppage or reduction of earnings, or the cost of necessary treatment that can result from ill health. Some special features of social health protection are to be taken into account:

- Social health protection is closely linked to the functioning of a specific economic sector – the health sector. This requires an integrated approach towards demand and supply of health care, the availability of health infrastructure, and the sector's own health

workforce, employment opportunities and administrative capacity. The situation on the supply side determines to a large extent potential access to quality health-care services in a country.

- Globally, a significant amount of funds for financing health care is paid directly, in the form of out-of-pocket payments to providers such as health facilities, doctors, nurses, pharmacies, and so on. In many countries, these payments occur despite the fact that nominally free health care is available. Against this background, social health protection needs to provide for effective coverage combining *financial protection with effective access to quality health care*.
 - *Financial protection* has to address risks of impoverishment due to catastrophic health events and the capacity to finance any kind of out-of-pocket payments: those to be paid directly to providers, for example user fees or co-payments required by health insurance arrangements, other direct payments for health services and goods, and related costs such as the transport necessary to reach health-care facilities, particularly in rural areas. It is further important that financial protection prevents people from falling into poverty as a result of loss of income due to sickness.
 - *Effective access* to health services, medicines and health-care commodities requires the physical availability of health-care infrastructure, workforce, medical goods and products, and the provision of affordable and adequate services.

In order to achieve the objectives of social health protection, *legal* universal coverage needs to lead to *effective* access to health services. This requires that at least an essential set of services and drugs is available, affordable and provided at a specified level of quality. Further, those in need should be informed about the services to be able to take them up. Finally, the utilization of health services should be linked to financial protection that includes income support such as paid sick leave. Specific indicators including the ILO Access Deficit Indicator (see ILO, 2008b) can best describe gaps in effective access to health services.

From an ILO viewpoint an essential benefit package should be at least in line with nationally and internationally agreed objectives such as the Millennium Development Goals (in particular those related to maternal and newborns' health), the requirements for the treatment of specific diseases such as HIV/AIDS or malaria, and the requirements of Convention No. 102. This Convention specifies the scope of medical care – general and specialized, inpatient and outpatient, including maternal benefits – which has to be available and accessible. The range of health-care services specified in the Convention (Article 10) has to be, in case of sickness, either provided free of charge or, if people are “required to share in the cost of the medical care...the rules concerning such cost-sharing shall be so designed as to avoid hardship”.

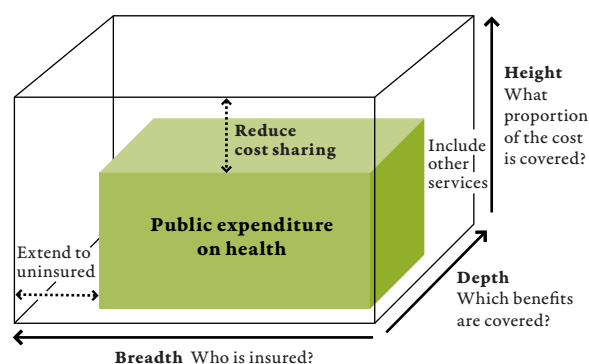
The ILO defines affordability of health care to households using four main criteria: (1) lack of financial barriers such as high user fees; (2) level of insurance contributions set in relation to the household's ability to pay; (3) no risk of catastrophic health expenditure that would exceed 40 per cent of household income net of subsistence expenditure; and (4) no risk of impoverishment due to ill health.

Notions of availability and quality refer to the existence of a sufficiently qualified health-care workforce and sufficient infrastructure to provide services in response to needs in a way that is gender-sensitive and inclusive (e.g. for indigenous people).

These ILO criteria of measuring health-care coverage – which will be discussed in more detail later – are based on the overall objective of ensuring that ill health does not lead to catastrophic loss of income and impoverishment. To meet this objective, health-care costs need to be pooled and financed through pre-payment mechanisms with a view to reducing out-of-pocket payments at the point of service delivery.

The ILO concept of measuring health-care coverage is thus multidimensional, like the concept of coverage

Figure 3.1 WHO: Towards universal health coverage



Source: WHO, 2008, p. 26.

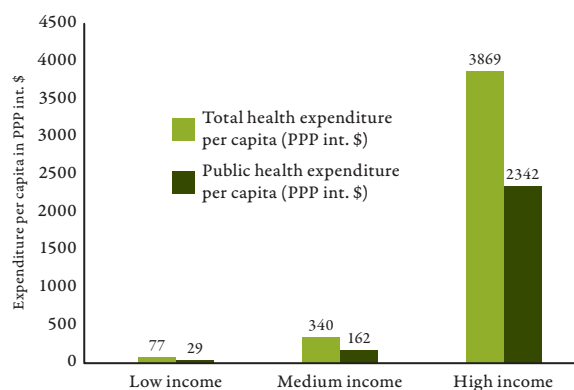
in social security in general. The overall approach, of distinguishing several dimensions regarding coverage, is shared by other international organizations such as the World Bank (2000) and the World Health Organization (WHO), which is focusing on breadth, scope and depth of health services as illustrated in figure 3.1. However, these concepts do not take into account important social aspects, such as loss of income in case of sickness, or paid sick leave; these require a broader social protection approach to address such impacts of ill health.

