International Labour Organization

ILO brief

Social Protection Spotlight

December 2022

Social health protection
A global overview from the World Social Protection Report

Key points

- The right to social health protection is not yet a universal reality. Despite laudable progress, barriers to access healthcare remain in the form of out-of-pocket payments (OOP) on health services, physical distance, limitations in the range, quality and acceptability of health services, long waiting times as well as opportunity costs such as lost working time.
- Significant progress was achieved in increasing population coverage, with almost two thirds of the global population protected by a scheme. Still, while population coverage increased, less attention was paid to adequacy and equity in some contexts.
- Collective financing, broad risk pooling and rights-based entitlements are key conditions to support effective access to healthcare for all in a shock-responsive manner. The principles provided by ILO standards are more relevant than ever on the road to universal health coverage. More and better data on legal coverage needs to be collected as a matter of priority to monitor progress on coverage and equity.
- Investing in the availability of quality healthcare services is crucial. The COVID-19 pandemic is drawing attention to the challenges faced in recruiting, deploying, retaining and protecting sufficient well-trained, supported and motivated health workers to ensure the delivery of quality healthcare services.
- Stronger linkages and better coordination between access to medical care and income security are needed to further address key determinants of health. The COVID-19 crisis further highlighted the role of the social protection system in shaping behaviours to foster prevention and the complementarity of healthcare and sickness benefit schemes. Coordinated approaches are particularly needed in respect of special and emerging needs, including human mobility, the increasing burden of long and chronic diseases, as well as population ageing. The impact of the disease on older people further shed light on the need for coordination between health and social care.
- The COVID 19 crisis demonstrated the importance of income security during ill health, including quarantine. Sickness benefits are crucial for prevention and physical recovery and to address health-related poverty. Currently, only a third of the world's working-age population have their income security protected by law in case of sickness. This coverage is not always adequate, as benefit level, duration and eligibility criteria (such as waiting periods) may create gaps in protection.
- Estimates of effective coverage for SDG indicator 1.3.1 show that only 44.9 per cent of women with newborns worldwide receive a maternity cash benefit, with large regional variations: coverage of childbearing women is universal in most of Europe, compared to a mere 7.5 per cent in sub-Saharan Africa.

Introduction

This brief presents a statistical picture extracted from the World Social Protection Report 2020-2022 of social protection coverage for the following benefits:

- health care,
- sickness, and
- maternity.

The crucial role of social health protection for individuals and the economy

A key contribution to the SDGs

The COVID-19 crisis has revealed large gaps in social health protection. Ensuring universality and continuity of coverage was essential in a pandemic where the health of one person affected the health of everyone. Accordingly, governments worldwide swiftly responded to the spread of the disease by ensuring access to health services and sickness benefits, extending their reach, improving their adequacy and facilitating their delivery. It is now necessary to build on the lessons learned from these temporary measures in moving towards more sustainable, comprehensive and universal social protection systems that offer effective access to affordable healthcare services and adequate sickness benefits for all. Both support the objective of UHC.

In September 2019, the UN Member States at the General Assembly adopted a political declaration on UHC, reinforcing their commitment to achieving the health-related SDGs (UN General Assembly 2019). Social health protection is central to reaching the objective of UHC, which emphasizes the importance of financial protection and effective access to healthcare services. The SDG targets on UHC (SDG 3.8) and universal social protection systems, including floors (SDG 1.3), are complementary and closely linked priority measures aimed at achieving a healthy and dignified life for all.

Extending social health protection to all is also implicit in SDG 8 on promoting sustained, inclusive and sustainable economic growth, full and productive employment and decent work, because achieving these ends will require a healthy workforce. Ill health and an inability to obtain medical care because of financial, geographical, social or other barriers has adverse impacts on the productivity of the workforce, undermines households' capacity to invest in productive assets and pushes them into poverty. More broadly, social health protection contributes to addressing poverty and inequalities (SDG targets 1.1, 1.2 and 10.4), as poor access to, and OOP costs for, healthcare have been shown to affect the poor disproportionately. Social health protection also contributes to reducing gender inequality (SDG target 5.4) through equitable access to care.

Many countries, including Colombia, Mongolia, the Philippines, Rwanda, Thailand and Viet Nam, have shown that extending social health protection to all is achievable even in low-income settings and/or where levels of informal employment are high. Their experience demonstrates that a sustained political and financial commitment embedded in a rights-based approach is indispensable if no one is to be left behind.

A rights-based pathway to UHC

Social health protection provides a rights-based pathway towards the goal of UHC. As an integral component of comprehensive social protection systems, social health protection comprises a series of public or publicly organized and mandated private measures to achieve (ILO 2008):

- effective access to quality healthcare without hardship, which is the focus of this section; and
- income security to compensate for lost earnings in case of sickness.

The lack of affordable quality healthcare risks creating both poor health and impoverishment, with a greater impact on the most vulnerable. For this reason, the principle of universality of coverage was underlined in social security standards early on (see box 1).

▶ Box 1. International social security standards on healthcare coverage

Universality

In 1944, the Medical Care Recommendation (No. 69) introduced the principle of universality, setting out that healthcare services should cover all members of the community, "whether or not they are gainfully occupied" (Para. 8). The right to health was subsequently formally enunciated by human rights instruments.1 The human rights to health and social security are understood as creating an obligation to guarantee universal effective access to adequate protection (ILO 2019a; UN 2008). Social health protection is rooted in this framework and represents the optimal mechanism to substantiate these human rights (ILO 2020e).

Financing and institutional arrangements

International social security standards promote collectively financed mechanisms to cover the costs of accessing health services, recognizing recourse to taxes

and contributions made by workers, employers and government. Likewise, the standards recognize a range of institutional arrangements, namely national healthcare services, by which public services deliver affordable health interventions, and national social health insurance, by which an autonomous public entity collects revenues from different sources (social contributions and/or government transfers) to purchase health services, either only from public providers or from both public and private providers. In practice, most countries use a combination of financing sources and institutional arrangements to reach universal coverage.

Coverage extension

The horizontal extension of coverage aims to cover the entire population with at least a minimum level of protection across four basic social protection floor guarantees, including healthcare, in line with Recommendation No. 202 (ILO 2021a, 2017, 2019c).

The vertical extension of coverage aims to improve benefit adequacy progressively, ensuring higher levels of protection. International social security standards establish a minimum level of benefit to be guaranteed by law. The benefit level for healthcare encompasses two dimensions:

- the range of services effectively accessible; and
- financial protection against the costs of such services.

With respect to the first element, the range of services to be included has been progressively widened. While social protection floors should include the provision, at a minimum, of "essential healthcare" as defined nationally, including free prenatal and postnatal care for the most vulnerable, countries should progressively move towards greater protection for all, as reflected in Conventions Nos 102 and 130, which stipulate the provision in national law of access to a comprehensive range of services. To be considered adequate, in line with human rights compliance monitoring mechanisms, health services need to meet the criteria of availability, accessibility, acceptability and quality (Recommendation No. 202, Para. 5(a)) (UN 2000b).

With respect to the second element (financial protection), ILO instruments stipulate legal entitlements to healthcare "without hardship". OOP payments should not be a primary source for financing healthcare systems. The rules regarding cost-sharing must be designed to avoid hardship, with limited copayments and free maternity care.

[1] Universal Declaration of Human Rights, 1948 (Art. 25); International Covenant on Economic, Social and Cultural Rights, 1966 (Art. 12).

Monitoring social health protection coverage

Monitoring progress in social health protection requires considering both population coverage and adequacy of benefits (that is, the range of health services covered and the extent of financial protection), in law and in practice. The SDG framework has fostered additional data collection and provides new proxies for dimensions relating to effective coverage (WHO and World Bank 2020). Nevertheless, more and better data are still needed, particularly on legal coverage, public awareness and quality of care, which remain poorly or unsystematically captured (Kruk et al. 2018).

The complexity and interdependency of these dimensions, as well as the lack of systematic data collection on many of them, make social health protection coverage difficult to monitor. Good performance in one dimension does not automatically translate into good performance in others. For instance, while in Latin America over two thirds of the population are registered with a scheme and effectively use health services, financial protection remains a matter of concern, with high and impoverishing OOP costs for health. The following sections present available indicators and discuss important data gaps.

Population coverage

Legal coverage

Given the importance of legal frameworks to guarantee people's rights to health and social security, bridging the current data gap in this dimension should be a priority (see box 2). While there is some provision for systematic information collection in European countries, there remain significant data gaps for the rest of the world.

Many countries in Asia have established entitlements to healthcare for the whole population within their respective legal frameworks: these include China, Indonesia, the Philippines, Nepal, Sri Lanka, Thailand and Viet Nam.

▶ **Box 2. Monitoring legal coverage of social health protection: An urgent need**

Monitoring legal coverage should include key dimensions of:

- population coverage, enabling the identification of any group(s) excluded;
- adequacy of entitlements, including a guaranteed benefit package (defined positively or negatively), the level of financial protection (defined positively or through the establishment of maximum copayments) and the range of healthcare providers that can be accessed.

Persistent coverage gaps often reflect socio-economic inequalities and multidimensional discrimination against certain population groups. For example, some countries focus legal entitlements on citizens or permanent residents and exclude or limit the adequacy of benefits for temporary residents, such as migrant workers on temporary work permits, who may represent the majority of the workforce in some country contexts.

Awareness of entitlements and effective protection

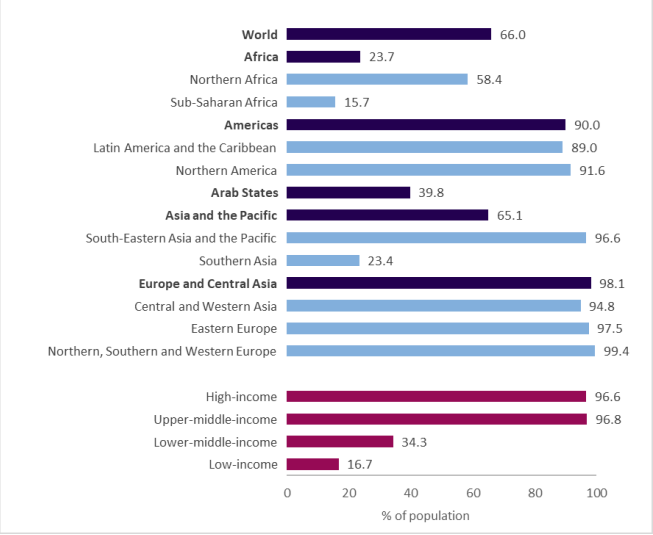
For individuals to effectively access health services when they need them without hardship, it is important that such access be considered a right and embedded in the legal framework. It is equally important that people are aware of their legal entitlements and how to obtain them. A correlated proxy indicator is the percentage of population protected by a scheme. In striving for universal protection, a large number of countries across all income levels have made laudable progress in extending the effective reach of social health protection schemes, to the point where more than half of the world's population are now protected by such a scheme (see figure 1). Regions with lower rates of coverage are Africa, the Arab States and Asia and the Pacific; those with higher rates are Europe and Central Asia and the Americas.

A common challenge encountered by countries at various levels of development is the protection of populations who rely on the informal economy, including informal economy workers themselves and other members of their households (children, young people and older adults) who depend on those revenues for their livelihood (OECD and ILO 2019). It is necessary to ensure that they are aware of their rights, trust publicly mandated schemes and are willing to use them for the primary coverage of the entire household (Traub-Merz and Öhm 2021).

Setting the right incentives, and eliminating obstacles to joining the formal economy more broadly, can support improving awareness of rights and entitlements (ILO 2021c). Some categories of workers, such as self-employed and domestic workers, may be excluded from mandatory schemes. In the case of contributory schemes, contribution levels and modalities may not be adapted to patterns of income for informal workers (which may be seasonal or otherwise fluctuating). Conversely, health benefits can be a strong incentive for workers and employers to contribute to social protection systems and thereby support their transition to the formal economy.

For non-contributory and contributory schemes alike, distance and complex administrative procedures (such as geographical and cultural distance from administrative authorities, issues related to identification documents, length of procedures and so on) can be significant barriers to registration, disproportionately affecting those who depend on the informal economy. To counter these obstacles, a number of health schemes have developed innovative enrolment procedures (see box 3). Greater public awareness of rights and entitlements, and efforts to improve health literacy, are an essential part of empowering people to demand health services. Only when people understand their entitlements and how to avail themselves of them can they play a role in improving the quality and accountability of, and trust in, the system. Such steps should accompany interventions in the political and institutional environment to improve benefit adequacy (see below), scheme accountability and the associated perceptions of fairness and trust (ILO 2021b).

