International Labour Organization

ILO brief

Social Protection Spotlight

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Towards Universal Health Coverage: Social Health Protection Principles

Key points

- Social health protection provides a rights-based approach to reaching the objective of universal health coverage that ensures financial protection and effective access to health care services.
- As part of the 2030 Agenda for Sustainable Development, the extension of social health protection contributes to two complementary targets on universal health coverage (SDG 3.8) and universal social protection systems, including floors (SDG 1.3).
- Social health protection is firmly grounded in the international rights framework: The Universal Declaration of Human Rights, the International Covenant on Economic, Social, and Cultural Rights, the Social Security (Minimum Standards) Convention (No. 102), and the Social Protection Floors Recommendation (No. 202).
- There is no one-size-fits-all approach for Governments to guarantee health protection to all. International standards provide guiding principles to ensure universal protection in a way that reflects risk-sharing, equity and solidarity – between income groups, men and women, generations - in a fiscally, economically and socially sustainable fashion.

Social health protection: a rights-based approach to universal health coverage

Each year, 100 million people are pushed into poverty because of expenses for medical care, while 800 million people spend at least 10 per cent of their household budgets on health care, with a particularly adverse impact on the poor (WHO and World Bank, 2017).

In September 2019, the United Nations (UN) General Assembly adopted a political declaration on universal health coverage (UHC), reinforcing its commitment to achieving the health-related Sustainable Development Goals (SDGs) (UN, 2019a).

Social health protection is central to reaching the objective of universal health coverage, which emphasizes the importance of financial protection and effective access to health care services. The SDG targets on universal health coverage (SDG 3.8) and universal social protection systems, including floors (SDG 1.3) are two complementary and closely linked priority measures aimed at achieving a healthy and dignified life for all, which is at the heart of sustainable development and social justice (ILO, 2017b).

Extending social health protection to all is also implicit in the targets of SDG 8 on promoting sustained, inclusive and sustainable economic growth, full and productive employment and decent work, because achieving them will require a healthy workforce. Social protection is therefore a core part of a human-centred approach to the future of work (Global Commission on the Future of Work, 2019). Ill-health and the failure to obtain medical care due to financial, geographical,

social or other barriers have a negative impact on the productivity of the workforce. The lack of income security in case of sickness undermines the capacity of households to invest in productive assets and pushes them into poverty.

In the framework of the 2030 Agenda for Sustainable Development, UHC is defined as ensuring that all people can access the promotive, preventive, curative, rehabilitative or palliative health services they need without facing financial hardship (WHO and World Bank, 2017).

Social health protection provides a rights-based approach to achieve universal health coverage. As an integral component of comprehensive social protection systems, social health protection is the most adapted mechanism to give effect to the human rights to health and social security (UN, 2019b). Social health protection has a twofold objective: universal access to affordable health care of adequate quality, and income security in case of sickness (ILO, 2008).

A number of countries, such as Colombia, Mongolia, Rwanda, the Philippines, Thailand and many others, have shown that it is possible to extend social health protection to all even in low-income settings and with high levels of informal employment. Their experience demonstrates that a sustained political and financial commitment embedded in a rights-based approach is indispensable to leave no one behind (Ortiz et al., 2019).

International social health protection principles

Social health protection designates a series of public or publicly organized and mandated private measures to achieve:

(i). effective access to health care without hardship; and

(ii). income security to compensate for lost earnings in case of sickness.

The lack of affordable quality health care and income security in case of sickness for the majority of the world's population creates a risk of impoverishment, with greater impact on the most vulnerable.

The objectives, functions and principles of social health protection systems are grounded in international social security standards (see **Box 1**) adopted by the International Labour Organization (ILO). These instruments reflect an international consensus forged by governments as well as employers' and workers' organizations (ILO, 2019c).

Box 1: Key international standards

- Medical Care Recommendation, 1944 (No. 69)
- Social Security (Minimum Standards) Convention, 1952 (No. 102)
- Medical Care and Sickness Benefits Convention, 1969 (No. 130) and Recommendation, 1969, (No. 134)
- Maternity Protection Convention, 2000 (No. 183)
- Social Protection Floors Recommendation, 2012 (No. 202)

Principle 1 - Universality of protection

Health and social security are human rights and as such should be guaranteed to all persons, leaving no one behind. In practical terms, they are understood as the need to guarantee universal effective access to adequate protection (UN, 2008). Social health protection represents the optimal mechanism for substantiating these human rights.

