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Editorial

Social protection in health: the need for a transformative dimension

Joris J. A. Michielsen[1], Herman Meulemans[1], Werner Soors[2], Pascal Ndiaye[2], Narayanan Devadasan[3], Tom De Herdt[4], Gerlinde Verbist[5] and Bart Criel[2]

1 *Research Centre for Longitudinal and Life Course Studies, University of Antwerp, Belgium*
2 *Unit of Health Policy and Financing, Institute of Tropical Medicine, Antwerp, Belgium*
3 *Institute of Public Health, Bangaluru, India*
4 *Institute of Development Policy and Management, University of Antwerp, Belgium*
5 *Herman Deleeck Centre for Social Policy, University of Antwerp, Belgium*

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Today, Social Protection in Health (SPH) is commonly understood as an arrangement safeguarding income and financial support in case of sickness and ensuring that all people in need have effective access to adequate care of sound quality (ILO 2008). Yet, for many people worldwide, affordable health care of good quality remains elusive. Especially in developing countries, large groups of citizens remain uncovered by adequate mechanisms for SPH of any kind. For the excluded, illness jeopardises more than just their health. Their predicament often boils down to the uneasy choice between forgoing treatment and getting trapped in a downward spiral of impoverishment because of high health care expenses (Whitehead *et al.* 2001). According to the International Labour Organization (ILO), 80% of the world population remains excluded from adequate social protection (Pal *et al.* 2005). The World Health Organization (WHO) (2004) estimates that each year 178 million people suffer financial catastrophe as a result of out-of-pocket health payments while 104 million are forced into poverty simply because of health payments. These deficits in social protection were well documented before the current financial crisis and are likely to become worse if no appropriate action is undertaken (ILO/WHO 2009). Today, ILO estimates that 30–36% of the world population (and more than 74% of the population in developing countries) has no effective access to basic medical services (ILO 2010).

In most developing countries, formal SPH is of recent origin. In the early independence years, Social Health Insurance (SHI) – a European public construct geared to a model of industrial labour – was the norm. While, in principle, SHI aims at universal entitlement based on citizenship, in most developing countries, it typically did not cover more than a few fortunate groups because of financial and labour market-related constraints (DESA 2007). Similarly, tax-funded public provision of health care services also turned out to be problematic in the developing world and was rarely achieved in terms of coverage and quality. Financial constraints and liberalisation led to a steady rollback in public provision of health care and social protection. The introduction of user fees for health care in the 1980s prompted the initiation of private non-profit Community Health Insurance (CHI) by non-government organisations (Criel *et al.* 2008). Alongside CHI and other private savings-account schemes, there has also been a shift to means-tested safety nets, implying targeting (DESA 2007, 2009). In most developing countries, the picture today is one of a rich variety of organisational arrangements of SPH [SHI, private-for-profit health insurance, CHI, maternity benefit schemes, Health Equity Funds (HEF), conditional cash transfers and health vouchers amongst others], but with, unfortunately, poor results.

Still, there is room for hope. At least in the international policy sphere, the strong relationship between health and poverty was recognised by the inclusion of three specific health objectives amongst the eight Millennium Development Goals. From 2004 on, a consortium led by the German *Gesellschaft für Technische Zusammenarbeit* (GTZ), ILO and WHO has made a plea for the extension of SPH in developing countries (ILO/GTZ/WHO 2007). In 2005, ILO experts calculated that basic social protection – including health – would be affordable in poor countries, within a reasonable timeframe (Pal *et al.* 2005). In 2008, the WHO Commission on Social Determinants of Health

called for global action on the social determinants of health with the aim of achieving health equity in a generation and stressed universal social protection as a necessary living condition (CSDH 2008). The subsequent World Health Report put forward universal coverage and protection as core components of action (WHO 2008). From 2009 on, the United Nations Chief Executives Board has been making a plea for a social protection floor, a minimum package of essential services and social transfers meant to counter the economic crisis and its negative impact on human development, including health (ILO/WHO 2009).