Figure 1 Effective coverage for health protection: Percentage of the population covered by a social health scheme (protected persons), by region, subregion and income level, 2020 or latest available year



Notes: Based on data collected for 117 countries and territories

representing 89 per cent of the world's population, representing the best estimate of people protected by a healthcare scheme for their primary coverage. Mechanisms include national health insurance; social health insurance mandated by the State (including subsidized coverage for the poor); national healthcare services guaranteed without user fees or with small copayments; and other programmes (user fee waivers, vouchers, etc.). In all, 189 schemes for primary coverage were identified and included. To avoid overlaps, only public or publicly mandated, privately administered primary healthcare schemes were included. Supplementary and voluntary public and private programmes were not included, with the sole exception of the United States (the only country in the world where private health insurance plays a significant role in primary coverage). Global and regional aggregates are weighted by population.

Sources: Based on data from ILO Social Security Inquiry and OECD Health Statistics 2020; national administrative data published in official reports; information from regular national surveys of target populations on awareness on rights.

Link: https://wspr.social-protection.org.

▶ Box 3. Facilitating registration for those in the informal economy

Rapid expansion of affiliation to the National Health Insurance Fund (NHIF) in Sudan: The 2016 Health Insurance Act established that all residents should be covered by the NHIF to guarantee their access to healthcare services without hardship. In 2019, 27.2 million people (67.7 per cent of the population) were registered, a doubling of coverage since 2014 (Bilo, Machado, and Bacil 2020). This rapid extension was made possible by the State joining forces with non-contributory social protection schemes, using the same identification and eligibility mechanism to facilitate entry into the scheme, combined with a proactive campaign to disseminate information and encourage registration. Such rapid extension of the registered population requires an equal expansion of health services to ensure the adequacy of benefits.

Adapting national health insurance to the self-employed in Kazakhstan: The launch of the mandatory national health insurance scheme in 2020 led to the rapid affiliation of 88 per cent of the population within one year. The Government covers the cost of contributions on behalf of specific groups, including children under 18, pregnant women, pensioners, people with disabilities, mothers with children and full-time students. The self-employed pay a single flat-rate contribution differentiated between urban and rural settings, the largest part of which is allocated to the national health insurance scheme (40 per cent); the rest goes to other social insurance schemes and income tax (10 per cent of the contribution), thereby ensuring comprehensive coverage and formalization (Kazakhstan 2021).

The regional estimates presented in figure 1 hide significant inequalities across population groups within regions and countries, further influenced by various demographic trends. For instance, human mobility, whether voluntary or forced, within or across countries, is currently happening on an unprecedented scale. This makes it imperative to ensure portability of healthcare entitlements for migrants, including refugees, and to provide appropriate services (IOM 2019; Orcutt et al. 2020). Some countries are making efforts to include refugees in their social health protection systems (for an example, see box 4), despite numerous challenges.

▶ Box 4. Integration of refugees in urban areas of Rwanda into the national health insurance system

The national health insurance system in Rwanda comprises several schemes addressing different professional and socio-economic groups, including the community-based health insurance (CBHI) scheme, managed by a single central institution. In 2017, the Rwandan Government pledged to integrate refugees gradually into the system. The enrolment of 12,000 urban refugees began in September 2019, along with the issuance of identity cards by the Rwandan Government. A memorandum of understanding between the ministry responsible for refugees, the CBHI scheme and the Office of the United Nations High Commissioner for Refugees (UNHCR) ensures that refugees can access healthcare under conditions similar to those enjoyed by host communities (ILO and UNHCR 2020).

The scheme-level data collected to compute the estimates in figure 1 indicate that most countries rely on a diversity of financing mechanisms and institutional arrangements to cover their populations. While it is advisable to combine various sources of funding to ensure the maximum allocation of public resources to the health system, broad risk-pooling is also an important determinant of equity in effective access to care. In this respect, it is encouraging that a number of countries have achieved significant extension of coverage while reducing institutional fragmentation among social health protection schemes (for an example, see box 5) (ILO 2020b).

▶ Box 5. Reducing institutional fragmentation in Indonesia

With the enactment of the 2004 Law on the National Social Security System and Law No. 24 of 2011, Indonesia made a strong commitment towards UHC. In 2012, the National Social Security Board (Dewan Jaminan Sosial Nasional, DJSN) and the Ministry of Health laid out a road map to an integrated social health protection system and the establishment of a Social Security Administrative Body for Health (BPJS Kesehatan). In 2014, various fragmented health schemes were merged into the Jaminan Kesehatan Nasional (JKN) scheme, collecting revenues from both taxes and social contributions, managed by BPJS Kesehatan. JKN is now one of the world's largest single-payer systems, with 223 million members in 2020, more than 82 per cent of the population.

Figure 1 provides an indication of the number of people protected in a given country that has active monitoring policies in place. Registration in a scheme, or regular monitoring of entitlement awareness, do not themselves automatically translate into effective, affordable and adequate access to healthcare in times of need. Many barriers can remain in place, compromising adequacy:

- the availability, accessibility, acceptability and quality of healthcare services may be poor, in practice not allowing effective access or access to a level that would allow improvements in health status;
- benefit packages may be limited (covering few services and leaving patients to cover high OOP expenses for services needed);
- high official copayments or informal payments may be requested (again leaving a significant share of the total costs of care to be borne by patients).

Adequacy of benefits

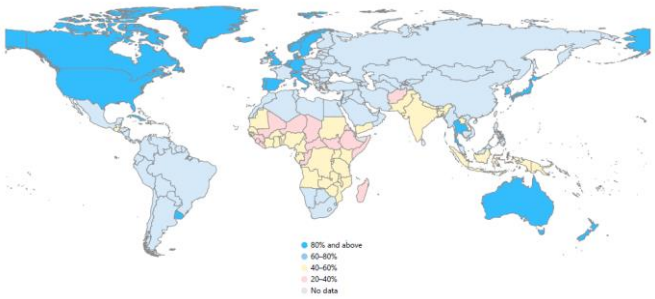
Legal entitlements to adequate healthcare benefits

A systematic approach to data collection is urgently needed to establish the extent to which core elements of adequacy (benefit packages, costs covered, network of providers) are guaranteed by law. Nonetheless, data available for SDG indicators 3.8.1 and 3.8.2 provide some insights into effective coverage of these aspects.

Service coverage

In 2017, almost four decades after the Alma-Ata Declaration on Primary Health Care,[1] half of the world's population still did not receive the essential services they needed, with large disparities across countries (see figure 2) (Hogan et al. 2018; WHO 2019d). Convention No. 102 covers care of both a preventive and a curative nature, and stipulates that health benefits should comprise at least a basic set of interventions,[2] including pre- and postnatal care. Convention No. 130 goes further, including dental care and rehabilitation services. SDG indicator 3.8.1 computes 14 tracer indicators for specific medical interventions across four clusters, namely reproductive, maternal, newborn and child health (RMNCH); infectious diseases; non-communicable diseases (NCDs); and service capacity and access. Though more data are needed to analyse the situation across a wider range of services, clearly the basic package stipulated by international social security standards cannot yet be accessed by the majority of the world's population.

Figure 2 Universal Health Coverage Index (SDG indicator 3.8.1): Average coverage of essential health services, 2017



Source: Based on WHO (2019d).

[1] Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978. See https://www.who.int/publications/almaata_declaration_en.pdf.

[2] At least general practitioner care, including domiciliary visiting; specialist care at hospitals for inpatients and outpatients, and such specialist care as may be available outside hospitals; essential pharmaceutical supplies, as prescribed by medical or other qualified practitioners; hospitalization where necessary; and pre- and postnatal care for pregnancy and childbirth and their consequences, either by medical practitioners or by qualified midwives, including hospitalization where necessary.

Link: https://wspr.social-protection.org.

Laudable progress has been made in service coverage over the last two decades, and scores on the service coverage index (SCI) rose as access to essential interventions on communicable diseases improved (WHO 2019d). Analysis shows that remaining deficits in service coverage are unevenly distributed across geographical locations, income levels, population groups and types of health interventions (Lozano et al. 2020). For instance, deficits can be particularly severe for interventions addressing NCDs, which are increasingly prominent within the global burden of disease (Vos et al. 2020). Similarly, low- and middle-income countries have lower SCI scores than high-income countries and, while service availability has increased, middle-income countries struggle to match the needs of their growing and ageing populations (WHO 2019d). More and better disaggregated data (by sex, age, location, migration status and income) are needed in order to identify in more detail the population groups left behind and devise inclusive policies (Lozano et al. 2020).

Access to treatment and prevention for infectious diseases (in particular TB, HIV/AIDS and malaria) has improved in a number of countries (Murray, Abbafati, et al. 2020). Efforts towards the integration of single-disease programmes within existing health schemes and systems would help to ensure the sustainability of the health gains made in this respect (for an example from Kenya, see box 6).

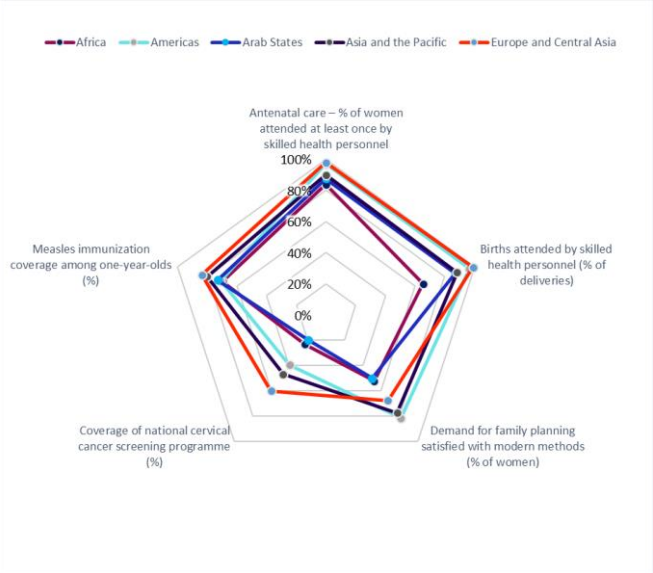
▶ Box 6. Articulating workplace health promotion and social health protection in the context of the HIV response in Kenya

With 84 per cent of workers in the informal economy, few of whom are covered by social protection programmes, Kenya launched voluntary modes of affiliation which have had limited success. While the National Hospital Insurance Fund (NHIF) covers over 3 million workers, only 10 per cent of these are voluntarily registered in the scheme. Many workers and their families are not aware of the scheme's benefits, or of how to enrol. This is an important issue for people living with HIV: although antiretroviral therapy is free through the National AIDS and Sexually Transmitted Infection Control Programme, other costs, such as medical consultations, are not covered. Affiliation to the NHIF is therefore complementary, as it provides access to those.

Under the Voluntary Counselling and Testing for Workers' Initiative (VCT@WORK Initiative) launched in 2013, Kenya enhanced access to HIV testing among workers in both the formal and the informal economies and facilitated their access to national social protection schemes (ILO and UNAIDS 2017). In particular, the programme incorporated advice on and support for enrolling with NHIF.

Similarly, many countries have made progress in providing effective access to RMNCH services, largely encouraged by the Millennium Development Goals, with the fastest increase in low-income countries (WHO 2019d). Nonetheless, significant inequities in access remain both across regions (see figure 3) and across wealth quintiles (see figure 4). More efforts are needed to ensure access to free, high-quality maternity care in line with international social security standards (for an example, see box 7), to expand maternity cash benefits, and to improve coordination between pre- and postnatal care and income security schemes. Indeed, access to both healthcare and income security is essential to ensure a healthy pregnancy, childbirth and postpartum period (Shaw et al. 2016), to reduce maternal and infant mortality, and to ensure that pregnancy and childbirth do not jeopardize women's rights, including their right to work and rights at work. Similarly, global monitoring of quality of care is needed; on this, much can be learned from the efforts made in respect of RMNCH (Fullman et al. 2018).

Figure 3 Unequal advances in service coverage for reproductive, maternal, newborn and child health (RMNCH)



Source: Data extracted from WHO World Health Observatory.