As early as 1944, the ILO Medical Care Recommendation (No. 69) introduced the principle of universality, providing that medical care services should cover all members of the community, whether or not they are gainfully occupied. The right to health was subsequently formally enunciated by human rights instruments. [1]

Social health protection principles provide a rights-based approach to achieve universal population coverage, which is one of the three dimensions of UHC (population coverage, service coverage and financial protection (WHO, 2010). These principles are also underlined in the ILO Social Protection Floors Recommendation, 2012 (No. 202), which recognizes effective access to essential health care as the first of four basic social security guarantees that constitute nation-al social protection floors for all (ILO, 2017a; 2017b; 2019c).

Acknowledging this important step forward in forging an international consensus around universal health coverage, the UN General Assembly adopted a resolution on global health and foreign policy in 2012, which underlines "the importance of universal coverage in national health systems, especially through primary health care and social protection mechanisms, including nationally determined social protection floors". [2]

Social protection floors guarantee a basic level of protection within comprehensive national social

[1] The right to health was enunciated in the Universal Declaration of Human Rights of 1948 and further elaborated in Article 12 of the International Covenant on Economic, Social and Cultural Rights. The right to social security, encompassing social insurance and social assistance mechanisms, similarly enjoys protection under the Declaration (Art. 22) and Covenant (Art. 9) and many other international and regional instruments.

[2] UN General Assembly, resolution 67/81, Global Health and Foreign Policy, A/RES/67/81 (2012), para. 3.

security systems. In addition to access to medical care and sickness benefits, the ILO Social Security (Minimum Standards) Convention, 1952 (No. 102) defines seven other life contingencies for which all members of society need protection along the life cycle.

While several pathways lead to universal coverage, most countries reach it through mandatory schemes financed by taxes, social contributions or a combination of both. The role of voluntary health insurance in health financing globally is small (WHO, 2018).

Principle 2 –Diversity of approaches and progressive realization

The term social health protection encompasses both access to medical care without financial hardship and income replacement in case of sickness.

ILO standards allow for a plurality of approaches to ensure effective access to medical care, in line with ILO Medical Care Recommendation No. 69, 1944 and Recommendation No. 202, 2012. The diversity or arrangements that can exist for the financing, purchasing and provision of health care is recognized as long as those respect key principles. The recourse to social health insurance, national health service or a combination of such models is identified. [3] In practice, most countries use a combination of such mechanisms in order to reach universal coverage.

While human rights bodies have recognized the progressive realization of the right to health, they also require governments to take effective measures to secure the maximum extent of available resources to guarantee this right (UN, 2000).

Principle 3 - Risk-sharing and solidarity in financing

Whether financed through social security contributions, taxes or both, ILO standards promote collectively financed mechanisms to cover the costs of health care and sickness. They generate positive redistributive effects and transfer the financial and labour market risks from individuals to society.

There are different modalities of ensuring solidarity in health care financing. Publicly mandated health insurance may be implemented in some cases by private actors (private insurance companies or not-for-profit organizations). In such cases, the features of the schemes are defined by a legal framework and monitored by the State but their implementation is delegated to thoroughly regulated private actors.

Privately managed health insurance schemes are considered within this framework only when they are publicly mandated, thus guaranteeing a level of solidarity. **Box 2** explains the technical basis of social and private health insurance financing modalities and illustrates the difference between them with regard to solidarity (Cichon et al., 1999).

Box 2: Social and private health insurance financing

The difference between social and private health insurance financing lies in the actuarial calculation of the premium and the pattern of reserve accumulation.

Social health insurance is characterized by mutual support. The level of the contribution is not related to individual risk but to the ability of the persons covered to contribute. Contributions to social insurance schemes are calculated on the basis of the principle of collective equivalence between income and expenditure and contribution levels are graduated according to ability to contribute.

Contributions in private health insurance are usually not related to income or capacity to contribute but rather to individual risks and are called “premiums”. Private insurance premiums are calculated on the basis of individual equivalence, which means that the present value of expected contributions and expenditures over a defined period or the entire expected duration of the insurance policy must be equal for each individual.

In addition to the calculation of the premium itself, some elements of private health insurance schemes – such as co-payments, exclusions of risks by not covering preexisting conditions and health examinations upon entry into the scheme, which sometimes form part of the individual insurance policy and distinguish private insurance from social insurance.

