

Health and Social Protection*

Cindy Hörmansdörfer, GTZ

- Social health protection is of utmost importance for sustainable poverty reduction. However, there are no general blueprint solutions for successful social health protection systems. Policy advice on social health protection has to offer tailor-made approaches adapted to the specific needs and characteristics of each country.
- Donors should support national policy-makers in embedding the issue of social health protection within the national economic and social policies of partner countries. The successful extension of social health protection requires a coherent sectoral and multisectoral coordination of national policies and the alignment of donor activities as defined in the Paris Declaration.
- The successful extension of social health protection requires a long-term commitment. External funds should be made available to partner countries on a predictable and longer term basis and be linked to the national public and private financial capacities.

Relevance of the Topic

Health risks are among the major life risks tackled by social protection. In developing countries, sickness is one of the most frequent causes of poverty. In turn, poverty is one of the greatest health risks. The importance of good health and social health protection has been highlighted by several international resolutions and campaigns, such as the “Resolution and Conclusions concerning Social Security, International Labour Conference (ILC) 2001” and the “Resolution on Sustainable Health Financing, Universal Coverage and Social Health Insurance, World Health Assembly (WHA) 2005”¹. The “Global Campaign on Social Security and Coverage for All”² founded in 2007 stresses the need to ensure access to essential services for the most vulnerable groups.

Based on the core values of universal access, solidarity, equity and social justice, social health protection comprises all the instruments that aim at removing financial barriers preventing access to health services and protecting people from the impoverishing effects of medical expenditures. Whereas the empirical evidence of the beneficial effects of social health protection on economic growth is strong, it is also true that the economic costs of inaction are very high. Not investing in social health protection leads to tremendous follow-up costs ranging from deteriorating health conditions and increasing poverty levels to societal instability due to social raptures. Social health protection is consequently an important tool for overcoming the vicious circle of poverty

* The opinions expressed and arguments employed in this paper are the sole responsibility of the authors, and do not necessarily reflect those of the OECD or the governments of its member countries.

and ill health. In particular, it facilitates pro-poor growth and poverty reduction through the following channels:

- **It helps to improve the health status of people:** High illness-related costs prevent people from seeking health services when in need: in time and at any time. Social health protection removes this barrier and thus enables the provision of a range of timely interventions which help to improve the health status of people, including prevention, treatment, and rehabilitation.
- **It prevents impoverishing health care expenditures:** In countries where patients are required to pay substantial user charges or co-payments, the financial burden associated with medical care can spell economic ruin for whole families, especially if hospital treatment is needed. The WHO estimates that every year more than 150 million individuals in 44 million households face catastrophic health expenditure as a direct result of health problems. About 25 million households or more than 100 million people impoverish due to medical expenses.
- **It substitutes inefficient risk coping mechanisms:** Faced with illness-related costs, people in developing countries often sell productive assets, cut down expenditures on other basic necessities such as food and clothing, and take their children out of school. These types of risk coping mechanism strongly contribute to the persistence of poverty. Their substitution by effective social health protection systems has a positive impact on cross-sectoral poverty issues such as nutrition and education.
- **It increases people's productivity:** By improving the health status of people and by substituting inefficient risk coping mechanisms, social health protection augments people's productivity, which in turn promotes employment and economic growth and further facilitates increases in income levels.
- **It fosters investments:** By reducing existential fears, social (health) protection encourages individuals to take risks which they otherwise would not be willing to take, such as investing in education, new business opportunities, or the creation of workplaces.
- **It promotes social stability and social cohesion:** Social health protection is firmly grounded on values such as solidarity and equity. It thereby strengthens the bonds of cooperation and reciprocity, thus enhancing social stability and social cohesion within a society.
- **It contributes to empowerment:** A better health status enhances the employability of poor people and increases their earning capacities. Social and micro health insurance schemes further provide participatory decision-making structures which strengthen the voice of poor people and may improve the responsiveness and quality of health services.

The above mentioned impact channels demonstrate that social health protection is linked to various MDGs: They include halving extreme poverty (MDG 1), reducing child mortality (MDG 4), improving maternal health (MDG 5), and combating HIV/AIDS, malaria, and other diseases (MDG 6). By the above mentioned mechanisms, social health protection is also linked to the attainment of universal primary education (MDG 2).