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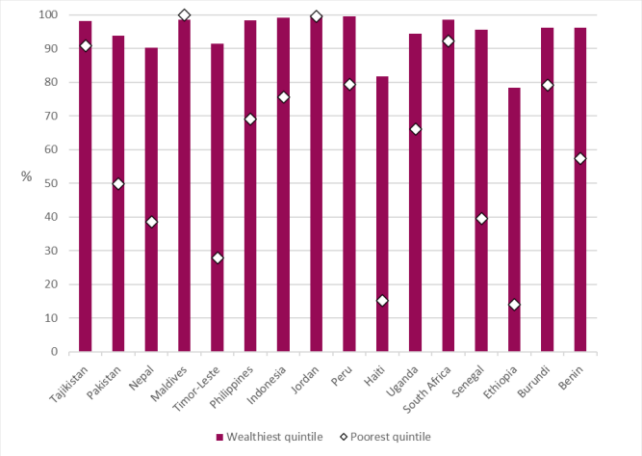
Figure 4 Inequities in access to maternal healthcare services: Percentage of live births attended by skilled health personnel by wealth quintile, countries with data for 2016 or later



Source: Data extracted from WHO World Health Observatory.

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▶ Box 7. Free maternity care in Burkina Faso

In April 2016, Burkina Faso introduced a free healthcare policy for pregnant women, whereby official user fees for maternal and childcare (for children under 5 years) were removed. This translated into a significant reduction, though not a complete removal, of OOP expenses for maternal care, illustrating the need to consider additional measures for tackling informal payments. In 2019, the programme benefited over 700,000 women during their pregnancies and over 10 million children. Delays in the reimbursement to medical facilities remain an impediment in the programme's implementation. Community monitoring mechanisms help to ensure awareness and accountability.

Sources: Based on Bilan (2019); Meda et al. (2019); ThinkWell (2020).

Alongside medicine and medical devices, a central component of the availability of healthcare services is investment in infrastructure and equipment, along with the recruitment and retention of a qualified health sector workforce. This is true for both public and private health sectors (see box 8). Significant inequalities in both physical and human resources persist across countries and regions, as well as between rural and urban areas (see figure 5).

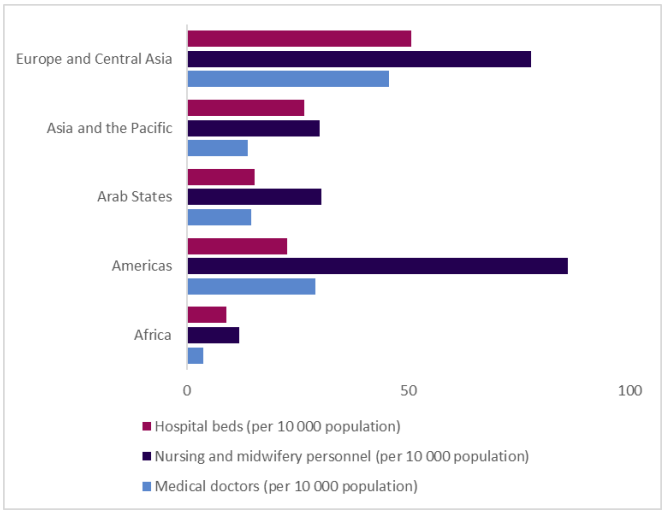
▶ Box 8. Public and private provision of health services

The provision of health services may be realized by public or private entities, and in practice many health systems rely on a combination of both. The involvement of the private sector allows additional investments in infrastructure and the expansion of the service offer. Nevertheless, the strong stewardship and regulatory role of ministries of health are essential to ensure both the quality of care and equitable access to health as a public good for all. It is also important that social health protection agencies in charge of purchasing health services align their incentive structures towards providers with the national vision for service provision.

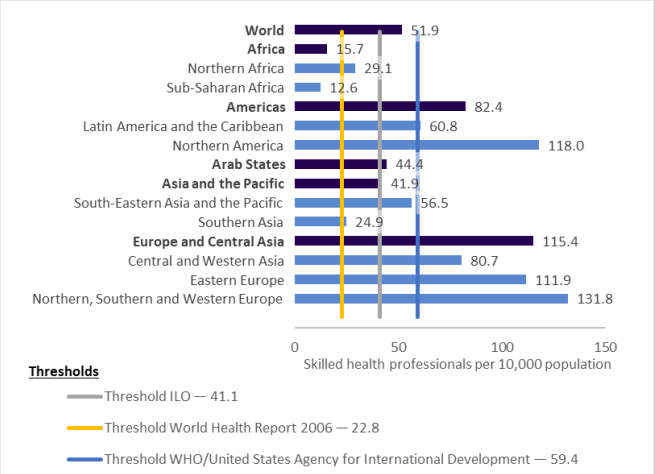
In countries where a large proportion of health services, including health interventions essential to the guaranteed benefit package, are provided by the private sector, considerable effort should be deployed to ensure the population is adequately protected financially. Indeed, evidence from Bangladesh, India and Nigeria indicates that dominant private-sector provision without appropriate social health protection mechanisms often goes hand-in-hand with high OOP expenditure on health (Mackintosh et al. 2016; Islam, Akhter, and Islam 2018).

Figure 5 Deficits in staff and infrastructure at the heart of inequalities in access to healthcare

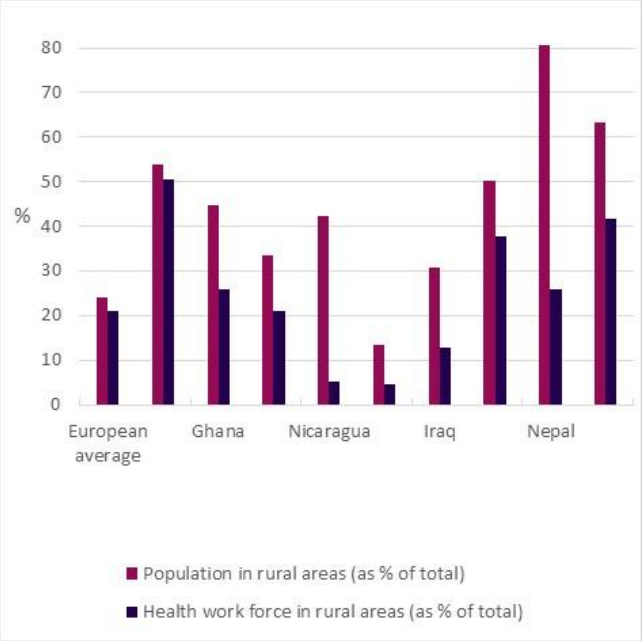
(a) Regional estimates for hospital bed and selected skilled health professional density, latest available year



(b) Skilled health staff density against three thresholds across regions



(c) Inequalities in the availability of health workers in urban and rural areas, selected countries



Notes: Panel (b): More details on the use of these reference points can be found at https://www.who.int/workforcealliance/knowledge/resources/GHWA-a_universal_truth_report.pdf. (c) European average represents 28 countries for which data were available.

Sources: ILO Labour Force Surveys; ILO-OECD-WHO Working for Health Programme and the WHO World Health Observatory.

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Ensuring availability and quality of care requires the creation of decent jobs in the health sector, which currently faces a global deficit of 18 million workers, projected to increase further by 2030 (High-Level Commission on Health Employment and Economic Growth 2017). A large number of those workers are needed in nursing and midwifery, where the projected shortfall of nurses is expected to reach 5.7 million by 2030 (McCarthy et al. 2020). Nurses and midwives play a central role in improving service coverage, and have been key contributors to the progress made in RMNCH services. Hiring, training and retaining them, including in rural areas, is a key building block in ensuring availability, accessibility, acceptability and quality of care in line with international labour standards (ILO 2018b). Workers in this field account for nearly half the global health workforce, and are predominantly women (WHO 2019a). Hence, investing in decent working conditions, in line with Recommendation No. 69, the Nursing Personnel Convention (No. 149) and its accompanying Recommendation (No. 157), 1977 is urgent and requires the use of a gender lens to take account of the fact that most workers in the sector are women. The COVID-19 pandemic has highlighted the essential role of these front-line care workers and the need to secure decent work for them, including access to social protection and occupational safety and health.

Finally, it is important that the national and global monitoring of quality of care and patient experience indicators is improved (Kruk et al. 2018). Social health protection institutions can contribute to this effort (see box 9).

▶ Box 9. The EsSalud national socio-economic survey of access to health services in Peru

The survey was conducted in 2015 on a sample of 25,000 households, complementing information from administrative records and national health surveys. The survey focused on knowledge and use of health entitlements, user experience at the point of service, and users' degree of confidence in EsSalud and the health facilities at their disposal. It covered services from 29 healthcare networks and over 200 health centres. Disparities on factors relating to socio-economic status were explored, providing a basis on which to identify and prioritize necessary quality improvements.

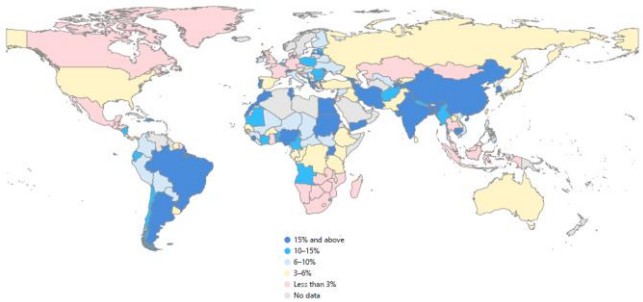
Source: Based on information from EsSalud.

Financial protection

In 2015, 930 million people worldwide incurred catastrophic health spending (defined as OOP expenditures exceeding 10 per cent of total yearly household consumption or income), creating a major poverty risk, with significant disparities across regions (see figure 6) and country income groups (see figure 7) (WHO and World Bank 2020). It is important to note that low catastrophic health spending could be a result of insufficient service coverage rather than improved financial

protection, reinforcing the need to analyse the various dimensions of coverage together.

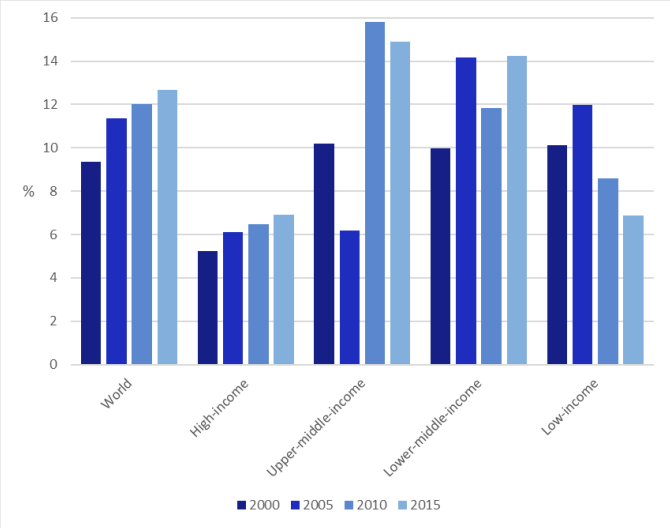
Figure 6 Incidence of catastrophic health spending (SDG indicator 3.8.2: More than 10 per cent of annual household income or consumption), latest available country data 2000–18 (percentage)



Source: Based on WHO and World Bank (2020).

Link: https://wspr.social-protection.org.

Figure 7 Incidence of catastrophic health spending (more than 10 per cent of annual household income or consumption), by income level, 2000–15 (percentage)



Note: Countries are grouped according to the groupings for the World Bank fiscal year in which the data were released.

Source: Based on WHO and World Bank (2020).

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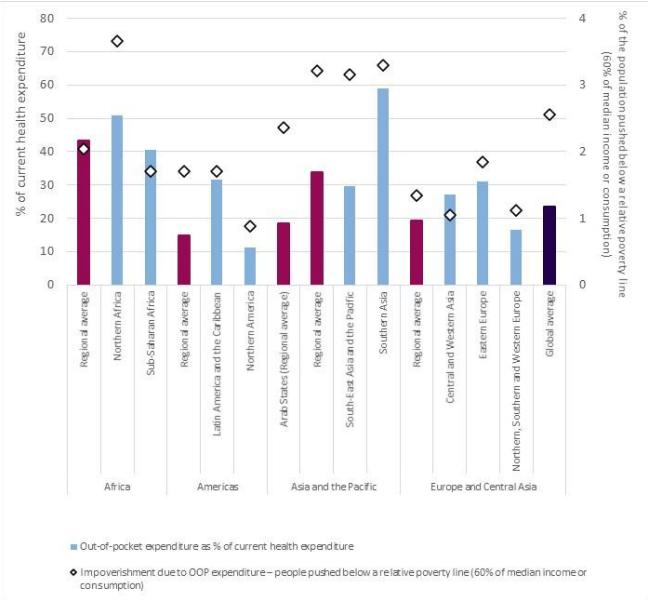
Reasons why so significant a share of health costs is borne by households may include some or all of the following factors operating at the country level.