At country level, national governments increasingly reassume responsibility for SPH. The cases of Ghana and India are illustrative. Ghana initiated its National Health Insurance Scheme in 2003, as one effort amongst others to reach the Millennium Development Goals (Agyepong & Adjei 2008). The federal Indian government started the publicly subsidised national health insurance scheme *Rashtriya Swasthya Bima Yojana* for below poverty line families in 2008 (Devadasan & Swarup 2008). While these initiatives are not without challenges, they do indicate a pendulum shift towards renewed government involvement.

The need for a framework: transformative social protection in health

Given the myriad of current SPH arrangements and the fact that exclusion is still widespread, it is legitimate to question what adequate SPH should entail. The current perspective on SPH is largely technical: i.e. it zooms in on the benefits offered and the population coverage achieved by specific SPH interventions. Without minimising the importance of appropriate technical designs, we argue that the impact of SPH arrangements is also related to the extent to which they succeed in transforming those socio-political and institutional elements that create and sustain people's vulnerability when falling ill.

Combining a capability approach to poverty (Sen 1999) and a social exclusion approach (Vranken 2009), Bastiaensen *et al.* (2005) argued that poverty-reduction strategies cannot be dissociated from the local institutional context in which they are developed. They need to take into account this context to promote empowerment through well-considered provision of entitlements and capabilities and eventually to be effective. If social inequities are not carefully taken into consideration, the interventions run the risk of reproducing or even reinforcing exclusion. Mackintosh and Tibandebage (2004) pointed to the same complexity in the domain of health. Health systems are social constructs that reflect the social inequities and exclusions that exist in the society in which they are embedded. Health systems can thus reinforce existing inequities and intensify exclusion, but they can also serve as arenas to challenge and overcome inequities and foster empowerment and inclusion. SPH is no exception: it can be an oppressive or an emancipative tool.

A comprehensive framework for analysing the power dynamics of SPH would benefit from the concept of transformative social protection as developed by Devereux and Sabates-Wheeler (2004). In a reaction to the overemphasis on economic vulnerability in mainstream social protection frameworks, Devereux and Sabates-Wheeler pointed out the need for social protection as a set of public and private initiatives, both formal and informal, that provide: '*social assistance* to extremely poor individuals and households; *social services* to groups who need special care or would otherwise be denied access to basic services; *social insurance* to protect people against the risks and consequences of livelihood shocks; and *social equity* to protect people against social risks such as discrimination or abuse' (Devereux & Sabates-Wheeler 2004). Accordingly, they extended ILO's provision-prevention-promotion framework (Van Ginneken 1999), including also transformative measures to challenge existing power imbalances that actually cause social vulnerability and exclusion. When applied to health, the key hypothesis of this expanded social protection framework resonates with the call for action of the WHO Commission on Social Determinants on Health: 'Tackle the inequitable distribution of power, money, and resources – the structural drivers of the conditions of daily life – globally, nationally, and locally' (CSDH, 2008).

We propose to adopt the transformative social protection framework in the study of SPH. We argue that to be effective, SPH interventions also need to address the structural determinants of power imbalances and social exclusion in health. We suggest conceptualising transformative SPH as three overlapping functions with one crosscutting dimension:

- *The function of provision*: providing relief from deprivation caused by limited access to healthcare (e.g. social assistance, health vouchers, HEF, abolition of user fees for the extreme poor);
- *The function of prevention*: preventing deprivation and impoverishment caused by health-related expenditure or loss of resources during illness (e.g. SHI, CHI, total abolition of user fees);
- *The function of promotion*: enhancing real incomes and capabilities (e.g. an increase in economic productivity because of better health, abolition of school fees in exchange for health service utilisation);
- *The dimension of transformation*: transforming the social and institutional context of the health system to

counteract exclusion and deprivation of the right to health and quality care.

The transformative dimension cuts across the functions of provision, prevention and promotion and may occur at all levels within a health system (Michielsen *et al.* 2009): the micro-level of the household and community, i.e. the individual distribution of resource ownership, access and use; the meso-level, i.e. the interaction of individuals and groups with service providers and local institutions; and the macro-level, i.e. regional, national and international policy-making circles and the broader society. The following examples, which come from our own field experience with CHI and HEF, illustrate possible transformative dynamics in different contexts in Africa and Asia.