3.2 Financing health care

It is obvious that all dimensions of effective access to health care depend strongly on the amount of resources which are made available. In this context, countries vulnerable (see Scheil-Adlung, Bonnet and Wiechers, 2010) in terms of high poverty rates and levels of informal economy are challenged by the need to generate sufficient funds from taxes and contributions. Before moving to a more detailed discussion of the different dimensions of coverage, it is thus important to examine global patterns in the levels of financing health-care coverage and access.

Figure 3.2 shows the enormous differences between countries in health expenditure per capita – both total (public and private taken together) and even more so public expenditure. Per capita public health expenditure amounted in 2007 in low-income countries to international \$29 (PPP) as compared to international \$162 in middle-income and international \$2,342 in high-income countries. Lower-income countries have higher private health expenditure than public, but the

Figure 3.2 Health-care financing: Total and public per capita expenditure by national income level of countries, 2007



Link: <http://www.socialsecurityextension.org/gimi/gess/RessFileDownload.do?ressourceId=15103>

Source: ILO calculations based on WHOSIS (WHO, 2009a), 2006 data. See also ILO, GESS (ILO, 2009d).

ability to sufficiently cover necessary health expenditure from private sources is limited to the wealthier sections of their populations and thus cannot compensate for low public expenditure in coming closer to universal coverage. The impact of inadequate or low funding in poor countries is enormous, given that people not only lack access to health services but are also more likely to die from diseases that are curable in richer countries – for instance, respiratory infections, which account for 2.9 per cent of all deaths in low-income countries, but for relatively few deaths in high-income countries (Deaton, 2006).

In order to finance health care, countries tend to draw on different sources simultaneously. Many low-income and vulnerable countries rely heavily on private un-pooled out-of-pocket payments and user fees to be paid at the point of delivery as a key financing mechanism for health care. This has to be seen as a deeply inefficient form of health-care financing which impacts significantly on the income situation of workers and their families. Also, the use of different financing sources often takes place in an uncoordinated way, which affects effectiveness and efficiency. Moreover, in many countries their impact on various groups of the population goes un-monitored, resulting in significant gaps in coverage and access to health care, and thus leading to impoverishment. Figure 3.3 shows that in 2006, while public sources dominated on average (as a percentage of GDP) in Europe, CIS, the Middle East and Asia, private expenditure dominated health-care financing in Africa, while in North America, Latin

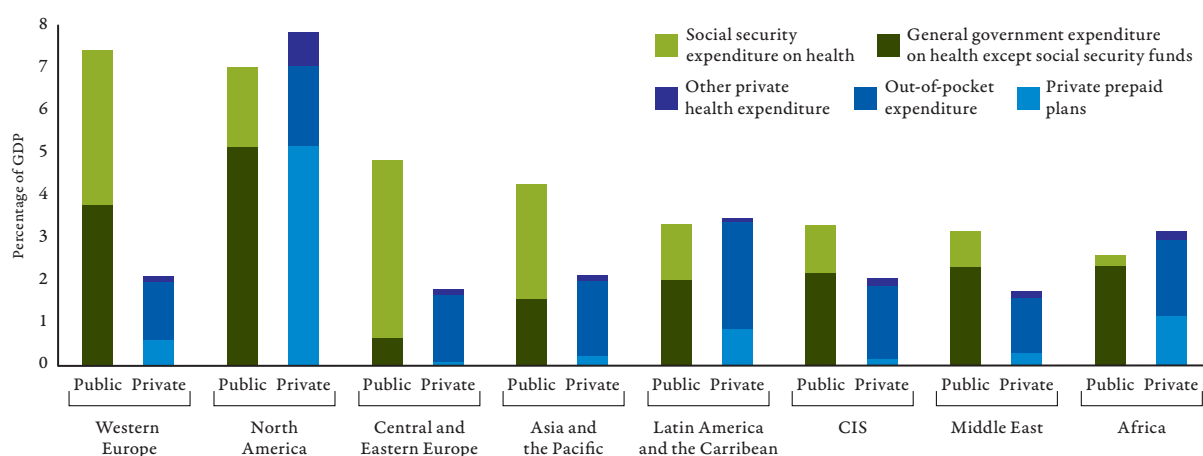
America and the Caribbean financing came from private and public sources in more or less equal parts. In Africa, North and Latin America, the Middle East and CIS public health-care financing comes mainly from general taxation, while in Asia and Central and Eastern Europe social insurance financing dominates. In Western Europe – again on average – health-care financing comes in nearly equal shares from social insurance contributions and general taxation. Private health insurance plays a major role mainly in North America (United States). Out-of-pocket spending everywhere is at the level of 1–2 per cent of GDP; however, while in some countries (such as in Europe) it forms only a small portion of overall health spending, in others (such as the low-income countries discussed below) it accounts for more than half or even up to 80 per cent of total health expenditure (ILO, 2008b). In some low-income countries, and in particular in sub-Saharan Africa, scarce domestic fiscal resources are significantly supplemented with foreign aid in order to ensure the availability of essential levels of health care.