- Limited benefit packages (covering few services) push individuals to pay OOP for any other services they require. This is increasingly common in emerging economies, where service coverage has increased but social health protection schemes may lag behind in terms of updating their benefit packages (see figure 7). Benefit packages must be adapted to both population needs and developments in the disease burden. Also, in some countries the healthcare landscape has changed, with an increasing share of providers in the private sector, while the social protection framework may cover a network limited to public providers, leaving a significant share of effective health expenses uncovered.
- Ineffective implementation of, and the absence of universal entitlements to, social health protection push the costs of care on to households, creating incentives to delay or forgo necessary care, with direct impact on health outcomes. Low public expenditure on health correlates with higher rates of impoverishment owing to OOP expenses (see figure 8).
- Low levels of cost coverage, with remaining user fees, copayments and/or substantial informal payments representing a high share of the total cost of care to be borne by patients. In this respect, recent analysis has shown that even non-catastrophic health expenditure has a significant impoverishing effect (see figure 8), with significant disparities across wealth quintiles and between urban and rural areas (Wagstaff et al. 2018). These changing realities underline the urgency of guaranteeing the right to social health protection for all.

Figure 8 Impoverishment owing to OOP healthcare expenses: Shares of OOP expenditure in total health expenditure, and of population pushed below a relative poverty line (60 per cent of median income or consumption), by region, 2018 (percentage)



Note: Data for 2018 were unavailable for Libya and Yemen; for these two countries figures from 2011 and 2015, respectively, were used.

Sources: Data extracted from WHO Global Health Expenditure Database and World Bank World Development Indicators.

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Especially worrying is the fact that the share of the global population affected by catastrophic OOP spending increased between 2000 and 2015, leading to 2.6 per cent of the global population – roughly 200 million people – currently being impoverished by OOP spending on healthcare (figures 7 and 8) (WHO and World Bank 2020). Adequacy of the benefits provided clearly remains a key challenge for social health protection systems.

Although the share of OOP expenses in total health expenditure is decreasing, its absolute value in monetary terms is increasing, and so is its impact on poverty. These trends, which are linked to increasing healthcare costs, demonstrate the need for improvements in the healthcare supply in many countries, and the need to ensure the adequacy of health benefits (the cost coverage component and in some cases also the extent of the benefit package) as well as to adapt the purchasing policies of social health protection schemes with due consideration for equity in accessing quality healthcare.

Adequate health and long-term care in an ageing society

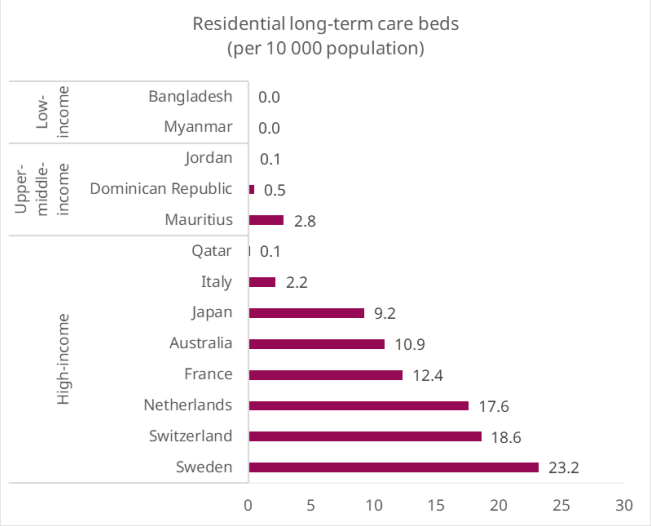
The acceleration of population ageing calls for increased efforts to promote healthy and dignified ageing (Wang et al. 2020). With an increasing global burden of NCDs, ensuring healthy ageing requires a life-cycle approach where prevention is prioritized from an early age, and determinants of chronic and long-term diseases are addressed (Vos et al. 2020; Murray, Aravkin, et al. 2020). Health systems should evolve with a greater emphasis on preventive and early detection services, as well as services responsive to the needs of older people coordinated with social care services (WHO 2015). Social health protection needs to support this shift.

In old age, people tend to suffer the compounded effects of healthcare deficits experienced throughout their lives, and this tendency disproportionately affects women. Indeed, women are over-represented among the older population in all country income groupings, especially as they advance in age (UN Women 2019). Women are also more likely than men to report disabilities and difficulties with self-care, owing to their overall greater longevity and the steep rise in disability after ages 70–75 years (Vos et al. 2020).

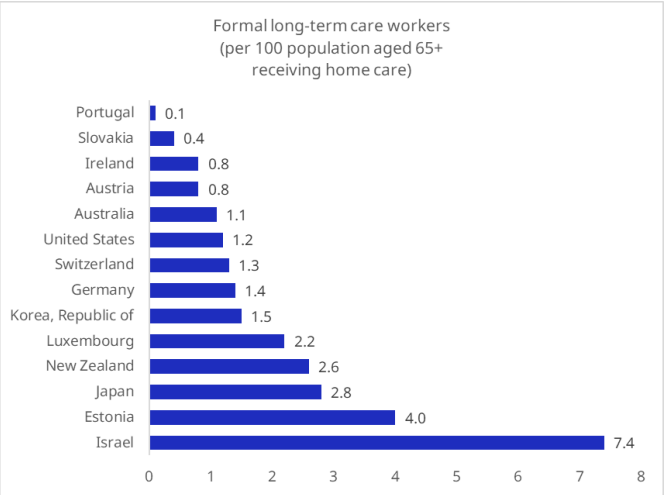
There are limited data on legal and effective coverage for long-term care (LTC); the evidence that is available highlights significant coverage gaps, suggesting that as little as 5.6 per cent of the global population live in countries that provide universal coverage based on national legislation (Scheil-Adlung 2015). The limited available data suggest that investments in LTC infrastructure and human resources are marked by large disparities, some in countries with similar demographic structures (see figure 9). The absence of LTC coverage often results in women in particular having to care for older family members, with limited support or respite, which can have adverse impacts on their physical and mental well-being, as well as their participation in paid work and income security in working life and old age alike (ILO 2018a).

Figure 9 Long-term care (LTC) infrastructure: Unequal investments across countries for which data are available, 2016–19

Availability of residential long-term care beds (per 10 000 population)



Availability of formal long-term care workers (per 100 population aged 65+ receiving home care)



Note: "Formal LTC workers" include nurses and personal care workers providing LTC at home or in LTC institutions (other than hospitals); for more details, see Global Health Observatory (WHO 2020c).

Source: Data extracted from WHO Global Health Observatory.

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While the need for qualified staff is growing, evidence gathered by the ILO–OECD–WHO Working for Health partnership in selected countries indicates that working conditions need to improve to make the sector attractive. The personal care workforce[3] is predominantly female (up to 90 per cent in some European countries), with a wider gender pay gap than for other categories of health professionals, and a relatively lower level of income (in Europe, 60 per cent of personal care workers fall into the two lowest income quintiles).

A number of countries have invested in LTC schemes with a variety of institutional and financing arrangements (see box 10). These include:

- dedicated LTC schemes;
- "top-up" pension benefits and/or expansion of the scope of disability benefits;
- LTC provision embedded within social health protection benefit packages.

These schemes can either encompass the effective provision of LTC services or provide a cash benefit that can be used to buy services from LTC providers. In most cases, the effective provision of good-quality LTC services without hardship requires strong coordination between income support and healthcare schemes, as well as high levels of integration between health and social care. Insufficient investment in both areas leaves important adequacy gaps, even in countries where LTC is recognized as a life contingency in its own right. The impact of COVID-19 on older people has shed further light on the need for closer coordination between health and social care services (Gardner, States, and Bagley 2020).

▶ Box 10. Investment in LTC in Singapore

Older people represent an increasing share of the population in Singapore, which has the highest life expectancy in the world combined with low fertility rates. People aged 65 and above represented 15.2 per cent of the resident population in 2017, and the old-age support ratio (of people in the working-age group to older people) was 5.2, representing half of its 1990 level. Hence the country anticipated an increased demand for LTC and a commensurate need for financial protection.

In 2002, ElderShield was introduced as a basic LTC insurance scheme addressing severe disability, especially during old age. Enrolment into the scheme is automatic at the age of 40, from when the contribution period continues until the retirement age of 65. An assessment conducted in 2018 prompted reform, and the CareShield Life and Long-Term Care Bill (Bill No.

[3] Including institution-based personal care workers, home-based personal care workers, healthcare assistants and other categories of care attendants in health services.

24/2019) was subsequently adopted to replace ElderShield by CareShield Life. While the management of ElderShield was delegated to private insurance companies, CareShield Life is publicly managed, with the stated objective of ensuring greater equity. Under the scheme, eligible people who need support in the activities of daily living are entitled to lifetime monthly cash benefits to cover the related costs.

In parallel, the Ministry of Health engaged in a reform process aiming at better integrating the different levels of healthcare, as well as health and social care, with a view to improving service supply. The Agency of Integrated Care symbolizes the high priority given to overcoming bottlenecks for patients who need to navigate complex health and social care systems.

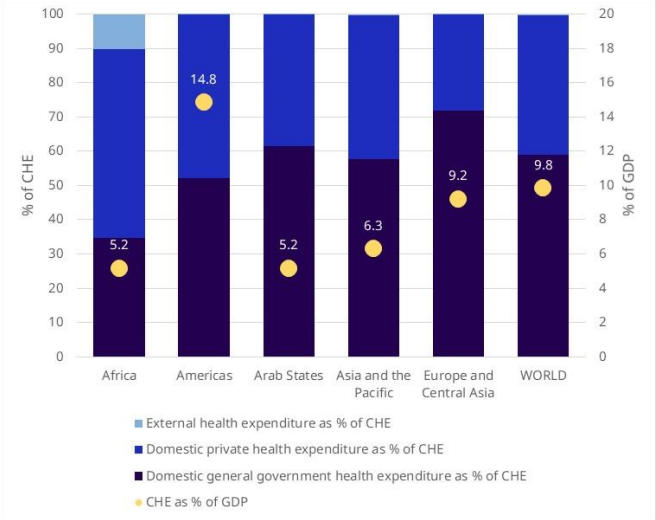
Sources: Based on information from the Singapore Department of Statistics and Ministry of Health; Nurjono et al. (2018); Ow Yong and Cameron (2019).

Persistent gaps in public financing

Insufficient funding is a key determinant of persistent healthcare deficits. It results in increased risk of financial hardship and lack of effective access to adequate healthcare services. Both taxes and social contributions are captured within general government health expenditure (GGHE), which represented 59.5 per cent of current health expenditure (CHE) globally in 2018, with significant disparities across regions (see figures 10 and 11). Although there is a consensus that the efficient allocation of resources should be prioritized and geared towards high-quality care to achieve positive health outcomes, various reports have noted that guaranteeing UHC with appropriate levels of financial protection is challenging if GGHE is below 5 per cent of GDP (Jowett et al. 2016; Røttingen et al. 2014; WHO 2010). Of the countries for which data are available, two thirds fall below this target.

Public domestic financing is the largest source of health financing in developing countries (WHO 2018b). Its share has increased as a percentage of total health expenditure in recent years (WHO 2019b). Consequently, the relative share of OOP health expenditure decreased between 2000 and 2016, with the largest decline in South-East Asia, followed by Africa. However, OOP expenditure remains relatively high (at 44 per cent of CHE on average), and, as noted above, its value in absolute terms and its impact on relative poverty have both increased, illustrating the need for further investment in public domestic health financing. Indeed, increased public spending on health from pooled sources (taxes and social contributions) is positively correlated with lower OOP expenditure on health, while no such correlation was found with funds channelled through private health insurance (WHO and World Bank 2020). This suggests that publicly mandated social health protection schemes, in line with international social security standards, provide the most appropriate pathway towards financial protection that is inclusive of the poorest and most vulnerable. Publicly led programmes are at the heart of coverage extension strategies, underlining the pertinence of international labour standards in respect of the principle of solidarity in financing, as illustrated by box 11.

Figure 10 Current health expenditure as percentage of GDP, and composition of current health expenditure, by region, 2018



Notes: Data for 2018 were unavailable for Yemen, instead figures from 2015 were used. Global and regional aggregates are weighted by GDP. CHE: current health expenditure.

Source: Based on WHO (2020a).