At the micro-level data from focus group discussions in Nongon, Mali suggest that membership of the local CHI scheme improves the social position of women within the household. Apart from prevention against health-related impoverishment, female members also seem to acquire more power in the decision-making process over health. They become less dependent on their husband: '*Si tu es dans la mutuelle, même si ton mari n'accepte pas t'amener au centre, tu peux partir te faire soigner avec le petit morceau d'argent que tu as*' (Ndiaye *et al.* 2008). In a different context, a decrease in dependency is also visible at community level. Analysis of some CHI schemes in Indore and Agra, India, shows a drop in the level of loans from informal moneylenders taken up by the insured. These schemes therefore not only provide economic protection, but also reduce the need to enter patronising relationships (Agrawal 2008).

At the meso-level of the interface between patients and providers, SPH interventions could improve the access to quality health care by combining upgrading of the available health infrastructure with the generation of both formal and informal accountability mechanisms. Data from focus group discussions in Pune, India, illustrate how such dual accountability by way of a CHI scheme can improve quality of health care used by female slum dwellers. Formally, the CHI scheme monitors the technical quality of the health care providers. It also fosters interpersonal quality through social workers, who mediate between CHI members and hospital staff in case of perceived maltreatment. The engagement of social workers has an informal empowering effect on the female slum dwellers: '*Doctors are afraid of us. They think we are social workers, if we complain, they will lose their job; so they treat us properly*' (Michielsen *et al.* 2009). A similar emancipative effect was noticed in the Guinean CHI scheme of Maliando, where patients gained voice and confidence in claiming their right to good quality care – a change that providers did not necessarily like as it challenged existing power hierarchies: '*Les mutualistes ont un agent bien déterminé à les défendre efficacement. Il nous bouscule suffisamment chaque fois qu'un mutualiste n'est pas mis à l'aise ...*' (Criel *et al.* 2005). Leverage through social workers is not exclusive to CHI: in HEF experiences in Cambodia (Noirhomme *et al.* 2007) and Mauritania (Criel *et al.* 2010), the involvement of social workers provided the poorest with a continuum of care they were formerly deprived from. Nor is the effect of CHI necessarily transformative; it can also be a-transformative or even anti-transformative. In Cinzana, Mali, moral hazard of the health care provider towards CHI members – and the CHI management being unaware of this problem – initially increased the CHI members' dependency by increasing the cost of medical care (Soors & Criel 2009).

Recent publications on SPH arrangements other than CHI and HEF implicitly recognise the presence of transformative (and a-transformative) elements at micro- and meso-level. Conditional cash transfer programmes (CCTs) are a case in point. CCTs are a particular form of social assistance that transfer funds to members of a targeted population provided they follow a specified course of action (Barrientos 2009). Transformation through a CCT is documented in Nicaragua's *Red de Protección Social* (RPS), in operation from 2000 until 2005 and with important health components. Evaluation of RPS revealed that the programme had gradually improved self-esteem and bargaining power of the women in the targeted households (Moore 2009). A-transformation through a CCT is documented in Mexico's *Oportunidades* – one of the most publicised CCTs to date – in operation since 2002, and also with substantial health components. An early internal evaluation expected to find evidence of decreased child labour – because of increased school attendance – but had to admit that no decrease in child labour had taken place (Escobar & González de la Rocha 2003). Reviewing CCTs in six countries, Bastagli (2009) identifies how different institutional arrangements in CCTs can lead to opposing outcomes. In a recent and comprehensive review of initiatives for poverty reduction (DESA 2009), the authors point to the questionable assumption of CCTs that poor people do not have the capacity to understand what is in their best health interest, implying an intrinsic absence of empowerment in most CCTs.

At the macro-level of policy-making, West African federations of CHI schemes – such as the *Union Technique de la Mutualité Malienne* in Mali and the *Coordination Régionale des Mutuelles de Santé de Thiès* in Senegal – play an important role in lobbying for pro-poor decisions (Fonteneau & Galland 2006), such as developing a

regulatory framework for health insurance and developing proper accountability measures of insurance organisations.

Conclusion

We argue that SPH, in addition to important provision, prevention and promotion functions, also needs to address the structural determinants of health-related social vulnerability. In other words, it needs to be transformative. We advocate the use of a transformative social protection framework in the study and evaluation of SPH. Taking stock of transformative, a-transformative and anti-transformative elements of any SPH arrangement is essential to understand and maximise its contribution to health and development. We are aware that the prism of transformative SPH needs more empirical testing. This should also contribute to fine-tuning a still incipient tool. The use of the framework will hopefully contribute to the orientation of the design, implementation and evaluation of SPH in the direction of sustainable empowerment of the excluded, in health and beyond.