Figure 3.4 again shows the composition of health-care financing sources, this time according to the level of “vulnerability” of countries (combined poverty and informality). It can be seen that there is a clear correlation between the level of vulnerability as so defined in a country or its population, and the roles of public and private financing, in particular out-of-pocket financing. The poorest and most vulnerable have to rely mostly on their own resources for health care because they have much less financial protection than the less vulnerable.

The *level* of financial protection provided by existing social health protection mechanisms refers to the proportion of health-care costs covered through pooling and pre-payment mechanisms either by general government (national health services, social health insurance) or by private health insurance. In other words, it is the proportion of costs *not* borne out of pocket at the point of service delivery. Therefore, gaps in financial protection are reflected by the level of out-of-pocket expenditure borne to cover individuals’ health costs. Levels of coverage become lower when out-of-pocket payments increase; high out-of-pocket payment rates thus indicate gaps in financial coverage – insufficient financial protection provided by the existing social health protection mechanisms. However, it does not indicate other dimensions of coverage – those related to effective access to health services, such as whether the required services are available in terms of quantity and quality.

Making health-care services *affordable* to workers and their families in both the informal and formal

Figure 3.3 Health-care financing levels and sources of funds, 2006 (percentage of GDP)

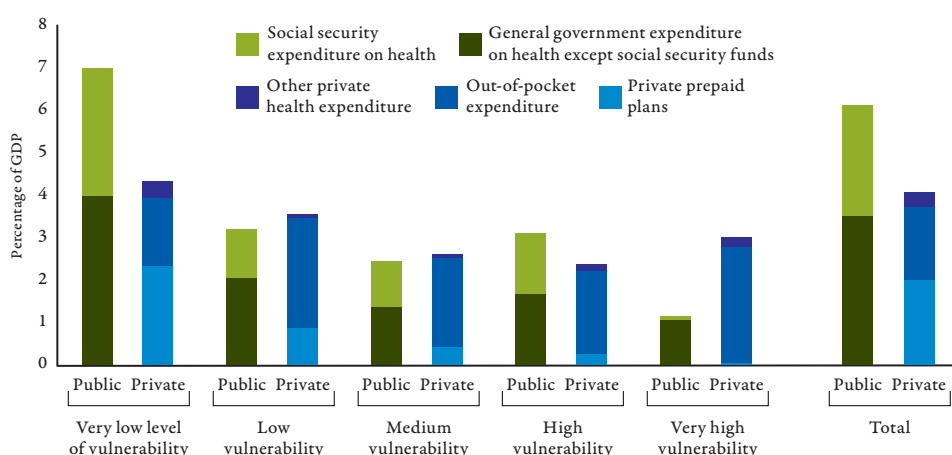


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Source: ILO calculations based on WHOSIS (WHO, 2009a), 2006 data. See also ILO, GESS (ILO, 2009d).

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Figure 3.4 Vulnerability of countries and sources of funds: Public and private health expenditure and composition of health expenditure by level of vulnerability at the country level, 2006 (percentage of GDP)



Link: <http://www.socialsecurityextension.org/gimi/gess/RessFileDownload.do?ressourceId=15212>

Note: The grouping of countries by level of vulnerability is based on the combination of two criteria: employment and poverty level (for more details see Chapter 2 of this report, pp. 30–31, and the Statistical Annex).