Main facts and figures

Good health promotes economic growth (Sachs, J.D., 2002; Gyimah-Brempong and Wilson, 2004; Bloom, Canning, and Sevilla, 2004). According to estimates by the WHO Macroeconomic Commission on Health, a 10% increase in life expectancy leads to an additional increase of 0.3-0.4 percentage points in the annual *per capita* income. As a result, a typical high-income country with an average life expectancy of 77 years has a 1.6% higher annual growth rate in comparison to a typical low-income country with an average life expectancy of 48 years.

Extending social health protection means to move towards enhanced risk-pooling of financial resources within a society. Empirical evidence supports the hypothesis that the degree of risk sharing within a country's health financing system impacts positively on the attainment of the overall health system goals, namely fair financing and the level of health and of responsiveness their distribution across the respective population (Carrin *et al.*, 2001). Studies from Kenya, Senegal, and South Africa showed that where patient fees exist, the insured use more outpatient services than the non-insured (Scheil-Adlung *et al.*, 2007). Other countries such as Uganda, Zambia, and Burundi have increased utilisation of health services by replacing user fee revenues with increased public funds. A recent study from Mexico analyzed the relationship between health insurance coverage and the use of preventive health-care services. The results suggest that the detection of disease and the treatment in a relatively early stage is more likely among the insured than among the non-insured (Pagán, Puig and Soldo, 2007).

Another important issue, social health protection reduces to a certain extent a household's financial loss (Scheil-Adlung *et al.*, 2007). A study on social health protection in Vietnam not only confirmed these findings but also found that a reduction of out-of-pocket payments leads to a higher-than-average increase in consumption. This is consistent with the hypothesis that households tend to considerably hold back consumption when faced with the risk of high out-of-pocket expenditures (Wagstaff and Pradhan, 2005). Evidence from rural China, where health insurance coverage has dropped dramatically after the dismantling of agrarian collectives in the 1980s, suggests that the risk associated with expenditures for health care does influence a variety of financial household decisions, including the extent of temporary migration and school enrolment (Jalan and Ravallion, 2001).

Key issues and debates

Introducing or extending social health protection involves broad changes in a country's institutional (*e.g.* legislative and regulatory requirements) and organisational frameworks (*e.g.* relationships between public and private providers, health insurance organisations, and patients). In this context, the effectiveness of government stewardship constitutes a key factor for success. Skilled and accountable administrative personnel are crucial for creating public confidence in the health financing system. Moreover, civil society (*e.g.* cooperatives, religious bodies, non-governmental organizations) may play an important role in promoting the key values equity and solidarity within a society, facilitating the extension of coverage to excluded groups, and in increasing the accountability of the entire system.

In low-income countries domestic financial resources might not be sufficient to finance approaches to include the poor. Depending on country-specific needs, external

funds can assist in financing measures of social health protection. External funds should however not substitute national public funding. In the long term, all schemes should become as financially independent of external funding as possible. In recent years a series of global health initiatives such as the GAVI Vaccine Fund or the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) has emerged. Often, these funds provide substantial support for specific health sector deficiencies. However, they should be provided in way that is consistent with national health financing systems.

The extension of social protection in health needs to be embedded in a comprehensive strategy of health sector reform and enabling social and economic policies. In many developing countries, this strategy could involve an improvement of human resources within the health sector and an ensured availability of a regular supply of medicines and equipment. Furthermore, reliable data and information management systems are needed to measure progress, target interventions and formulate policy objectives. Beyond the health sector, the broader determinants of ill-health such as social exclusion of specific groups (*e.g.* the rural population, ethnic minorities, migrants, and unemployed), low levels of education, unequal gender relations, high risk behaviour, malnutrition and an unhealthy environment necessitate the inclusion of a health promotion strategy in any social protection policy.

Several options for ensuring social health protection exist. It is important to note that those options are not mutually exclusive, but can be combined in order to achieve full population coverage: Tax-funded health financing as well as contribution-based social health insurance constitute the primary health financing options, whereas forms of Voluntary for-profit (*i.e.* micro health insurance and private health insurance) and non-for-profit health insurance (*i.e.* community-based health insurance and mutual health organizations) are complementing options.

Irrespective of the type of social health protection scheme in place, health services may either be provided by public or private providers. However, due to their strong impact on the quality of provided health services as well as on the effective prevention of cost escalation it is important to design appropriate provider payment mechanisms for purchasing health services. Within the last years there has been a growing trend to improve quality of health care through quality-based purchasing and accreditation schemes. The institutional set-up of social protection systems such as the purchaser-provider split and increased purchasing power facilitates these quality assurance programmes.

