International Labour Organization

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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. International standards provide guiding principles for Governments to ensure universal protection in a way that reflects risk-sharing, equity and sol-idarity 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 an especially serious 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 that aim to allow people a healthy and dignified life, 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 impossibility of obtaining 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 the objective of 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 succeed in effectively leaving 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 the loss of 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 constitutes a high risk of their falling into poverty and of the most vulnerable being left behind.

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).

Principle 1 - Universality of protection

Health and social security are human rights and as such should be guaranteed universally, 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.

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)

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] The UN human rights bodies, while they have recognized the progressive nature of the implementation of this right, have also required measures to be effectively taken to guarantee it to the maximum extent of available resources (UN 2000).

Social health protection principles provide a rights-based approach to 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 national 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 security systems. In addition to access to medical care and sickness benefits, the ILO Social Security (Minimum Standards) Convention,

[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.

1952 (No. 102) defines seven other life contingencies for which all members of society need to be protected along the life cycle through a rights-based approach.

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 – Risk-sharing and solidarity in financing

Collectively financed protection mechanisms, whether financed by social security contributions, taxes or both, generate positive redistributive effects and do not transfer the financial and labour market risks onto individuals.

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** details the technical basis of social and private health insurance financing modalities and illustrates the difference between them in terms of the principle of solidarity in financing (Cichon et al. 1999).

In practice, income security during sickness can be provided through the following main policy instruments, alone or in combination:

- Statutory sick pay provided by individual employers under labour or social security legislation (employer liability).
- Sickness benefits provided through social insurance (with contributions from employers and workers), social assistance (financed through general taxation) or a combination of both.

ILO social security standards prioritize collectively financed sickness benefit (through contributions, taxes, or a combination of both) as a more robust protection mechanism. Where statutory paid sick leave is a responsibility of individual employers (employer liability), solidarity in financing is de facto limited and coverage often encompasses only salaried work, sometimes excluding some categories of workers, such as casual workers and workers paid hourly wages. In this modality, enterprises are left to bear the costs of workers' sickness. This may cause adverse effects in terms of 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.

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 pre-existing 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.

Principle 3 - 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

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

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 4 - 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[3] 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 and not maternity care.

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 that free prenatal and postnatal medical care for the most vulnerable should also be considered (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).

The instruments also prescribe minimum levels of periodic payments to compensate the loss of income 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.).

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 5 – 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. Recommendation No. 202 thus also calls for efficient and accessible complaint and appeal procedures within a comprehensive accountability framework.

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

Principle 6 - 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. 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 7 - 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 frameworks need to foster institutional coherence and quality public services. Recommendation No. 202 thus also calls for regular monitoring of implementation, and periodic evaluation within a comprehensive accountability framework.

Principle 8 – Participation and social dialogue

Social dialogue and participation ensure that social health protection is responsive to the needs of the protected population and gives a voice to the stakeholders of the system. Representation of protected persons, including representatives of the interests of patients, in the governance bodies of institutions in charge of social health protection is an important element of good governance.

Principle 9 – Diversity of approaches and progressive realization

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

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: through social health insurance and medical care services or a combination of such models.[4]

ILO Recommendation No. 202 also recognizes the need to make universality of coverage a central objective of social protection systems, using taxes, social contributions or a combination of both. In practice, most countries have recourse to a combination of such mechanisms in order to extend both medical care and income security in case of sickness coverage to all.

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).

In addition, achieving universal health coverage requires 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, mostly in middle- and high- income countries (High-Level Commission on Health Employment and Economic Growth 2017). Ensuring decent work in the health sector is essential for ensuring not only good working conditions but also the high quality of the care provided (see **Box 3**) and public support for the health system.

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4 "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).

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