Sources: ILO calculations based on WHOSIS (WHO, 2009a), 2006 data for health expenditure as a percentage of GDP; ILO, LABORSTA (ILO, 2009e) and *KILM* (ILO, 2008e); World Bank, 2009a; and national statistical offices for employment and poverty statistics regarding levels of vulnerability. See also ILO, GESS (ILO, 2009d).

economy is a major objective of social health protection. The affordability of health services can be defined as the absence of financial barriers to households in receiving health services when they need them. It aims at opening access to health-care services to all in need, at the same time preventing health-related poverty. Affordability can be assessed by looking at the share of out-of-pocket health-care expenditure made by a household of its total household income or expenditure, net of necessary subsistence expenditure (including – for

example – food and basic housing costs), and comparing it with a selected threshold value. Setting the threshold value beyond which a household's out-of-pocket health expenditure would have a catastrophic impact on its financial situation requires research into actual household spending patterns. The level of threshold value is not only country-specific but may be different for households at various income levels: for many households simply nothing is left after deducting the amounts necessary for survival, for many incomes are below the

subsistence level. Still, it may be useful to set a threshold for catastrophic health expenditure¹ so long as account can be taken of the fact that it applies only to households living above the subsistence level. For example, Scheil-Adlung et al. (2007) consider health-care expenditure to be unaffordable if it amounts to more than 40 per cent of the household income remaining after subsistence needs have been met. That share of health-care expenditure is considered to be catastrophic for households above the subsistence level, while for households at or below the subsistence level all out-of-pocket health expenditure may have catastrophic impact. Universal coverage, including effective access to social health protection, is therefore necessarily associated with equity in financing, assuring that households are asked to contribute only in relation to their ability to pay.²

In the 1980s and 1990s many countries introduced user fees in an effort to infuse new resources into struggling services, often in a context of disengagement of the State and dwindling public resources for health. Most undertook these measures without anticipating the extent of the damage they would do. In many settings, dramatic declines in service use ensued, particularly among vulnerable groups, while the frequency of catastrophic expenditure increased. Some countries have since reconsidered their position and have started phasing out user fees and replacing the lost income from pooled funds (government subsidies or contracts, insurance or pre-payment schemes). This has resulted in substantial increases in the use of services, especially by the poor. In Uganda, for example, service use increased suddenly and dramatically and the increase was sustained after the elimination of user fees. Pre-payment and pooling institutionalizes solidarity between the rich and the less well-off, and between the healthy and the sick. It lifts barriers to the uptake of services and reduces the risk that people will incur catastrophic expenses when they are sick. Finally, it provides the means to re-invest in the availability, range and quality of services.

We use here data on out-of-pocket payments as one of the proxies for the size of the coverage gap in the context of a set of indicators with respect to the level of financial protection provided, assuming that the essential quantity and quality of services is available. It

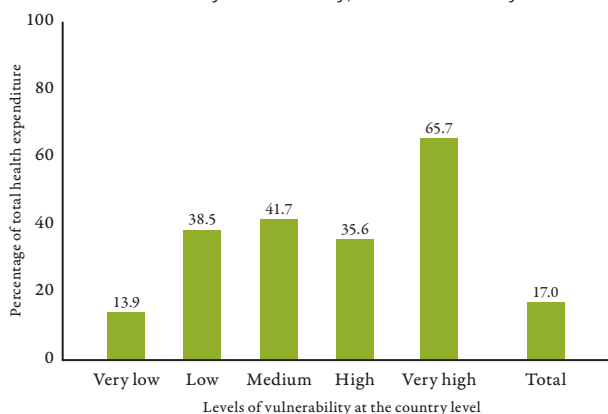
must be understood, however, that this indicator only takes into account costs that have actually occurred; it does not reflect situations where the existing financial barriers actually prevent the use of health-care services when needed owing to individual cost-sharing rates that are too high. If a sick person cannot afford a consultation with a doctor, treatment or medication, this is not taken into account by this indicator. Further, the only data available refer to out-of-pocket payments *at the point of service*. These figures therefore underestimate actual out-of-pocket payments, since costs such as transportation to get to the doctor or hospital are not taken into account. Such unaccounted out-of-pocket costs matter more in rural than in urban areas, since infrastructure is better in urban and semi-urban areas so that distances and the consequent cost of travel are on average higher in rural areas. Nor does this indicator take into account any indirect costs borne by individuals and households, such as loss of income due to sickness. Nevertheless, data on out-of-pocket payments, in the context of a set of other indicators measuring effective access, offer a comparatively deep insight into the financial burden on individuals and households caused by illness and other health-care-related events. High out-of-pocket payment rates correlate positively to reduced affordability of service and high risk of impoverishment due to catastrophic illness events.

Figure 3.5 shows the range of out-of-pocket payments by level of country vulnerability. More than 65 per cent of expenditure in the most vulnerable countries derives from private out-of-pocket funds; this indicates not only a significant gap in sharing the health financing burden but also related issues of equity, fairness in financing, and affordability. Many people in countries such as Cambodia, India and Pakistan, for example, shoulder up to 80 per cent of total health expenditures, with only a small portion of the population being covered by any form of social health protection mechanisms providing medical benefits such as tax-funded services or social, national or community-based insurances. The issues persist even in countries of medium and low vulnerability. The share of out-of-pocket payments is even higher in countries of medium vulnerability (42 per cent) than in those that are highly vulnerable (35 per cent). The reason is most likely that in countries of medium vulnerability there is a higher availability of services and infrastructure, as well as fewer extremely poor people who cannot afford any access to health care at all, than in countries of high vulnerability. At the same time, high poverty rates in the countries of highest vulnerability, together with the

¹ "Catastrophic health expenditure" is defined by WHO; see Scheil-Adlung et al., 2007.