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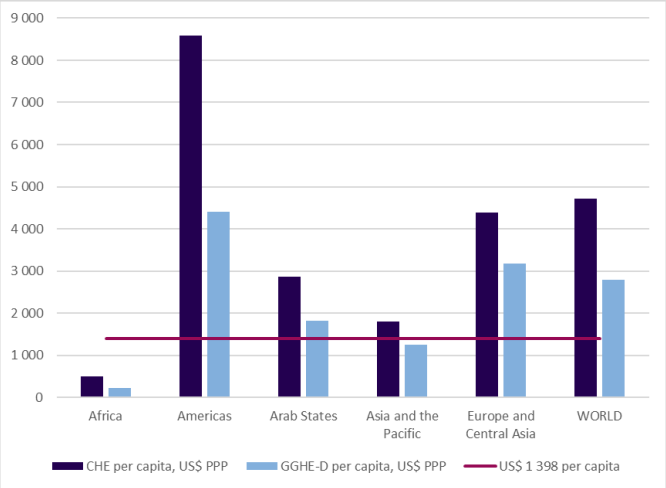
Figure 11 Current health expenditure per capita in US$ PPP, including domestic general government health expenditure (GGHE-D) per capita in US$ PPP, by region, 2018



Notes: Recent analysis suggests that countries need to allocate US$1,398 PPP per capita in pooled health spending to reach a score of 80 on the SCI (Kruk, Ataguba, and Akweongo 2020). Data for 2018 were unavailable for Yemen and the Syrian Arab Republic; for these countries, figures from 2015 and 2012, respectively, were used.

Source: Based on WHO (2020a).

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▶ Box 11. Solidarity in financing and voluntary private health insurance

International social security standards acknowledge a diversity of arrangements that can legitimately exist for the financing, purchasing and provision of healthcare, as long as they respect key principles, in particular the principle of solidarity in financing (ILO 2020e).

In some countries, publicly mandated national health insurance schemes are administered by private actors (private insurance companies or not-for-profit organizations). Nevertheless, social health insurance should not be confused with voluntary private health insurance. Social health insurance is characterized by mutual support. The level of individual contributions is not related to individual risk (factors such as age, sex, previously existing conditions) but to the ability of the people covered to contribute financially. By contrast, private health insurance premiums usually relate to individual risks. As such, they are not based on solidarity and can be exclusionary of people with pre-existing conditions.

Advancing social health protection within social protection systems, and in coordination and articulation with other social protection guarantees across the life cycle, creates the opportunity to further address key determinants of health (WHO 2008; WHO 2019c). Indeed, recent evidence shows that social protection has a role both in mitigating the consequences of ill health and in addressing the social determinants of poor health (WHO 2019c). In conclusion, healthcare and income security are closely linked. Their effective implementation and coordination lays the basis for a common agenda to mobilize fiscal space, and is crucial to ensure that no one is left behind.

Sickness benefits

Definition and legal basis

Sickness benefits aim at ensuring income security during sickness, quarantine or sickness of a dependent relative. As such, they are a social protection instrument with a public health objective. Sickness benefits allow recipients to stay at home until they are fully recovered, thereby protecting their own health and, in the case of communicable diseases, the health of others. Sickness benefits contribute to the human rights to health and to social security (ILO 2017), and are more important than ever when both individuals and societies are facing adverse health events.

The COVID-19 crisis put sickness benefit coverage gaps in the spotlight, illustrating how they compelled people to work when sick or quarantined, increasing the contagion risk (ILO 2020d). The consequent negative impact on disease prevention has long been documented, both in previous public health crises such as severe acute respiratory syndrome (SARS) or Middle East respiratory syndrome (MERS) (Drago 2010) and in the literature on occupational safety and health in the workplace (James 2019).

The ILO adopted the first Convention on sickness benefits in 1927; this was subsequently updated by further standards (see box 12) (ILO 2020e). Sickness benefits should not be confused with sick leave; box 13 provides some conceptual clarification. Although income security during sickness is included in the Social Protection Floors Recommendation, 2012 (No. 202), sickness benefits are not reflected in the SDGs. Despite its importance as a socio-economic determinant of health, income security during illness is not mentioned in either SDG target 1.3 on social protection or SDG target 3.8 on universal health coverage. Income security in times of ill

health has limited visibility within the SDGs and is under-researched, especially in low- and middle-income countries (Lönnroth et al. 2020; Thorpe 2019).

▶ Box 12. Key principles of sickness benefits in international social security standards

The following ILO social security standards provide essential guidance on sickness benefits: the Income Security Recommendation, 1944 (No. 67); the Social Security (Minimum Standards) Convention, 1952 (No. 102); the Medical Care and Sickness Benefits Convention, 1969 (No. 130); and the Medical Care and Sickness Benefits Recommendation, 1969 (No. 134). These instruments reflect an international consensus on the following principles.

Scope: Sickness benefits are provided in case of "incapacity for work resulting from a morbid condition and involving suspension of earnings" (C.102, Art. 14, and C.130, Art. 7(b)). They should be granted until recovery, including in the case of seeking preventive or curative care and being "isolated for the purpose of quarantine" (R.134, Para. 8(a) and (b)).

Coverage for all through public measures: Sickness benefits should be organized in the most efficient way (R.202, Para. 9) to guarantee access to benefits for all.

Solidarity in financing: The cost of sickness benefits and their administration should be borne collectively by way of social insurance contributions, taxation or both in a manner which avoids hardship to people of small means, ensuring that they can maintain their families in health and decency, and takes into account national economic situations (C.102, Arts 67 and 71; see also R.202, Para. 3(h), and R.67, Annex, Para. 26(8)).

Waiting periods to access sickness benefits, if any, should not exceed three days (C.102, Art. 18; C.130, Art. 26.3).

Benefit level: Sickness benefits shall be paid periodically, providing at least 45 or 60 per cent of past earnings (C.102, Arts 16 and 67, and C.130, Art. 22, respectively).

Care for dependants: Appropriate provision should be made to help economically active people who have "to care for a sick dependant" (R.134, Para. 10).

▶ Box 13. Sick leave and sickness benefits: Definitions

Sick leave addresses the need for a person to take leave when sick and should be defined in labour law. The right to take sick leave is recognized as an entitlement separated from other types of leave, such as holidays, in both the Holidays with Pay Recommendation, 1954 (No. 98), and the Holidays with Pay Convention (Revised), 1970 (No. 132). Sick leave entitlements should be reflected in contracts and should provide equality of treatment across several categories of workers, in particular for temporary and other types of vulnerable employment (ILO 2011a, 2019a). Each country may define instances in which there is a suspension of earnings during sick leave, and may also define a period, if any, during which there is a legal obligation for employers to cover the salary of workers (employers' liability).

Sickness benefits guarantee that an adequate income is provided during sick leave when earnings are suspended. To maximize the impact of sickness benefit schemes, social security standards provide guidance for their design features and financing structure (see box 4.9). Sickness benefits should be provided in the most effective and efficient way based on broad risk-pooling and solidarity, for example through universal benefit schemes, national social insurance schemes, social assistance schemes or some combination of these. The cost of such benefits and their administration should be borne collectively, not by the employer or worker alone.

Legal and effective coverage

Legal coverage

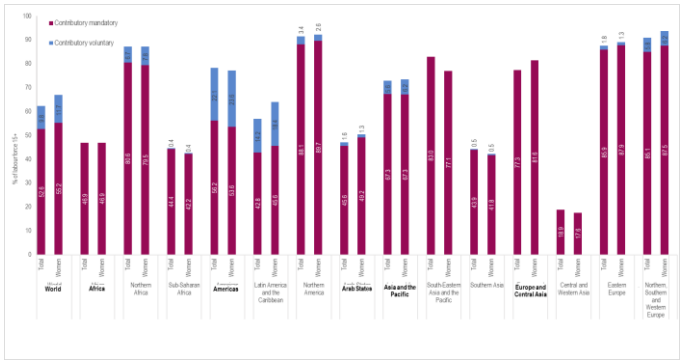
The ILO estimates that 62 per cent of the global labour force, representing 39 per cent of the working-age population, is legally entitled to some income security via paid sick leave through an employer's liability, sickness benefits (provided by social insurance or assistance) or a combination of both mechanisms. This leaves nearly four in ten workers without legal coverage (see figure 12. There are wide regional differences, with high levels of legal coverage in Europe and Central Asia and the Arab States, and lower levels in Africa and Asia and the Pacific.

Although legal protection can be provided by employers' liability, sickness benefits offer a more robust way to provide income security in case of ill health. Reliance solely on

employers' liability may have adverse effects. Coverage is limited, by definition, to salaried work only (the self-employed being their own employers), and often also excludes specific categories of employees, such as casual workers and workers who are paid hourly wages. Solidarity in financing is also limited as individual enterprises are left to bear the costs of workers' sickness. This may lead to pressure on workers not to take sick leave and to discrimination in recruitment against individuals with declared medical conditions. Small enterprises in particular may struggle with the financial implications, and therefore have an incentive to employ workers in forms of employment that are not subject to statutory sick leave (ILO 2020c).

Most countries have legal provisions for paid sick leave through employer's liability or for sickness benefits, or a combination of both, for at least one category of workers (see figure 13). Yet 59 countries rely exclusively on employer's liability to compensate for the loss of income during sickness, and only one third of African countries have legal provisions for sickness benefits. Also, existing provisions may exclude some categories of workers, and special efforts are needed to extend protection, including to workers in part-time and temporary employment, the self-employed and jobseekers (ILO 2021d).[4]

Figure 12 Legal coverage for sickness protection: Percentage of labour force aged 15+ years covered by sickness cash benefits, by region, subregion, sex and type of scheme, 2020 or latest available year



Note: Global and regional aggregates are weighted by labour force aged 15+ years.

Sources: ILO, World Social Protection Database, based on the SSI; ISSA/SSA, Social Security Programs Throughout the World; ILOSTAT; national sources.

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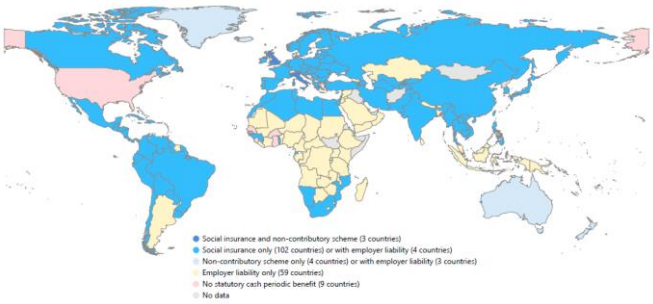
Figure 13 Sickness protection (cash benefits) anchored in law, by type of scheme, 2020 or latest available year



Sources: ILO, World Social Protection Database, based on the SSI; ISSA/SSA, Social Security Programs Throughout the World; ILOSTAT; national sources.

Link: https://wspr.social-protection.org.

Effective coverage

Even if workers are legally covered for sickness benefits, they will only be effectively covered once they are affiliated to a scheme, understand how to access benefits and actually receive their benefits when they fall ill. While income security in case of ill health should be monitored under SDG target 1.3, a lack of comprehensive and systematic data collection on the different aspects of effective coverage has led to this dimension currently being excluded from SDG monitoring efforts (Lönnroth et al. 2020).

Many countries have introduced measures via both contributory and non-contributory programmes, such as Brazil, Malawi, Malaysia (see box 14), Peru, South Africa, Viet Nam and Zambia. Even so, universal effective coverage remains concentrated in the European region, where broad risk-pooling and solidarity in financing are the basis of long-established systems (as in Finland; see box 15) (Thorpe 2019). Obstacles to effective coverage can include administrative or geographical barriers, non-compliance with registration procedures or lack of awareness (Scheil-Adlung and Bonnet 2011; ILO 2014, 2017).

[4] Unemployment benefits should not be used in cases of sickness; instead, sickness benefit should be guaranteed.

▶ Box 14. Introduction of sickness benefit in Malaysia

With a view to improving financial protection against ill health, in 2019 the Malaysian Government launched a sickness cash benefit programme to complement the national healthcare service in cases of critical illness and/or hospitalization. The MySalam national health protection scheme aims to cover 3.69 million citizens and permanent residents of working age and their spouses with income support in cases of selected illnesses. This total represents about 10 per cent of the total population, a little less than a quarter of the labour force. MySalam covers people included in the Bantuan Sara Hidup (BSH) register,1 and people aged 18–65 years who are not in the BSH register, with an annual income of up to US$23,000 per year (MySalam 2020).

The scheme focuses on covering costs associated with hospitalization not otherwise covered and providing some income replacement during hospitalization. The benefit is means-tested and provides a lump sum upon diagnosis of one of 45 critical illnesses and daily hospitalization income replacement up to US$161 per year at any public hospital (MySalam 2020). A broader reform would allow for the expansion of both the population covered and the adequacy of the benefit to reach beyond cases of hospitalization.

