SOCIAL DETERMINANTS OF HEALTH SECTORAL BRIEFING SERIES 4

SOCIAL PROTECTION: SHARED INTERESTS IN VULNERABILITY REDUCTION AND DEVELOPMENT

World Health Organization

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PREFACE

Public health is built on effective interventions in two broad domains: the biomedical domain that addresses diseases; and the social, economic and political domain that addresses the structural determinants of health. Effective health policy needs to tackle both domains. However, less rigorous and systematic attention has been paid to health issues in social, economic and political domains in recent decades.

Increasingly complex social, economic and political factors are affecting health and health policy-making. One area of complexity relates to health inequities. As emphasized by the WHO Commission on Social Determinants of Health, the social gradient in health is driven by policies in other sectors. Hence, looking at population well-being from the perspective of health and health equity rather than disease demands a new approach to intersectoral collaboration and an imperative to participate earlier in policy processes. Some of the new responsibilities for public health include:

- understanding the political agendas and administrative imperatives of other sectors;
- creating regular platforms for dialogue and problem solving with other sectors;
- working with other arms of government to achieve their goals and, in so doing, advancing health and well-being[1].

By providing information on other sectors' agendas and policy approaches, and their health impacts, and by illustrating areas for potential collaboration, the *Sectoral Briefing Series* aims to encourage more systematic dialogue and problem solving, and more collaboration with other areas of government.

Examples of intersectoral action for health – current and historical – reveal that health practitioners are frequently perceived as ignoring other sectors' goals and challenges. This 'health imperialism' creates barriers to intersectoral work, limiting its sustainability and expansion. In order to avoid this perception, instead of starting from the goals of the health system (e.g. health, health equity, responsiveness, fairness in financial contributions), the *Sectoral Briefing Series* focuses on the goals of other sectors. Rather than concentrating on traditional public health interventions (e.g. treatment, prevention, protection), the series use the goals of other sectors to orient its analysis and explore areas of mutual interest.

The target audience for the series is public health officers, who are not experts on determinants of health, but who have responsibilities for dealing with a broad range of development issues and partners. Each briefing will focus on a specific policy area, summarizing and synthesizing knowledge from key informants in health and other areas, as well as from the literature. They will present arguments, and highlight evidence of impacts and interventions, with special emphasis on health equity. They will make the case to health authorities for more proactive and systematic engagement with other sectors to ensure more responsive and cohesive governments that will meet broader societal aspirations for health, equity and human development.

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1 WHO and Government of South Australia. *Adelaide Statement on Health in All Policies*. Adelaide, 2010.

SOCIAL PROTECTION: AN OVERVIEW

Mutually reinforcing interests

Despite an unprecedented global increase in wealth in the last few decades, poverty and vulnerability continue to affect millions of people and their incomes, health and well-being (ILO, 2010a). Unexpected negative life events, known as "shocks", cause unemployment, illness, malnutrition and injury, all of which reduce people's ability to work, diminish household consumption capacity, and very often trap people in chronic poverty. Global poverty estimates suggest that almost 1.4 billion people are living below the poverty line of US$ 1.25 per day (World Bank, 2011). Of these, around 500 million live in chronic poverty (CPRC, 2009)[2]. Households impacted by poverty, and specially those in chronic poverty, lack economic and productive assets, very often have no voice in public decision-making, and are unable to provide for their members. Chronic poverty creates vicious circles of deprivation that reduce capability and human development (CPRC, 2009).

Social protection services and income transfers are put in place by governments to reduce households' vulnerability to poverty, to manage risks and counteract the negative impacts that unexpected life events may have on their income, wealth or health, and to lift them out of chronic poverty. Vulnerability, unexpected life events, and impoverishment not only have an impact on low- and middle-income countries but also on high-income countries, where unemployment resulting from economic crises and cuts in public spending, can increase economic insecurity for millions of people in middle-income brackets. In economic downturns, being born into poverty means few prospects for social mobility later in adult life (SEKN, 2008).

The international community has forged a consensus on the need to address these challenges by prioritizing Millennium Development Goal 1 to eradicate extreme poverty and hunger by halving the proportion of people living on less than US$ 1 a day. There is also increasing international consensus that reducing poverty and vulnerability to shocks is not just about ensuring employment through policies aimed at increasing economic growth. It requires the extension of social protection policies to all to create an inclusive and resilient economy (ILO 2010a; CSDH, 2008). Social protection can guarantee income security, promote access to health care, and stimulate household capabilities to contribute to the economy (OECD, 2009; ILO, 2010a; WHO, 2010).

Policy-makers in the social protection and health sectors have common interests. Social protection is a key determinant of population health and health equity. The increased length that people spend in poverty greatly reduces the likelihood of their exiting from it, pushing households into more poverty and ill-health (CPRC, 2005). Social protection mechanisms that protect people from negative life events and poverty (or that help them out of chronic poverty) have a positive impact on health. Social protection shields household income and ensures access to basic living conditions (e.g. food, education, housing). This increases people's capability, ensuring that they lead healthier lives (CSDH, 2008). Similarly, a country's health policy contributes to social protection when financial protection from catastrophic costs and impoverishment is adopted. A healthier population is less vulnerable, more resilient, and economically productive.