² See ILO Convention No. 102 (Article 10) referred to above, as well as Article 71 of the same Convention which points out that financing of social security in general "should avoid hardship of persons of *small means*" (italics added).

Figure 3.5 Share of out-of-pocket expenditure as a percentage of total health expenditure by level of country vulnerability, latest available year

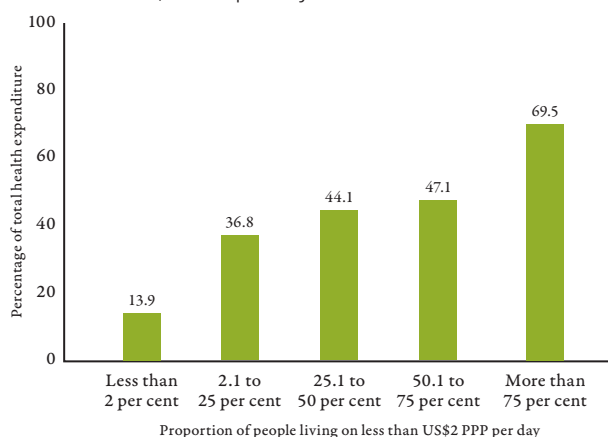


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Note: The grouping of countries by level of vulnerability is based on the combination of two criteria: employment and poverty level (for more details see Chapter 2 of this report, pp. 30–31 and the Statistical Annex).

Sources: ILO calculations based on WHOSIS (WHO, 2009a), 2006 data for out-of-pocket health expenditure as a percentage of total health expenditure; ILO, LABORSTA (ILO, 2009e) and KILM (ILO, 2008e); World Bank, 2009a; and national statistical offices for employment and poverty statistics regarding levels of vulnerability. See also ILO, GESS (ILO, 2009d).

Figure 3.6 Out-of-pocket expenditure as a percentage of total health expenditure by poverty incidence, 2006 (percentage of people living on less than US\$2 PPP per day)



Link: <http://www.socialsecurityextension.org/gimi/gess/RessFileDownload.do?ressourceId=15108>

Source: ILO calculations based on WHOSIS (WHO, 2009a), 2006 data. See also ILO, GESS (ILO, 2009d).

absence of any financial protection mechanisms, lead to extreme shares of out-of-pocket payments.

High out-of-pocket payments are a major cause of impoverishment, and so it is not accidental that there is a strong correlation between the shares of out-of-pocket expenditure in a country and poverty incidence there, as shown in figure 3.6.

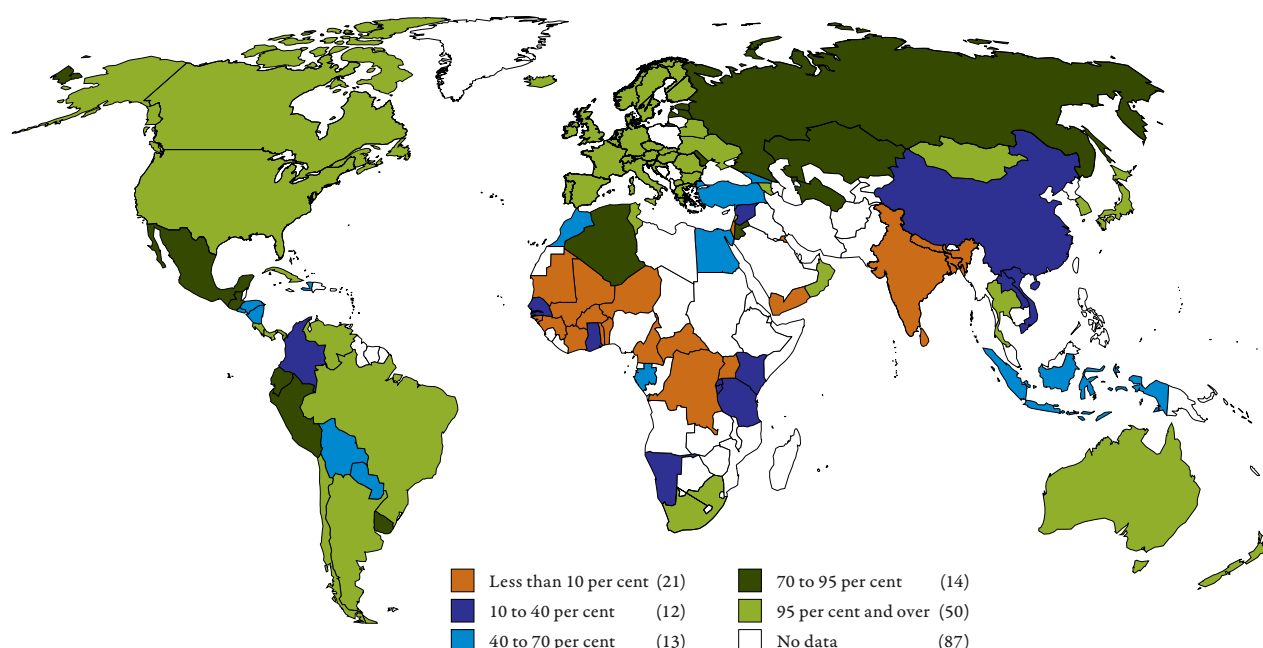
That high out-of-pocket payments are a major factor leading to, maintaining and sharpening poverty is clearly shown in figure 3.6. The figure differentiates between shares of out-of-pocket expenditure among country groups with different incidences of poverty (measured as the proportion of people living on less than US\$2 a day). At the country level there is a strong correlation between the proportions of out-of-pocket payments and poverty incidence. In the 27 countries where less than 2 per cent falls below the US\$2-poverty line, on average less than 15 per cent of total health expenditure has to be borne out of pocket (this is consistent with the overall share in high-income countries shown in figure 3.5). But in countries with poverty rates between 2 per cent and 75 per cent the rate of out-of-pocket expenditure is roughly 40 per cent, and it is considerably higher in those 27 countries in which more than 75 per cent of the population falls below the poverty line. Here, two-thirds of total health expenditure is paid out of pocket.