1 The BSH register was established by the Government in 2019 to help reduce the cost of living for people on low incomes (the group defined as B40) (Bantuan Prihatin Nasional, 2020). It includes the following categories of those eligible for benefits under MySalam: (1) individuals aged 18–65 years with spouses; (2) single individuals aged 40–65 years with an income of less than 24,000 Malaysian ringgit (US$5,500) per year; and (3) disabled individuals aged 18–65 years with an income of less than 24,000 ringgit (US$5,500) per year.

▶ Box 15. Sickness benefit for all in Finland

Finland has a national social insurance sickness benefit scheme which covers all non-retired residents aged 16–67 years (employees, self-employed, students, unemployed jobseekers and those on sabbatical or alternation leave1) as well as non-residents who have worked in the country for at least four months. The scheme is financed through employer and employee contributions as well as by the State, ensuring solidarity between those who can work and those who cannot. The benefits are either a proportion of previous earnings or a minimum allowance, depending on the recipient's employment status. In 2007, the country introduced the possibility of combining part-time sick leave and part-time work, with a view to allowing people with long-term conditions, such as mental illnesses, to stay connected with the workplace even when they are not able to work on a full-time basis (Kausto et al. 2014).

1 This is an arrangement whereby an employee takes a period of leave, and an unemployed person fills the vacant position. The employee receives an unemployment benefit for the leave period, which must be between 100 and 360 calendar days.

Adequacy of benefits

Benefit adequacy depends on the level of income replacement, the duration of payments, and the existence and length of a waiting period. When benefit levels are calculated as a percentage of past earnings, the existence of a guaranteed minimum level is essential for low-income workers (ILO 2021a, 253). Out of 94 countries for which information is available on social insurance schemes providing sickness benefits, 27 countries have provisions for income replacement lower than 60 per cent of past earnings, while an additional six countries offer flat-rate benefits.

Benefit duration is also important, as people affected by long-term illnesses are in critical need of income and may lose their jobs if there is no or insufficient sickness benefit provision. Indeed, with no sickness benefit in place, employers may not be able to afford to retain workers who are unable to work for extended periods of time. With a view to covering such cases, some countries have created specific benefits for long-term diseases, or have even integrated chronic diseases into the eligibility criteria for disability benefit schemes (see box 16). Among the 94 countries for which information is available, 33 provide benefits for a maximum duration not exceeding 26 weeks.

Finally, in some countries sickness benefits may cover only periods of sickness, sometimes with a waiting period,[5] and not time spent seeking care, in quarantine or self-isolation, or caring for dependants. Sickness benefits should cover those undergoing preventive care or isolating for the purpose of quarantine, in line with ILO standards and as widely observed during the COVID-19 pandemic (see box 17). Provision should

[5] If they exist, such waiting periods should not exceed three days.

also be made available for economically active people who have to care for sick dependants (see box 18).

▶ Box 16. Efforts to support income security for people affected by TB and HIV: Achievements and limitations

Considering the needs of HIV and TB patients facing income loss and additional non-medical expenses, in the absence of sickness benefit schemes, governments have been prompted to take action in many countries where these conditions impose a heavy burden. Such actions have included the following.

Disease-specific schemes. For example, a conditional cash transfer was made available to people living with drug-resistant TB in Ecuador (Cazares 2012). The programme was funded through Ecuador's National Tuberculosis Programme and provided cash benefits linked to adherence to treatment for up to 24 months (Presidencia de la Republica de Ecuador 2012). Currently, caregivers of children with severe illnesses and people living with HIV are also eligible under Executive Decree No. 804 of 2019. The limited evidence available warrants caution about disease-specific programmes, given the risk of exacerbating stigma and discrimination.

Granting access to disability benefits that were already in place. For example, South Africa provides a disability grant for people living with HIV, if the disease limits their activity and if the CD4 count is below a certain threshold.1 This is the only non-contributory scheme that provides free healthcare and income security in the event of loss of working capacity owing to HIV infection for South Africans. While it provides a solution for a number of people living with HIV, it does not meet the needs of those with diseases that are less visible to policymakers (with a lower national burden).

Granting households with at least one member living with HIV and/or TB access to social assistance programmes. For example, in Botswana, the Orphan Care Program Short Term Plan of Action on Care Orphans, a cash transfer for households caring for an orphan, is available to children living with HIV. It offers children and their caregivers assistance with educational needs, free medical treatment in government health facilities, a transportation allowance and other income support assistance. While this has provided relief to children living with HIV and their caregivers, it does not offer income security while the family copes with a sick breadwinner.

1 CD4 cell count is an indicator of immune function in people living with HIV.

▶ Box 17. Adjustments to sickness benefit schemes in response to COVID 19

Several countries have expanded sickness benefits in an attempt to curb the spread and impact of COVID 19. For example:

in **Colombia**, beneficiaries of the regimen subsidiado, a non-contributory scheme that targets low-income families not covered by other schemes, were made eligible to receive lump-sum benefit payments equal to seven days' worth of the minimum wage if they contracted COVID 19 (Ministerio de Salud y Protección Social 2020);

in **El Salvador**, the Government mandated the official social security institution, the Instituto Salvadoreño del Seguro Social, to assume full responsibility for benefit payments to any workers who need to quarantine, without a waiting period and regardless of whether or not they fell ill (El Mundo 2020);

in **Japan**, cash sickness benefits were extended to those in quarantine or diagnosed with COVID 19, while simultaneously requirements to obtain medical certificates were waived (ISSA 2020).

▶ Box 18. Benefit to care for sick dependants

In Portugal, the scheme Subsídio para Assistência a Filho ensures that workers receive 65 per cent of their average daily earnings for up to 30 days a year if they need to take care of a sick child aged under 12, and 15 days a year to take care of sick children aged 12–18 in need of care and living in the same household. The benefit duration is extended to six months for children with disabilities or chronic illness, regardless of age, as long as they are dependent and living at home. The benefit may be extended for up to four years (ISSA and SSA 2018; ILO 2020c).

Such an example of expanded sickness benefit echoes the recommendations provided by the Medical Care and Sickness Benefits Recommendation, 1969 (No. 134). The benefit is available to fathers and mothers alike,

recognizing the importance of sharing the burden of care, which tends to fall disproportionately on women (ILO 2018a).

The case for universal sickness benefits

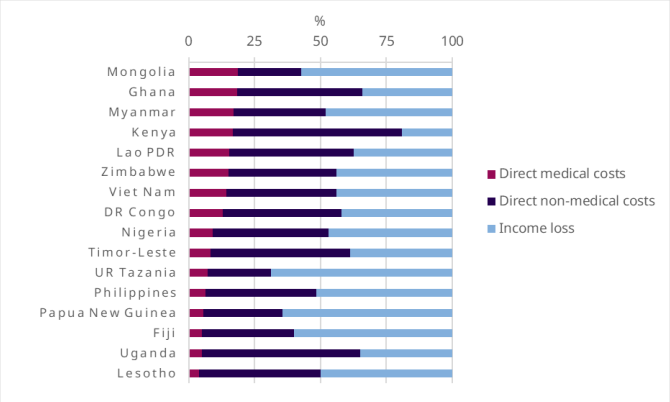
Where sickness benefits are not available, both the health and the income security of workers and their families, as well as public health, are at risk. In this respect, valuable lessons can be learned from impact studies of long-lasting and chronic diseases.

Addressing the non-medical costs of illness

Non-medical costs,[6] including income loss, increase the risk of poverty for sick people and their families. The impoverishment risks are even greater when healthcare benefits are not guaranteed and the cost of healthcare services must be borne out of pocket. In such cases, the compounded impact of illness on household health, income and well-being is immediate and may have a lasting effect (ILO 2020c).

The impoverishing impact of sickness arising from income loss and direct non-medical costs is increasingly documented (WHO, 2018a). The global TB and HIV/AIDS strategies have included an income security component, and social protection access is monitored (WHO 2014; UNAIDS 2015; Lönnroth et al. 2014). For those diseases, while affordable or free healthcare services have been scaled up, the importance of other costs, such as productivity or job loss, is also increasingly recognized (Lönnroth et al. 2020, 2014). For instance, the national TB patient cost surveys coordinated by the WHO show that patients face not only varying levels of direct medical costs, depending on the country context, but also significant direct non-medical costs (mostly transport and nutrition) and income loss, creating incentives to forgo care (see figure 14).

Figure 14 Snapshot of cost distribution (percentages of total incurred costs) from patient cost surveys conducted under the WHO Global Tuberculosis Programme in 16 countries



Source: WHO (2020b).

Link: https://wspr.social-protection.org.

Reaching universality

A number of countries with a high TB and HIV burden have tried to expand coverage in the absence of universal sickness benefits through disease-specific programmes and other initiatives, as illustrated in box 4.14. While this effort is laudable, early evidence indicates that income loss and the resulting need for sickness benefits is also a challenge for people with a range of other communicable and non-communicable diseases, in particular in low- and middle-income countries (Thorpe 2019). Therefore, efforts should be made to extend income security protection in the event of sickness to all.

[6] Costs that patients face due to their medical condition are typically classified as: (1) direct medical costs that occur within the health system (e.g. cost of drugs or fees of healthcare staff); (2) direct non-medical costs, that is, care-related costs that patients incur outside the health system (e.g. the cost of transportation to and from health facilities or increased food spending owing to a treatment-related change in diet); and (3) indirect costs, namely the opportunity cost of seeking care or being sick, notably the income loss caused by lost working time.

Maternity protection, and paternity and parental leave benefits

A comprehensive approach to maternity protection

Maternity protection is essential to prevent and reduce poverty and vulnerability, promote the health, nutrition and well-being of mothers, achieve gender equality and advance decent work. It comprises income security, maternal healthcare, maternity leave, breastfeeding arrangements, employment protection and childcare solutions after return to work. While significant progress has been made, it is estimated that far too many women still face impoverishment or suffer from preventable consequences of complications during pregnancy or childbirth. In 2017, 295,000 women died of causes related to pregnancy and childbirth, 86 per cent of those deaths occurring in sub-Saharan Africa and South Asia (WHO 2020c). From a social protection perspective, ensuring effective access to maternal healthcare and income security in the critical period before and after childbirth are essential (ILO 2020e, 2019b, 2018c).

As a fundamental element of maternity protection and social health protection, good maternal healthcare provides for effective access to adequate healthcare and services – including reproductive health services – during pregnancy and childbirth and beyond, to ensure the health of both mothers and children. As with social health protection in general, a lack of coverage puts the health of women and children at risk and exposes families to significantly increased risk of poverty.

UNICEF estimates that 116 million children were born between the WHO declaration of the COVID-19 outbreak as a pandemic on 11 March 2020 and the end of that year. The pandemic compromises access to maternal and other health services (already scarce in many countries even before the pandemic), owing to the significant disruption of health systems it has caused, including pre- and postnatal care, skilled delivery and neonatal care services (UNICEF 2020a). Models estimate a resulting increase in maternal mortality, even in the least severe scenario, of at least 8 per cent over six months (Roberton et al. 2020). In order to prevent a further deterioration of maternal and newborn outcomes, the United Nations Population Fund (UNFPA) calls for maternity services to be prioritized as an essential core health service, alongside other sexual and reproductive health services such as family planning, emergency contraception, treatment of sexually transmitted diseases and safe abortion, among others, that need to be maintained during the pandemic (UNFPA 2020).

In addition to providing good-quality maternal healthcare, maternity cash benefits are of critical importance for the well-being of pregnant women, new mothers and their families, not least in order to enable adequate nutrition during pregnancy and breastfeeding. The absence of income security forces many women to keep working into the very late stages of pregnancy and/or to return to work prematurely after the birth, thereby exposing themselves and their children to significant health risks. Women in the informal economy are particularly vulnerable to the risks of income insecurity and ill health because of discrimination, unsafe and insecure working conditions, lack of employment protection, often low and volatile incomes, limited freedom of association, lack of representation in collective bargaining processes and lack of access to social insurance (ILO 2016b). The challenges facing women in the informal economy are often compounded by other factors. For example, indigenous women are 25.6 percentage points more likely to work in the informal economy than their non-indigenous counterparts (86.5 per cent versus 60.9 per cent) (ILO 2020a).