Similarly, in practice, income security during sickness is provided through various modalities. The two main mechanisms are: [4] statutory sick pay provided by individual employers under labour or social security legislation (employer liability) or sickness benefits provided through social insurance (with contributions from employers and workers), social assistance

[3] “Medical care should be provided either through a social insurance medical care service with supplementary provision by way of social assistance to meet the requirements of needy persons not yet covered by social insurance, or through a public medical care service.” (ILO Recommendation No. 69, para. 5).

[4] Some countries use a combination of the two modalities.

(financed through general taxation) or a combination of the two.

ILO standards promote collectively financed sickness benefit as a sustainable protection mechanism. Sole reliance on employer liability may have adverse effects:

- Solidarity in financing is de facto limited and coverage often encompasses only salaried work, sometimes excluding categories of workers, such as casual workers and workers paid hourly wages.
- Individual enterprises are left to bear the costs of workers' sickness. This may cause pressure not to take the sick leave, discrimination at recruitment towards individuals with declared diseases, and small enterprises may struggle with the financial implications, creating an incentive to employ workers in forms of employment that are not subject to this statutory sick leave.

Principle 4 - Overall and primary responsibility of the State

This overarching principle refers to the obligation of the State as the overall guarantor for social protection in general and social health protection in particular. It implies that the State must take measures to ensure that all internationally established principles are duly observed and that measures are taken to secure the proper administration of revenue collection, pooling and purchasing of health services as well as health service provision.

Recommendation No. 202 highlights this principle as paramount for enabling and guaranteeing the application of all other social protection principles, including the "financial, fiscal and economic sustainability" of the national social protection system "with due regard to social justice and equity", by collecting and allocating the needed resources with a view to effectively delivering the protection guaranteed by national law. Under human rights instruments, the State is required to demonstrate that policies conducted at the national level aim to ensure respect, protection and fulfilment of the human right to health.

Principle 5 - Adequacy of benefits

Both medical care (including maternity care) and cash sickness benefits need to be adequate and meet the needs of all persons in terms of the range, scope and quality of the benefits provided. Social health protection principles provide for a rights-based approach, not only to population coverage but also to the two other dimensions of UHC – financial protection and service coverage.

International standards [5] envisage the provision of medical care and maternity care – both preventative and curative – by defining a minimum set of goods and services that should be provided with a view to maintaining, restoring or improving health and the ability to work and attend to personal needs.

Out-of-pocket payments should not be a primary source to finance health care systems. To that end, the rules regarding cost-sharing should be designed to avoid hardship, with limited co-payments authorized only with respect to medical care while maternity care is exempt.

Specifically, Recommendation No. 202 provides that persons in need of health care should not face hardship and an increased risk of poverty due to the financial consequences of accessing essential health care, and urge to consider free prenatal and postnatal medical care for the most vulnerable (para. 8).

It further underlines that to be considered adequate, including by human rights bodies monitoring compliance with the right to health, health services should meet the criteria of availability, accessibility, acceptability and good quality (Recommendation No. 202, paragraph 5a) as illustrated in Box 3 (UN, 2000). A strong and well-designed financing structure (see principle 3) should provide incentives for health service providers to meet such criteria and reinforce the overall health system of a country. This requires close and effective coordination between the actors involved in the financing, purchasing and provision of health services.

In addition, achieving UHC and ensuring social health protection as per the criteria set in **Box 3** require the development of the health sector, which is an important provider of employment. About 40 million new health sector jobs would be needed by 2030 (High-Level Commission on Health Employment and Economic Growth, 2017). Ensuring decent work in the health sector is essential to guarantee not only good working conditions but also the high quality of the care provided and popular trust in the health system.

ILO instruments also prescribe minimum levels of periodic payments to compensate the loss of earnings during sickness and maternity. To be adequate, income security in case of maternity should be provided for the period of time necessary to guarantee the health of the mother and the child (ILO and UNICEF, 2019; UNICEF n.d.).

[5] Social Security (Minimum Standards) Convention, 1952 (No.102), Medical Care and Sickness Benefits Convention, 1969 (No. 130) and Maternity Protection Convention, 2000 (No. 183).

Box 3: Availability, accessibility, acceptability and good quality of health care

Accessibility: health facilities, goods and services must be accessible physically (in safe reach for all sections of the population, including children, adolescents, older persons, persons with disabilities and other vulnerable groups) as well as financially and in a way that prevents discrimination. Accessibility also implies the right to seek, receive and impart health-related information in an accessible format for all, including persons with disabilities, but does not impair the right to have personal health data treated confidentially.