Out-of-pocket expenditure represents the major part of overall private expenditure in developing countries. For example, among all African countries, only in Botswana, Namibia and South Africa is the share of out-of-pocket payments in overall private expenditure less than 25 per cent. In the majority of African countries, the share reaches 80 per cent and even higher. At the same time, in many of these countries more than half of the total expenditure on health is borne privately. This interaction between high shares of out-of-pocket payments in private health expenditure and high rates of that expenditure underlines once more the lack of financial protection against health-care costs. In those countries with a small portion of public health expenditure per capita, the level of out-of-pocket expenditure is relatively high.

3.3 Gaps in health-care coverage and access deficits

The gap in affordability and financial protection coverage is of course closely connected to the existing gap in extent of coverage: legal and effective coverage by social health protection mechanisms. These mechanisms include a broad variety of institutionalized solutions such as public schemes, social insurance schemes, private insurance, and also the community-based schemes that are widespread in many developing countries. In some countries all people should by law have free access to health-care services (100 per cent legal coverage) – but

Figure 3.7 Health protection: Proportion of the population covered by law, latest available year (percentages)



Link: <http://www.socialsecurityextension.org/gimi/gess/RessFileDownload.do?ressourceId=15109>

Source: National legislation, various dates. See ILO, GESS (ILO, 2009d).

in reality they do not have such access when they need it (effective coverage much, much lower). Figures 3.7 and 3.8 describe legal coverage by contributory health insurance mechanisms. As figure 3.7 shows, formal legal coverage by these mechanisms remains low in many countries and especially in Africa and Asia.

When countries are grouped by vulnerability level it can be shown that legal coverage is lowest in those countries with high levels of poverty and informality. This highlights the close connection between formal employment and coverage. Figure 3.8 shows legal coverage by country “vulnerability” groups. Nearly 90 per cent of people living in the most vulnerable countries are not covered formally by any scheme or system, as compared to less than 4 per cent in the least vulnerable countries.

Indicators of legal coverage or “access” to social health-care protection mechanisms based on results are, however, insufficient. The ILO has developed an indicator which also reflects the supply side of access availability – in this case the availability of human resources at a level that guarantees at least basic, but universal, effective access to everybody. To estimate access to the services of skilled medical professionals, it uses as a proxy the relative difference between the density of health professionals in a given country and its median value in countries with a low level of vulnerability (population

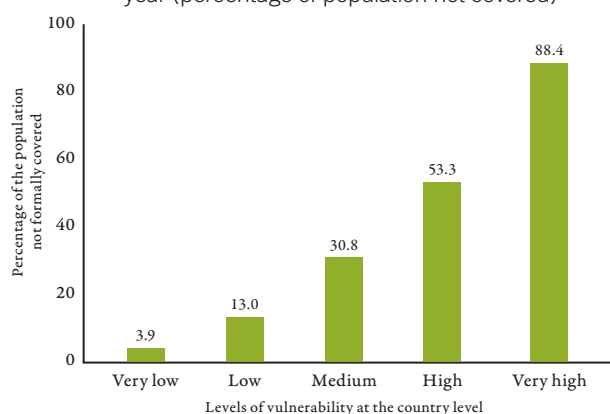
access to services of medical professionals in countries with low vulnerability is thus used as a benchmark for other countries). Figure 3.9 provides a global overview of this access deficit by income level of countries. It suggests that 30–36 per cent of the world’s population has no access to the services of an adequate number of skilled medical professionals. Low-income countries in Africa and Asia show the highest levels of access deficits.