2 A poverty line is often defined in terms of consumption or income capacity. A key feature of chronic poverty is its duration; people in chronic poverty may live under these conditions for most of their lives (Hanlon, 2010; CPRC, 2009).

Global trends in social protection

There is no single universally accepted indicator to measure social protection coverage. Commonly, it is measured by focusing on different regimes characterized by the types of life events covered or for whom coverage is intended. Common types of protection include: income security in old age (e.g. old age pensions), income support to the unemployed (e.g. unemployment benefits), health-care protection, and other schemes that include maternity protection and employment injury. Framed in this way, some level of protection exists in nearly all countries. However, globally, only one-third of countries have a comprehensive social protection system that provides, at least, old-age pensions, unemployment benefits, and health-care protection. Overall, it is estimated that only about 20 per cent of the global working-age population and their families have access to this range of social protection (ILO, 2010b).

READER'S GUIDE

This briefing describes challenges to ensuring comprehensive social protection, health coverage as part of social protection, and potential areas for joint work across different government agencies responsible for social protection. It has three sections.

1. Social protection overview. This section covers mutual public policy interests between health and other areas of social protection; global trends in social protection regimes and the challenges; the goals and principles for policy action; and a typology of common policy interventions. It situates these issues within a broad policy, economic, and stakeholder context.

2. Interventions. The second part describes in more detail the different types of interventions presented in the previous section, their health impacts and pathways, and provides some examples of areas for joint work between health and other areas of social protection.

3. Summary messages. Summarizes key messages and examples of areas for collaboration between health and other areas of social protection.

The briefing has been structured to permit those with limited time to obtain a well-rounded perspective of the topic by reading only sections one and three.

To illustrate current trends, we can compare the cases of old-age pensions, unemployment insurance and health-care protection. Around 40 per cent of the global labour force is entitled to old-age pension. Up to 50 per cent of this population live in high-income countries. In Latin America, this share is 25 per cent in Asia and the Middle East it is 20 per cent, while in sub-Saharan Africa it is 5 per cent (ILO, 2010a).

Unemployment insurance is available in only 10 per cent of countries in Africa, Asia and the Middle East. The very use of the term "unemployment" is challenging in low-income countries as large population segments engage in precarious and irregular employment mostly in the informal sector (ILO, 2010b). Millions of children in poor countries have no choice than to leave school to start income-generating activities in the informal sector. In these contexts, the term informality is used to describe the absence of social protection. Although there are discrepancies in data, informal workers represent around 65 per cent of the non-agricultural labour force in Latin America, and 80 per cent in sub-Saharan Africa. There is broad recognition that informal workers are highly vulnerable (EMCONET, 2007).

In the absence of effective financial protection for health-care costs, each year nearly 150 million people globally incur catastrophic health-care costs, with 100 million falling into poverty as a result (WHO, 2010). In Asia, around 100 million people a year incur catastrophic health costs, with 90 million falling into poverty[3]. In the Americas, 35 million people incur catastrophic costs and 10 million fall into poverty. In Africa, data show that out of 20 million people hit by financial catastrophe, 10 million fall into poverty (WHO, 2009). Although most people living in WHO's European Region (which comprises 48 countries in eastern and western Europe and countries in central Asia) have health-care coverage, in 2007, differences in the level of coverage caused 5 million people to fall into poverty (WHO, 2009). Other sources show that in 2006, in India alone, 40 million people fell below the poverty line due to health expenditures (WHO, 2009).

The outlook is stark. Even if the Millennium Development Goals are achieved by 2015, at least 800 million people will still be trapped in poverty, 500 million of whom will be in chronic poverty (CPRC, 2009). The challenge is huge; yet there is increasing evidence that, rather than being a financial burden on governments, social protection is an investment that can enable people to escape from poverty. Governments are using social protection to tackle risk and vulnerability, protect consumption capacity, enable households to cope with shocks and escape chronic poverty (ILO, 2011). Social protection promotes productive activities, improves children's health, nutrition and educational opportunities, thus breaking the intergenerational transmission of poverty. It ultimately improves a country's social cohesion and sense of citizenship, helping to reduce conflict (Samson, 2009).

Goals and principles: towards inclusivity

The overarching objective of social protection is to shield households from external shocks that impoverish them, and to help those in chronic poverty to escape it. It is widely accepted that the causes of poverty are multidimensional going beyond the lack of material assets. They include deficits in material and human capital, as well as structural aspects such as social, political and cultural factors that generate deprivation (Drèze & Sen, 1989). Counter-measures, therefore, comprise protecting households' material and financial assets, building people's capability, and addressing the underlying structural factors (or determinants) that cause poverty in societies (Barrientos, Hulme & Moore, 2006). Key instruments for social protection include social transfers in cash or in kind (e.g. cash and food transfers, nutritional supplements, public works, food subsidies), access to services, social support, and equity-enhancing legislation.