Examples of good and bad practice: What are the lessons learned?

Lesson 1: Several examples show that social health protection is a feasible option in low- and middle-income countries.

- Many countries which by today have achieved universal coverage were low or lower middle income countries when they started implementing social health protection. Examples include South Korea, Thailand, Costa Rica, Germany, Japan or Austria.
- A study on the equity performance of health systems in Asia found that the ability of countries to reach and protect the poor varies considerably not by level of economic development, or level of public spending, but by how health systems are organised. For example, Sri Lanka, Philippines and Thailand show that it is

possible to mitigate the worst inequalities with government expenditures at less than 2% of GDP (Rannan-Eliya and Somanathan, 2005).

Lesson 2: Developing sustainable systems of SHP, however, is not a short-term project but requires long-term planning, strategy, and tenacity. Donors need to be ready to support a long-term process.

- South Korea is a prominent example for the successful introduction of social health insurance. After the adoption of the Health Insurance Act in 1963, it took South Korea only 26 years until the entire population was covered by social health insurance in 1989. High economic growth rates since the 1980s facilitated this development.
- Regarding the extension of social health protection coverage, Thailand is very successful too. The first national social welfare scheme for the poor was introduced already in 1975. In 2003 Thailand after 28 years reached almost full population coverage in terms of financial access. This was achieved by combining contributory social health insurance, tax-based financing and Voluntary private health insurance.
- In other countries the process to reach universal coverage lasted longer than this. In Japan it took 39 years, while it took 59 years in Costa Rica and 134 years in Germany.

Lesson 3: Universal coverage is usually achieved through a mix of health financing tools. To include the poor and informal sector workers tax-based financing as well as micro health insurances are appropriate instruments. However, the poorest of the poor can only be reached by tax-financed approaches. In various countries, experiences of initiatives to link up different funding systems are already available. Different financing approaches are not in competition with one another. Instead they complement each other in order to overcome the most outstanding obstacles on the way towards worldwide universal coverage.

- **Ghana** took first steps to replace its out-of-pocket health financing system by introducing the National Health Insurance System (NHIS) in 2004. It presents a unique mix of Social Insurance and Mutual Health Organisation principles that is driven by strong political commitment, a pro-poor focus, and support from several development partners. The government aims to integrate 50-60% of the Ghanaian population into the national health insurance scheme within the next 10 to 15 years.
- **Tanzania** started a reform of the health sector in 1993 to primarily assure its financial sustainability. The government-initiated schemes, the National Health Insurance Fund (NHIF) for public sector employees and the Voluntary Community Health Funds (CHF) for informal sector workers and poor households at local level, are being successfully supplemented by private health insurances and micro-insurance schemes run by churches, informal sector groups, and cooperatives.
- **Viet Nam** as well as the **Philippines** follow a ‘3-tier-strategy’ with standard social health insurance for formal sector employees and civil servants, Voluntary insurance for independent and informal sector workers, and a tax-financed component for the poor.

Lesson 4: The institutional mechanisms governing the purchasing of health services matter for the quality and cost effectiveness of the overall health system. Appropriate provider payment mechanisms not only motivate high quality healthcare but also take into account the need for efficient financial transfers and protection against fraud and corruption within the payment system.

- In **Rwanda** community-based health insurance schemes have developed contractual relations with health care providers for the purchasing of health care. Bylaws of CBHI schemes and their contracts with health care providers include measures for minimizing risks associated with health insurance (adverse selection, moral hazard, cost escalation, and fraud), thus increasing the financial sustainability of these schemes.
- The **Philippine Health Insurance (PhilHealth)**, which manages the National Health Insurance Programme (NHIP), has introduced an accreditation system. Accredited health facilities have to show on-going proof of a quality assurance programme which includes the presence of functional and necessary equipment, qualified staff, and adherence to a Code of Ethics, guidelines and protocols. Facilities have to agree to peer reviews and to the authority of PhilHealth to inspect and investigate the facility at any time. Another indirect effect of the accreditation programme is the access to a capitation fund which can be used to augment health budgets for primary health services. The fund can be used for necessary drugs and other medical supplies or provide additional pay to health workers and thereby increases motivation of health workers to provide quality health services.

Lesson 5: There is no general blueprint for successful social health protection systems. Social health protection policy has always to be rooted in a society's specific context. This refers to factors such as the prevailing economic situation, the structure of the labour market, the degree of urbanisation, or 'soft factors' such as cultural values or societal consensus.