The COVID-19 crisis has rendered pregnant women more vulnerable to income shocks and impoverishment, more likely to be laid off or lose their livelihoods in other ways and less likely to be able to return to work. Despite these increased risks, only a very few governments have introduced specific maternity-related measures in their COVID-19 social protection response packages: only ten measures on income security in ten countries, or 0.4 per cent out of some 1,600 measures introduced in over 200 countries or territories, are linked to maternity, placing this function second from last of the functions addressed by the response measures. In some cases, too, the design of COVID-19 response measures has created access barriers for women. For example, reliance on digital methods of outreach, registration and payout may have exclusionary effects for women – as for other vulnerable groups – owing to the gendered aspect of the digital divide, namely the uneven distribution of ownership of, access to and knowledge of new technologies (EBRD 2020; Holmes et al. 2020).

According to international labour standards (see box 19), maternity protection includes not only income security and access to healthcare, but also the right to interrupt work activities, to rest and to recover around childbirth. It ensures the protection of women's right to work and rights at work during maternity and beyond, through measures that prevent risks, protect women from unhealthy and unsafe working conditions and environments, safeguard their employment, protect them against discrimination and dismissal, and allow them to return to their jobs after maternity leave under conditions that take into account their specific circumstances, including the need for breastfeeding (ILO 2016a; Addati, Cassirer, and Gilchrist 2014; ILO et al. 2012). From the perspective of equality of opportunity for and treatment of women and men, maternity protection takes into account the

particular circumstances and needs of women, enabling them to enjoy their economic rights while raising their families (ILO 2014a, 2018c). Adequate provision for paid paternity leave and parental leave is an important corollary to maternity protection policies, and contributes to a more equal sharing of family responsibilities (ILO 2019b, 2018c; Addati, Cassirer, and Gilchrist 2014).

▶ Box 19. International standards relevant to maternity protection

Women's right to maternity protection is enshrined in the Universal Declaration of Human Rights of 1948, which sets out the right to social security and special care and assistance for motherhood and childhood. The International Covenant on Economic, Social and Cultural Rights (1966) establishes the right of mothers to special protection during a reasonable period before and after childbirth, including prenatal and postnatal healthcare and paid leave or leave with adequate social security benefits. The Convention on the Elimination of All Forms of Discrimination against Women (1979) recommends that special measures be taken to ensure maternity protection, proclaimed as an essential right permeating all areas of the Convention.

Since the adoption by the ILO of the Maternity Protection Convention, 1919 (No. 3), in the very year of its foundation, a number of more progressive instruments have been adopted, in line with the steady increase in women's participation in the labour market in most countries worldwide. The Social Security (Minimum Standards) Convention, 1952 (No. 102), Part VIII, sets minimum standards as to the population coverage of maternity protection schemes, including cash benefits during maternity leave, to address the temporary suspension of earnings. The Convention also defines the medical care that must be provided free of charge at all stages of maternity, to maintain, restore or improve women's health and their ability to work (see also box 1). Further, it provides that free maternal healthcare must be available to women and the spouses of men covered by maternity protection schemes.

The Maternity Protection Convention, 2000 (No. 183), and its accompanying Recommendation (No. 191), provide detailed guidance for national policymaking and action aiming to ensure that women:

are granted at least 14 weeks of maternity leave paid at a rate of at least two thirds of previous earnings (Convention No. 183) or up to 18 weeks at 100 per cent (Recommendation No. 191);

have employment protection during pregnancy, maternity leave and the right to return to the same or an equivalent position;

enjoy the right to one or more daily nursing breaks or a daily reduction of hours of work to breastfeed their children; and

are not required to perform work prejudicial to their health or that of their children.

In order to protect women's rights in the labour market and prevent discrimination by employers, ILO maternity protection standards specifically require that cash benefits be provided through schemes based on solidarity and risk-pooling, such as compulsory social insurance or public funds, while strictly circumscribing the potential liability of employers for the direct cost of benefits.

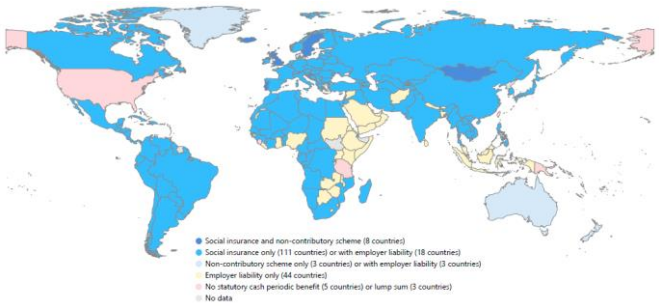
Recommendation No. 202 calls for access to essential healthcare, including maternity care and basic income security, for people of working age who are unable to earn sufficient income owing to (among other factors) maternity. Cash benefits should be sufficient to allow women a life in dignity and without poverty. Maternity medical care should meet criteria of availability, accessibility, acceptability and quality (UN, 2000a); it should be free for the most vulnerable; and it should not create hardship or increase the risk of poverty for people in need of healthcare. Maternity benefits should be granted to all residents of a country. Reinforcing the objective of achieving universal protection, the Transition from the Informal to the Formal Economy Recommendation, 2015 (No. 204), calls for the extension of maternity protection to all workers in the informal economy.

A diversity of schemes providing maternity protection

In 143 out of the 195 countries and territories for which information was available, periodic maternity cash benefits are anchored in national social security legislation and provided through collectively financed mechanisms: either social insurance that fully or partially replaces women's earnings during the final stages of pregnancy and after childbirth, or non-contributory schemes that provide at least a basic level of income (see figure 15). Almost all of these

countries (137) had social insurance schemes, of which eight also operate non-contributory tax-financed schemes. Forty-seven other countries – most of them in Africa or Asia – have provisions in their labour legislation for a mandatory period of maternity leave and establish the employer's liability for the salary (or a percentage thereof) during that period. Eighteen countries combine social insurance and employer liability mechanisms. Three countries provide maternity cash benefits exclusively through non-contributory schemes. In another three countries, women may take unpaid maternity leave, but do not benefit from income replacement.

Figure 15 Maternity protection (cash benefits) anchored in law, by type of scheme, 2020 or latest available year



Notes: Numbers of countries refer to numbers of countries and territories. In the United States there is no national programme. Under the Family and Medical Leave Act, 1993, maternity leave is unpaid as a general rule; however, subject to certain conditions, accrued paid leave (such as vacation leave or personal leave) may be used to cover some or all of the leave to which a woman is entitled under the Act. A cash benefit may be provided at the state level. Additionally, employers may offer paid maternity leave as a job benefit.

Sources: ILO, World Social Protection Database, based on the SSI; ISSA/SSA, Social Security Programs Throughout the World; ILOSTAT; national sources.

Link: https://wspr.social-protection.org.

The Maternity Protection Convention, 2000 (No. 183), recommends that countries introduce collectively financed maternity benefits (social insurance or tax-financed) rather than relying on employer's liability provisions. This improves equality of treatment for men and women in the labour market because it shifts the burden of bearing the costs of maternity benefits from the individual employer to the collective, reducing discrimination against women of childbearing age in hiring and in employment, and the risk of non-payment of due compensation by the employer. Such reforms can also facilitate the coverage of women with low contributory capacities and interrupted employment histories, including those in part-time or temporary employment, and those in self-employment.

In some countries, pregnant and childbearing women can benefit from non-contributory cash transfer programmes. However, these programmes are often not anchored in law and tend to cover only a small fraction of the population with often very modest benefit amounts that do not allow women to withdraw temporarily from paid or unpaid work. As a result, women continue working too far into pregnancy or return to work too soon after childbirth, with potentially negative effects on their own and their babies' health. Finally, in many low- and lower-middle-income countries, these cash transfer programmes come with behavioural conditions which tend to reinforce the traditional division of paid and unpaid care work between women and men (ILO 2016b, 2016a) (see box 20 below). For example, receipt of benefits may be conditional on uptake of pre- and postnatal care, skilled delivery or health check-ups for and vaccination of the child, and sanctions may be applied if the conditions are not fulfilled. Unless those services are affordable, accessible geographically, of high quality and culturally acceptable for women, conditionalities will result in women obtaining neither the cash benefit nor the needed health services.

In some countries, universal coverage and adequate benefit levels for maternity protection are achieved by combining contributory and non-contributory mechanisms. In Portugal, for example, women who are not entitled to paid maternity leave from social insurance receive a tax-financed maternity benefit. The effective coordination of these mechanisms within the social protection system is essential to guarantee at least a basic level, or floor, of income security for women workers who become pregnant. Likewise, cash and care benefits need to be well integrated, requiring coordination between health and social protection sectors.

▶ Box 20. The motherhood penalty: Why mothers bear a cost in terms of employment, wages and leadership positions

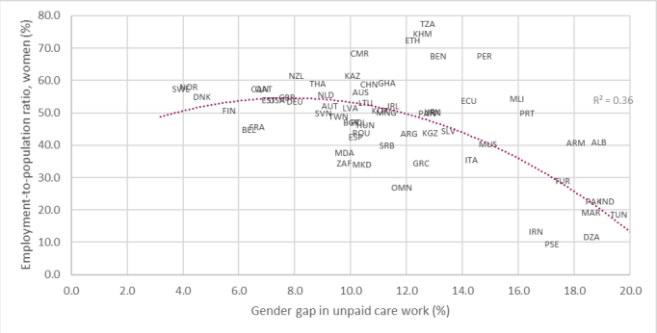
The focus of maternity protection is on the protection of the mother during a period of increased vulnerability and special need for protection around childbirth. However, maternity protection measures and the design of family policies more broadly have profound implications for gender equality and women's rights beyond delivery and childbirth. Social norms and structural inequalities, such as persistent gender pay gaps, continue to compel women to be the main caregivers and men to work longer hours as the main earners of household income. As a result, mothers of young children are less likely to be employed than women without children, fathers and men without

children. Emerging evidence from Brazil, Chile, Costa Rica and Mexico shows that partnered women with children have experienced sharper pandemic-related drops in labour force participation than men – and that these are most pronounced for women living with children aged under 6 years (Azcona et al. 2020). Women with children also receive lower wages and are less likely than men, and less likely than women or men without children, to work in managerial or leadership positions (ILO 2019b). All these factors effectively penalize women when they have children – the so-called motherhood penalty.

The trend is troubling: between 2005 and 2015, the motherhood employment penalty has increased by 38.4 per cent, and while mothers earn lower wages than women without children, fathers are more likely to receive higher pay than men without children: a fatherhood bonus (ILO 2019b). The motherhood wage penalty varies significantly across countries. It ranges from 1 per cent or less in countries such as Canada, Mongolia and South Africa to almost 15 per cent in the Russian Federation and as much as 30 per cent in Turkey (ILO 2019b). Lone mothers are particularly severely affected, as demonstrated by their significantly higher poverty rates compared with two-parent families (UN Women 2019). Ironically, low-income women, who can least afford it, bear the largest proportionate penalty for motherhood, while the fatherhood bonus largely accrues to men at the very top of the income distribution (Budig 2014).

The main drivers behind the disadvantages that women with children face are the unequal distribution of unpaid care work within families (see figure 16), the lack of affordable and good-quality care services (childcare, long-term care and support for people with disabilities) as well as discriminatory attitudes and expectations around gender roles. Other contributory factors are a lack of career breaks for paid and unpaid maternity and care leave, reductions in hours of work, lack of flexible work solutions, lack of sickness benefits for sick children, masculine corporate cultures and related gender-biased hiring and promotion decisions at the enterprise level.

Figure 16 Relationship between the gender gap in the share of time spent on unpaid care and women's employment-to-population ratio, latest available year



Source: ILO (2019b).

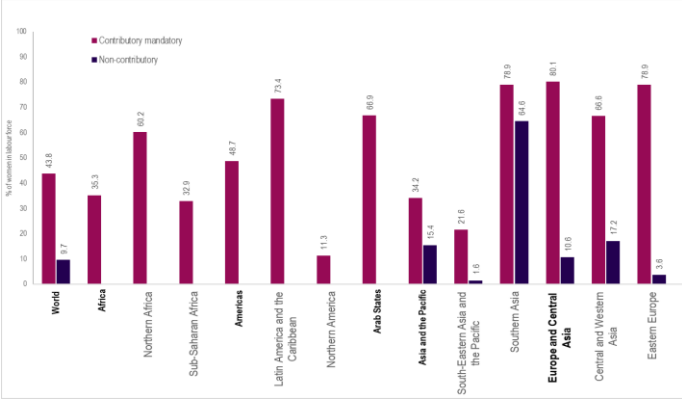
Link: https://wspr.social-protection.org.