The principles that inform social protection policy are *Prevention, Protection, Promotion and Transformation* (Devereux & Sabates-Wheeler, 2004). *Prevention* aims to anticipate negative shocks and reduce the likelihood of their impact on basic living standards (e.g. avoiding the economic impact of illness by ensuring health-care coverage, avoiding household poverty with employment insurance). *Protection* aims to support people suffering from poverty and actual deprivation by providing material and other income-protection resources. These two principles focus more on the income and material deficits associated with poverty. *Promotion* aims to improve human capability by adopting income transfer programmes that create incentives to increase specific behaviours (e.g. school attendance, medical check-ups, vaccinations, and employment retraining schemes). Poverty is not only caused by individual or household factors. The WHO Commission on Social Determinants of Health, among others, also identified structural forces in societies that create and perpetuate poverty that need to be addressed (CSDH, 2008). *Transformation* aims to promote social change by addressing these structural causes of deprivation (e.g. gender rules, racism, social exclusion, etc.).

Social protection practice has evolved in the last decade from focusing on the first two principles (which were at the core of the so-called "safety nets" of the 1990's) to include promotion and transformation in order to enhance human capability, address the structural causes of poverty, and recognize the importance of social solidarity (ILO, 2011). This informs the current work of international organizations like the International Labour Organization (ILO), the Organization for Economic Co-operation and Development (OECD), the United Nations Children's Fund, (UNICEF), the United Nations Development Programme (UNDP) and the World Bank. These principles are not presented here in hierarchical order; very often many of them inform the same social protection policy or intervention. This is why it is perhaps clearer to explain the links between social protection and the social determinants of health by adopting the criteria proposed by Barrientos, Niño-Zarazúa and Maitrot (2010). These authors classify social protection schemes based on their outputs (e.g. income transfers, income transfers accompanied by other interventions, or integrated interventions with several outputs delivered at the same time) as is shown in Table 1.

3 These data are calculated by adding all countries in the WHO Region of the Western Pacific (WPRO) and WHO Region of South East Asia (SEARO).

Table 1. Goals and examples of different types of social protection policies, services or interventions

	GOAL	EXAMPLES
1	Health, social services, and insurance schemes. Governments aim to ensure accessibility to health and other social services to reduce the probability of shocks and its impacts on well-being.	Health services (accessibility, affordability, acceptability, quality), social and community services (day care, homeless shelters, foster care, community social insurance), old age pension schemes (contributory), income support to the unemployed and other schemes including employment injury and maternity protection.
2	Income-only transfers (in cash or in-kind). Social protection measures aim to provide income for basic living (e.g. shelter, food) where people are destitute or suffer losses of income.	Income transfers in cash or in-kind (child support and household allowances), social pensions (non-contributory).
3	Income transfers plus services. Social protection measures aim to enhance people's assets and capability, and ensure economic and social inclusion.	Employment guarantee schemes, asset protection and accumulation schemes, conditional cash transfers.
4	Integrated and transformative approaches. Social protection measures promote equity and social change, addressing the structural causes of deprivation.	Comprehensive approaches targeting vulnerable groups, legislative interventions, and social-empowerment interventions.

Source: Adapted from Barrientos, Niño-Zarazúa and Maitrot (2010).

Policy perspectives

Historical perspective

Current social protection practice is the result of a historical process that led states to adopt measures to provide the poor and vulnerable with minimum living conditions. The cases of England and Germany highlight the development of this historical process through two distinct phases – the states' adoption of relief for the poor and the expansion of these entitlements during the industrial revolution.

In England, the first "Poor Law" known was adopted in 1601, which appointed "overseers of the poor" in each parish to care for the elderly and the disabled. All "able-bodied" poor people were obliged to work. In subsequent years, parishes were allowed to levy local taxes to supplement poor people's incomes (Hennock, 2009). "Poor relief" was the guiding principle of these laws; they aimed to ensure paupers a minimum subsistence level of protection. In 1834, England adopted a new law that ordered all able-bodied poor to enter workhouses, which were known for their hard working conditions. By 1840, poor laws were also adopted in Germany (Prussia) and mandated local and state governments to provide poverty relief interventions. This is when the first insurance funds shifted from "poor relief" to "income substitution" as contributions were brought in line with workers' salaries. Compensation was equivalent (or nearly equivalent) to the actual income lost by a worker (Hennock, 2009). In 1911, England passed its first National Insurance Act; all employers and workers had to contribute to a State fund to cover medical expenses (Hennock, 2009). The act adopted the German model linking entitlements to employment status. Yet, in 1946, England passed the National Insurance Act, a model promoted by William Beveridge, which created an insurance system that was universal regardless of beneficiaries' employment status (Hennock, 2009). This was followed by the creation of the National Health Service in 1948.

Currently, countries that adopt the "Bismarck Model" (or some of its elements) rely on one or multiple social insurance funds to which employers and formal workers provide "contributions" or "payroll taxes". Funds "pool" contributions to cover both contributors and their dependants. Countries with the "Beveridge Model" rely on general tax revenue transfers to provide benefits for all citizens. The key feature is the nature of the entitlements. In the Bismarck Model, entitlement is linked to a contribution made by a worker. In the Beveridge Model, entitlement is on the basis of citizenship or residence.