In health care, the triad between individuals/households, institutionalized health-care financing mechanisms, and the sector of health-care providers defines the field of social protection. Coverage thus means affordable access to (quality) health care by various public or private measures. Physical access to health-care providers, treatment and medication requires a sufficient health-care infrastructure and workforce as well as the provision of medical goods and services.

It is relatively easy to measure a formal coverage gap defined as the percentage of people not formally/legally covered by social health protection. But, as we have seen, measuring how many people are covered under legislation by social health protection does not reflect effective access to health services. A combination of various proxies is therefore used to sharpen the picture of coverage worldwide.

Data on effective coverage are very limited, at both the global and national levels. Despite the significant

Figure 3.8 Deficits in legal health protection coverage by vulnerability at the country level, latest available year (percentage of population not covered)

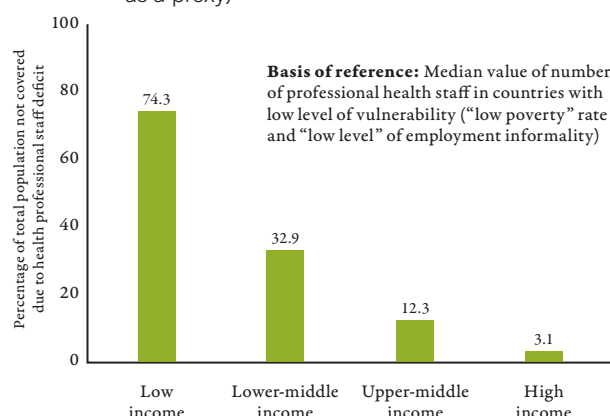


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Note: The grouping of countries by level of vulnerability is based on the combination of two criteria: employment and poverty level (for more details see Chapter 2 of this report, pp. 30–31, and the Statistical Annex).

Sources: ILO calculations based on WHOSIS (WHO, 2009a), 2006 data for health expenditure as a percentage of GDP; ILO, LABORSTA (ILO, 2009e) and KILM (ILO, 2008e); World Bank, 2009a; and national statistical offices for employment and poverty statistics regarding levels of vulnerability. See also ILO, GESS (ILO, 2009d).

Figure 3.9 ILO access deficit indicator, 2006 (shortfall of skilled medical professionals as a proxy)



Link: <http://www.socialsecurityextension.org/gimi/gess/ResFileDownload.do?ressourceId=15112>

Note: The median used as a benchmark is just over 40 health professionals per 10,000 population. This value is above the minimum set by WHO for primary care delivery, which is 25 per 10,000. This indicator is presented in the Statistical Annex.

Source: ILO calculations based on WHOSIS (WHO, 2009a), 2006 data. See also ILO, GESS (ILO, 2009d).

efforts of many national and international institutions to develop and provide data on access to health services, particularly by the poor, information gaps still exist. Often only very specific and non-comparable data are available at national and international levels; these do not allow assessments of effective coverage and access. Nevertheless, given the close link between access to health services and lack of coverage in social health protection, the availability of such data is vital when developing and advocating strategies for universal coverage.