Availability: functioning public health and health-care facilities, goods and services must be available in sufficient quantity within a State.

Acceptability: health facilities, goods and services should also respect medical ethics and be gender-sensitive and culturally appropriate. In other words, they should be both medically and culturally acceptable.

Good quality: health facilities, goods and services must be scientifically and medically appropriate and of good quality. This requires, among other things, trained health professionals; scientifically approved and unexpired drugs and hospital equipment; adequate sanitation; and safe drinking water.

Principle 6 – Predictability of benefits

In line with a rights-based approach to ensuring access to medical care without financial hardship and income security in case of sickness, the national legal framework should clearly establish the benefits to be provided and ensure that the necessary financial resources are secured accordingly.

Legal frameworks play an essential role in ensuring predictable entitlements. Predictability allows households to dispose of their income and avoids the risk of people forgoing health care because of the fear of financial consequences.

Principle 7 - Non-discrimination, gender equality and social inclusion

In order to secure non-discrimination, gender equality and be responsive to special needs, the design of social health protection systems should take these principles into account (Behrendt et al., 2017).

The design of benefit packages, financing mechanisms, eligibility conditions and benefit provisions should be developed in an inclusive and responsive manner (see principle 9). Particular attention should be paid to ensuring the inclusiveness and effective accessibility of social health protection schemes so as to leave no one behind (ILO, 2014c; ILO, 2019b; Scheil-Adlung and Bonnet, 2011).

Principle 8 - Fiscal and economic sustainability with regards to social justice and equity

Sustainability refers to the current and future capacity of the social health protection system to bear the costs associated to its operation taking into account the economic, fiscal and financial situation in the country.

Ensuring sustainability is a permanent challenge for the State in exercising its overall and primary responsibility to guarantee functional and comprehensive social protection and health systems. Recommendation No. 202 underlines the need to give due consideration to the principle of equity when considering the financial architecture of the system. The dimension of equity needs to be at the forefront of social health protection design and reforms (ILO, 2014b).

Good governance of the social health protection system aims at ensuring transparent financial management and administration. Sound legal and regulatory frame-works need to foster institutional coherence and quality public services. ILO standards thus also call for regular monitoring of implementation, and periodic evaluation within a comprehensive accountability framework (Recommendation No. 202) and, where appropriate, for periodical actuarial studies and calculations concerning financial sustainability to be conducted. [6]

Principle 9 – Participation, social dialogue and accountability

Social dialogue [7] and participation ensure that social health protection is responsive to the needs of the protected population and gives a voice to the stake-holders of the system. Representation of protected persons, including representatives of the interests of

[6] "In any event, prior to any change in benefits, the rate of insurance contributions, or the taxes allocated to covering the contingencies in question", ILO Convention No. 102 article 71.

[7] Social dialogue is defined by the ILO to include all types of negotiation, consultation or simply exchange of information between, or among, representatives of governments, employers and workers, as well as other stakeholders on issues of common interest relating to economic and social policy. The main goal of social dialogue itself is to promote consensus building and democratic involvement among the main stake-holders

patients, in the governance bodies of institutions in charge of social health protection is an important element of good governance. Listening to the views of the persons concerned allows to co-construct solutions that best fit their needs.

Recommendation No. 202 also calls for efficient and accessible complaint and appeal procedures within a comprehensive accountability framework. Ensuring effective dialogue between users, health care purchasing agencies and health care providers at both central and decentralized levels can support addressing concerns in a timely fashion.

Principle 10 – Integration within comprehensive social protection systems

Poverty is one of the determinants of health, underlying the interlinkages between SDGs 1, 3 and 8, as well as others (WHO, 2019). Social health protection should be considered as an integral part of universal social protection systems and coordinated with employment policies in a way that maximizes its impact on poverty and inequality reduction (Commission on Social Determinants of Health, 2008). For example, the importance of both access to medical care and income security in old age as complementary and necessary to healthy ageing was underlined in the framework of the Decade of Healthy Ageing 2020–2030 (WHO, n.d.).

Coordination between social protection – including social health protection – and employment policies is also necessary to ensure decent work for all (ILO, 2019a). It is particularly crucial when designing social health protection schemes to take into account the role of social protection in fostering the transition from the informal to the formal economy (ILO, 2014a).

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