Coverage of maternity cash benefits

Strictly speaking, maternity protection starts even before conception, with the ability of women to freely determine the number of children they want to have, and at what intervals, through access to affordable and good-quality family planning (Folbre 2021). In the absence of such services, women carry the social, economic and health consequences of unwanted pregnancies or unsafe abortions, which are especially severe in the case of adolescent mothers. Recent estimates show that most adolescent mothers live in developing regions, and that adolescent pregnancy disproportionately affects women from economically disadvantaged groups (UN Women 2019). Similarly, there is evidence that inequality in access to reproductive health and rights between wealth quintiles persists in a number of lower-middle-income countries (WHO 2020c).

Worldwide, roughly every second woman who becomes pregnant is not protected against loss of income. As figure 17 shows, only 43.8 per cent of the female labour force are entitled to maternity benefits through social insurance, and just 9.7 per cent are covered through statutory non-contributory benefits.

Figure 17 Legal coverage for maternity protection: Percentage of women in labour force aged 15+ years covered by maternity cash benefits, by region, subregion and type of scheme, 2020 or latest available year



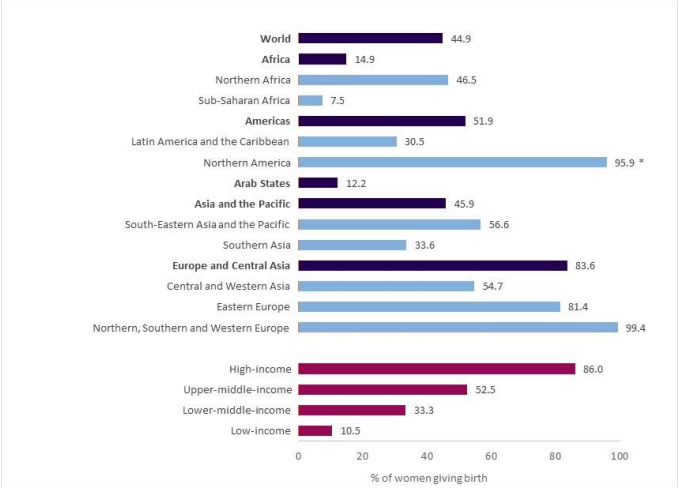
Note: Global and regional aggregates are weighted by labour force 15+ years.

Sources: ILO, World Social Protection Database, based on the SSI; ISSA/SSA, Social Security Programs Throughout the World; ILOSTAT; national sources.

Link: https://wspr.social-protection.org.

Moreover, not all women legally covered have effective access to their entitlements. Only 44.9 per cent of women giving birth actually receive maternity cash benefits (see figure 18). Forty-seven countries achieve close to universal coverage, with more than 90 per cent of pregnant women receiving maternity cash benefits, while in 23 countries (most of them in sub-Saharan Africa) this proportion is less than 10 per cent (figures 18 and 19). While in high-income countries 86 per cent of childbearing women are covered, this is the case for only 10.5 per cent of women in low-income countries. Coverage gaps largely relate to the prevalence of informal employment and the lack of appropriate mechanisms to cover women outside formal employment.

Figure 18 SDG indicator 1.3.1 on effective coverage for maternity protection: Percentage of women giving birth receiving maternity cash benefits, by region, subregion and income level, 2020 or latest available year



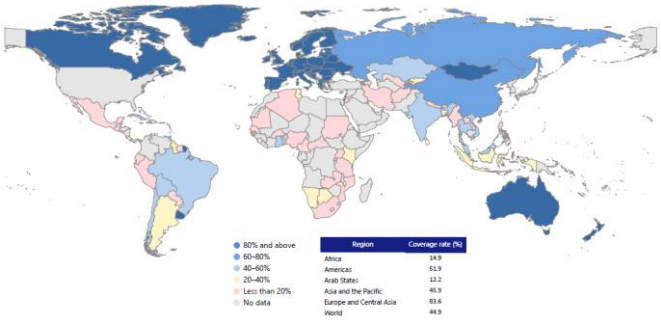
* To be interpreted with caution: estimates based on reported data coverage below 40% of the population.

Notes: Global and regional aggregates are weighted by number of women. Estimates are not strictly comparable with 2016 regional estimates owing to methodological enhancements, extended data availability and country revisions.

Sources: ILO, World Social Protection Database, based on the SSI; ILOSTAT; national sources.

Link: https://wspr.social-protection.org.

Figure 19 SDG indicator 1.3.1 on effective coverage for maternity protection: Percentage of women giving birth receiving maternity cash benefits, 2020 or latest available year



Notes: Global and regional aggregates are weighted by number of

women. Estimates are not strictly comparable with 2016 regional estimates owing to methodological enhancements, extended data availability and country revisions.

Sources: ILO, World Social Protection Database, based on the SSI; ILOSTAT; national sources.

Link: https://wspr.social-protection.org.

Adequacy of maternity benefits

Benefit duration and amount to ensure income security during maternity leave

The adequacy of cash benefits provided during maternity leave can be assessed in terms of their duration and amount. The purpose of maternity leave is rehabilitation; therefore, the leave needs to be sufficiently long for women to rest and recover. In contrast, longer periods of parental leave (in some countries more than one year) allow fathers and mothers to take care of the child and balance work and family obligations. These entitlements can typically be taken up by either parent, and are often designed in such a way as to encourage equal sharing of care work between both parents. Otherwise, long periods of parental leave for mothers have been shown to produce adverse effects for women's employment and career opportunities (Mandel and Semyonov 2006).

Of the 183 countries for which data were available in the ISSA country profiles,[7] 174 provide statutory periodic maternity cash benefits in order to allow women to rest before and recover fully after childbirth. Of these, 59 countries provide at least 14 weeks' paid maternity leave, meeting the standards of Convention No. 183, and 42 countries provide benefits for 18 weeks or more as advised in Recommendation No. 191. In 42 countries, the length of paid maternity leave is 12–13 weeks, which meets the minimum standard set out in Convention No. 102. In 31 countries, maternity leave with cash benefits is provided for less than 12 weeks.

The level of the maternity cash benefit, calculated as a proportion of women's previous earnings for a minimum number of weeks of paid maternity leave, varies widely. In 66 out of the 174 countries providing statutory periodic maternity cash benefits, women are entitled to paid maternity leave of at least two thirds of their regular salary for a minimum period of 14 weeks, meeting the benchmark of Convention No. 183. In 23 countries, women are entitled to 100 per cent of their regular salary for at least 18 weeks, meeting the highest standard set out in Recommendation No. 191. In 47 countries, women are entitled to benefits at a level of 45 per cent or more of previous earnings for a minimum of 12–13 weeks, which is in line with the minimum requirements of Convention No. 102. In 38 countries, however, the cash benefit corresponds to less than 45 per cent of the previous salary and/or the period of paid maternity leave is under 12 weeks.

Access to maternity care

Effective access to free, affordable and appropriate prenatal and postnatal healthcare and services for pregnant women and mothers with newborns is an essential component of maternity protection and social health protection alike. It is important to achieve progress towards SDG targets 3.1, 3.2, 3.8 and 5.6 on reducing maternal and child mortality, reaching universal health coverage and achieving gender equality. Access to maternity care is part of access to healthcare in general, which is highlighted in SDG target 3.8.

Where effective access to healthcare is not universal, economic deprivation too often translates into health deprivation, resulting also in significant inequities regarding access to maternity care, for example between urban and rural areas, and between richer and poorer groups of the population (see figure 4). The lack of skilled health personnel with adequate working conditions plays a key role in the persistence of these coverage gaps. These inequalities have detrimental effects on maternal health, with often harmful long-term consequences for poverty reduction, gender equality and women's economic empowerment.

The cost of accessing maternity care, and the importance to the health of both mother and child of physical rest around childbirth and adequate nutrition during pregnancy and when breastfeeding, necessitate a comprehensive approach to maternity protection. This can be achieved by combining maternity care and income security, complemented by occupational safety and health measures, employment protection and non-discrimination, and adequate breastfeeding arrangements and childcare solutions after the woman's return to work, as stipulated in ILO maternity protection standards.

Maternity protection, paternity and parental leave at the crossroads: Motherhood penalties or universal adequate maternity protection, leave policies and early life services

Effective maternity protection is one of the key social protection elements for improving the lives of mothers, supporting the health and nutrition of women and newborns alike, and contributing to gender equality. Yet too many women across the world do not enjoy adequate levels of maternity protection, with regard to maternal care, income

[7] https://ww1.issa.int/country-profiles.

security, maternity leave or labour protection. Pregnancy and childbirth are uniquely female experiences, meaning that women require a period of leave to ensure physical recovery from childbirth. In contrast, caring and parenting are not uniquely female and should be shared between the parents. Even in high-income countries, women shoulder a disproportionate share of unpaid care work, which places them at a disadvantage in terms of their participation in the labour market and in economic and social life more broadly, with detrimental consequences for their health and well-being. The difficulty of combining family responsibilities with employment is one of the reasons for the low fertility rates (below the population replacement rate) in some high-income countries.

A more equitable sharing of care responsibilities between women and men, in parallel with adequate, affordable public services – in particular, universal early childhood care and education services – is thus crucial to achieve SDG target 5.4 on gender equality and to make progress towards larger socio-economic objectives (ILO 2019b, 2018a). Gender-related interventions in the framework of cash transfer programmes have focused on breaking the intergenerational cycle of poverty, particularly for disadvantaged girl children, but have been weaker in protecting women during pregnancy and childbirth, and in promoting women's economic empowerment through employment or other forms of sustainable livelihood. Addressing these shortcomings requires maternity protection to be considered as part of a comprehensive approach to gender equality that promotes an equal sharing of work and family responsibilities between women and men. This means placing parental leave within transformative care policies, which guarantee the human rights, agency and well-being of caregivers, as well as those of care receivers, by avoiding potential trade-offs and bridging opposing interests. The State should have the overall and primary responsibility not only for maternity leave, but also for care policies that include the provision of public goods and services in general, including paternity and parental leave, childcare and long-term care.

Parental leave policies, part-time work, flexitime, teleworking, sickness benefits for sick children, breastfeeding arrangements and also tax policies should be designed in such a way as to promote gender equality at home and at work. Change is under way, although unevenly across countries. Forty years ago, the ILO Workers with Family Responsibilities Convention, 1981 (No. 156), and its accompanying Recommendation, No. 165, opened the door to paternity and parental leave entitlements; since then, some countries have reformed their leave policies to facilitate greater involvement of fathers in childcare by introducing or extending paternity leave, as well as designing parental leave in a way that encourages the participation of fathers. European experience shows that men's effective use of parental leave can be increased through higher replacement rates (benefits as a percentage of pre-leave earnings) and more flexible arrangements that reserve a non-transferable proportion of the parental leave for the father on a use-it-or-lose-it basis (Folbre 2021; ILO 2019b). Yet some men are still stigmatized for taking their entitlements. Of the 183 countries for which data are available,[8] just 16 provide leave entitlements for fathers or the second parent, while paternity benefits are provided in only 39 countries.

Recognizing and promoting the participation of men in household duties and care work at home, as well as in the labour market, is as important for gender equality as for creating equal employment conditions for women. In the absence of family policies that address both men and women, leave policies risk creating adverse labour market outcomes for women (Richardson, Dugarova, et al. 2020). Good-quality, affordable and accessible childcare services are the second key pillar for supporting female labour force participation (UN Women 2019). Public investment in care services also constitutes a reliable means of addressing social needs while creating decent jobs – a potentially critical element for a post-COVID-19 recovery.

COVID-19 has shown the risks of retrogression in gender equality as a result of shocks or crises. The pandemic has at best stalled and at worst reversed progress in fighting poverty, social exclusion and gender inequality. During lockdown, as schools, childcare and long-term care facilities were disrupted, the lion's share of unpaid care work was again shouldered by women. Women's high representation in sectors hardest hit by lockdown orders has translated into larger declines in employment for women than men in numerous countries, while domestic violence has increased in frequency and severity across countries (Kabeer, Razavi, and Rodgers 2021). Moreover, women, constituting close to 70 per cent of front-line workers in health and social care occupations, have faced a higher risk of contagion.[9] And finally, pregnant women in particular were more vulnerable to the pandemic as there was initially no vaccine approved for use during pregnancy.

[8] https://ww1.issa.int/country-profiles.

[9] See ILO Newsroom, "COVID-19: Protecting Workers in the Workplace. Women Health Workers: Working Relentlessly in Hospitals and at Home". 7 April 2020. https://www.ilo.org/global/about-the-ilo/newsroom/news/WCMS_741060/lang--en/index.htm.

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