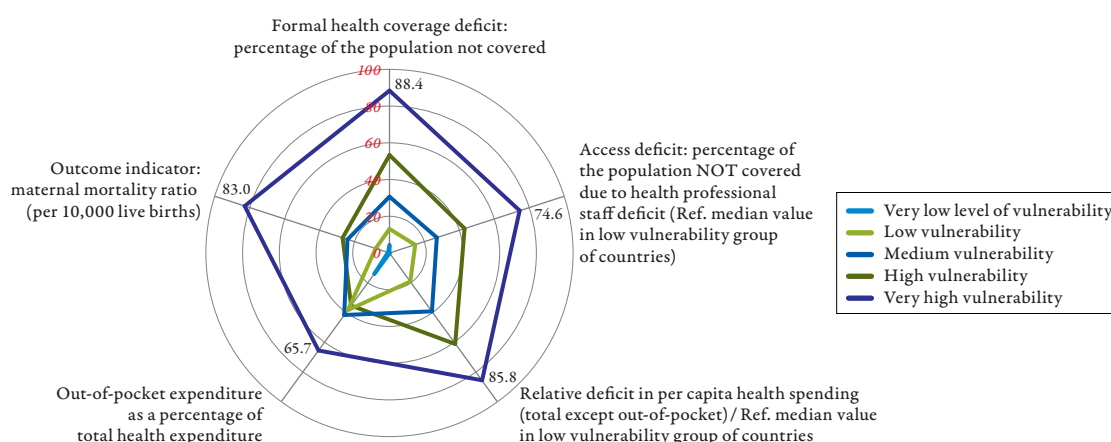
To measure effective access one has to look at a number of interlinked dimensions: legal coverage by social health protection measures, affordability of health-care services to households, availability of services in terms of qualified health workforce, infrastructure, and so on. But what one is likely to have in available statistics is only partial indicators related to these different dimensions – percentage of persons covered by law, out-of-pocket expenditure as a percentage of the total, density of medical personnel of different skills and some infrastructure indicators, overall levels of health spending and, finally, information on the actual utilization of selected health-care services (percentage of births attended by skilled medical personnel, percentage of children vaccinated, and so on). Effective access to health care and levels of actual utilization certainly depend on all the above factors – the level of financial protection being determined both by

legal coverage and effective coverage, as well as the availability of services – but at the same time there are other factors that influence access, including cultural ones.

Ideally, the most useful approach to measuring social health protection coverage in terms of effective access would be through a combination of key indicators reflecting the situation in a country, including the following:

- *Availability and financial protection*
 - Formal coverage gap: measured by percentage of people not formally/legally covered by social health protection;
 - Financial protection deficit: measured by proportion of out-of-pocket payments to total health expenditure.
- *Availability and quality of services*
 - Resources deficit: measured by proportion of actual total health expenditure per capita (less out-of-pocket expenditure) to a specific benchmark value (defined here as the median value for low-vulnerability countries);
 - Access deficit: measured by percentage of population not covered due to insufficient number of qualified medical personnel (using median density of medical personnel in low-vulnerability countries as the benchmark).

Figure 3.10 The global deficit in social health protection coverage and effective access to health services in 2006 (ILO methodology)



Link: <http://www.socialsecurityextension.org/gimi/gess/RessFileDownload.do?ressourceId=15113>

Note: The multiple dimensions of health coverage are presented in the Statistical Annex.

Sources: ILO calculations based on WHOSIS (WHO, 2009a), 2006 data. See also ILO, GESS (ILO, 2009d).

Another important indicator of effective access to health services relates to health outcomes such as maternal mortality, reflecting all social strata including the extremely poor.

Figure 3.10 gives an example of the result of such an analysis, combining selected indicators of the types described above. Countries are grouped into five levels of “vulnerability” as defined by two criteria: (a) percentage of population below the poverty line of US\$2 PPP per day, and (b) wage employment as a percentage of total employment. The highest vulnerability group includes countries with the highest poverty incidence and the lowest proportion of wage employment.

Figure 3.10 compares the selected set of coverage indicators. Until more reliable data become available, this set of indicators might serve as a proxy for estimating effective access to health care, even if they exhibit some inconsistencies. The simultaneous use of these proxy indicators opens up a range of relative values that might serve as a crude indicator for access or non-access to health services.

The figure reveals that in the most vulnerable group of countries represented in the outer line more than 80 per cent of the population have no legal coverage and no access to health services due to gaps in the health workforce, and experience significant gaps in financial protection and affordability of services, given the extreme values of out-of-pocket payments impacting on poverty. The deficit in per capita spending of 85 per cent based on the median value deepens the overall gap in financial protection. We also find in this group of

countries the highest values for maternal mortality of 82 deaths per 10,000 live births.

In this multidimensional statistical picture no specific indicators have been included for the third main dimension of health-care coverage discussed in Chapter 1, namely the *scope* of health-care services provided: what benefit packages are in place and whether they are accessible to all in need. This aspect of coverage is even more difficult to measure – particularly on an internationally comparable basis. In the ILO methodology of measuring coverage defined as effective access to health care this dimension is for the time being taken care of by using the health outcomes indicator of maternal mortality rates. There is general agreement that *benefit packages* should be set with a view to maintaining, restoring or improving health, guaranteeing the ability to work and meeting personal health-care needs. Countries should define health protection benefit packages specifying the health services, medicines and commodities that are to be made available to the population covered. The determination of the corresponding “essential package” of benefits can play a key role here, provided the process is conducted appropriately. As discussed above, effective access and coverage need to reflect the scope of benefits actually provided. While there is no one-size-fits-all solution, Convention No. 102 provides guidance on the scope of benefit packages. In order to achieve its objectives, social health protection benefit packages must be neither too extensive nor limited to a minimum, but need to ensure that certain essential pre-conditions are met.