- By its Federal Constitution of 1988, **Brazil** instituted the Unified Health System (Sistema Único de Saúde, SUS), which set as its goal universal coverage of the entire Brazilian population, offering comprehensive care under the principle of equity. SUS health programmes and services are tax-financed with revenues specific to each level of government (national, state, municipal) and with resources from intergovernmental transfers. The private sector can participate in a complementary manner but is subject to regulation, monitoring, and control by the State.
- **Costa Rica** is another example of a country that has opted for social health insurance as the main option to protect people from social risks. The Costa Rican Social Security Fund (CCSS), created in the early 1940s, is the main health financing source and population coverage is almost universal. Costa Rica has been tremendously successful in improving the health status of its people with health indicators that resemble those of high-income countries.

Lesson 6: All country examples mentioned above highlight the conviction that strong political commitment, good governance and stewardship are indispensable assets for achieving broad social protection. In line with the Paris Declaration on Aid Harmonisation, all development partners should align their efforts and harmonise their agendas.

Recommendations for donors

- Due to the utmost importance of social health protection for sustainable poverty reduction, donors should support national policy-makers in embedding the issue of social health protection within the national economic and social policies of partner countries.
- Policy advice on social health protection has to offer tailor-made approaches adapted to the specific needs and characteristics of each country instead of general blueprint solutions.
- As any successful extension of social health protection requires a long-term commitment external funds should be made available to partner countries on a predictable and longer term basis. All external funds should be linked to the national public and private financial capacities.
- The successful extension of social health protection requires a coherent sectoral and multisectoral approach. Sectoral and multisectoral coordination of national policies and alignment of donor activities are important.

Notes

- 1 www.who.int/gb/ebwha/pdf_files/WHA58/WHA58_33-en.pdf
- 2 www.ilo.org/public/english/protection/socsec/download/aconsens.pdf

References

- Bloom, D.E., D. Canning, and J. Sevilla (2004), “The Effect of Health on Economic Growth: A Production Function Approach”, World Development Bank, Washington D.C.
- Carrin, G. *et al.* (2004), “The Impact of the Degree of Risk-Sharing in Health Financing on Health System Attainment”, Preker, A.S.; Carrin, G. (ed.), pp.397-416, *Health Financing for Poor People*, World Bank, Washington D.C.
- Gyimah-Brempong, K. and M. Wilson (2004), “Health Human Capital and Economic Growth in sub-Saharan Africa and OECD countries”, pp.296-320, *The Quarterly Review of Economics and Finance* 44, Elsevier.
- Jalan, J. and M. Ravallion (2001), “Behavioural Responses to Risk in Rural China”, pp. 23-49, *Journal of Development Economics*. 66 (1), Elsevier.
- McWilliams, M. *et al.* (2003), “Impact of Medicare coverage on basic clinical services for previously uninsured adults”, pp. 757-764, <http://jama.ama-assn.org/cgi/reprint/290/6/757>, *Journal of the American Medical Association (JAMA)* 290 (6).
- Pagán, J.A., A. Puig, and B. J. Soldo (2007), “Health insurance coverage and the use of preventive services by Mexican adults”, pp. 1359-1369, *Health Economics* (16).
- Rannan-Eliya, R. and A. Somanathan (2005), “Access of the very poor to health services in Asia: Evidence on the role of health systems from Equitap”, paper presented at the “Meeting the health related needs of the very poor” workshop, 14-15 February 2005, Department for International Development (DFID), London.
- Sachs, J.D. (2002), “Macroeconomics and Health: Investing in Health for Economic Development”; *Report of the Commission on Macroeconomics and Health*, World Health Organization (WHO), Geneva.
- Scheil-Adlung, X. *et al.* (2007), “Impact of social health protection on access to health care, health expenditure and impoverishment - A comparative analysis of three African countries”, *Extending Social Protection in Health. Developing Countries' experiences, Lessons Learnt and Recommendations*. Berlin Conference Documentation, pp. 138, 140, www.socialhealthprotection.org/download/SHI-CR.pdf, VAS-Verlag, Frankfurt/Eschborn.
- Wagstaff, A. and M. Pradhan (2005), “Health Insurance Impacts on Health and Nonmedical Consumption in a Developing Country”, Working Paper Series 3565, World Bank, Washington D.C.