To put it bluntly: SPH will be transformative, or will not be social. And transformative SPH leads to more effective social protection. The time is now.

References

Agrawal S (2008) Improving access to quality healthcare services through community risk pooling. *Community Level Processes in Ensuring Health to the Urban Poor, New Delhi, India, 16 January 2008*, Urban Health Resource Centre.

Agyepong IA & Adjei A (2008) Public social policy development and implementation: a case study of the Ghana National Health Insurance Scheme. *Health Policy and Planning* **23**, 150–160.

Barrientos A (2009) Understanding conditions in income transfer programmes. *Global Social Policy* **9**, 165–167.

Bastagli F (2009) *From Social Safety Net to Social Policy? The Role of Conditional Cash Transfers in Welfare State Development in Latin America*. Working paper 60. International Policy Centre for Inclusive Growth, Brasilia.

Bastiaensen J, De Herdt T & D'Exelle B (2005) Poverty reduction as a local institutional process. *World Development* **33**, 979–993.

Criel B, Diallo A, Van der Vennet J, Waelkens MP & Wiegandt A (2005) La difficulté du partenariat entre professionnels de santé et mutualistes: le cas de la mutuelle de santé Maliando en Guinée-Conakry. *Tropical Medicine and International Health* **10**, 450–463.

Criel B, Waelkens MP, Soors W, Devadasan N & Atim C (2008) Community health insurance in developing countries. In: *International Encyclopaedia of Public Health*, Vol I (eds K Heggehougen & S Quah) Academic Press, San Diego, pp. 782–791.

Criel B, Bâ AS, Kane F, Noirhomme M & Waelkens MP (2010) *Une Expérience de Protection Sociale en Santé pour les Plus Démunis : Le Fonds d'Indigence de Dar-Naïm en Mauritanie*. Studies in Health Services Organisation & Policy, 26, ITGPress, Antwerp.

CSDH (2008) *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health. Final Report of the Commission on Social Determinants of Health*. World Health Organization, Commission on Social Determinants of Health, Geneva.

DESA (2007) *Report on the World Social Situation (2007) The Employment Imperative*. United Nations, Department of Economic and Social Affairs, New York.

DESA (2010) *Report on the World Social Situation 2010: Rethinking Poverty*. United Nations, Department of Economic and Social Affairs, New York.

Devadasan N & Swarup A (2008) Rashtriya Swathya Bima Yojana: an overview. *Insurance Regulatory and Development Journal* **IV**, 33–36.

Devereux S & Sabates-Wheeler R (2004) *Transformative Social Protection*. Institute for Development Studies. Working Paper 232, Brighton.

Escobar A & González de la Rocha M (2003) *Evaluación Cualitativa del Programa de Desarrollo Humano Oportunidades*. Serie Documentos de Investigación Secretaria de Desarrollo Social, 3, Mexico.

Fonteneau B & Galland B (2006) The community-based model: mutual health organizations in Africa. In: *Protecting the Poor A Microinsurance Compendium* (ed C Churshill) International Labour Organization, Geneva, pp. 378–400.

ILO (2008) *Social Health Protection: An ILO Strategy Towards Universal Access to Health Care*. Social Security Policy Briefings 1, International Labour Organization, Paper 1, Geneva.

ILO (2010) *World Social Security Report 2010: Providing Coverage in the Times of Crisis and Beyond. Preliminary version, 27 January 2010*. International Labour Office, Geneva.

ILO/GTZ/WHO (2007) *Extending Social Protection in Health: Developing Countries' Experiences, Lessons Learnt and Recommendations*. Deutsche Gesellschaft für Technische Zusammenarbeit, Eschborn.

ILO/WHO (2009) *The Social Protection Floor: A Joint Crisis Initiative of the UN Chief Executives Board for Co-ordination on the Social Protection Floor*. International Labour Office, Geneva.

Mackintosh M & Tibandebage P (2004) Inequality and redistribution in health care: analytical issues for developmental social policy. In: *Social Policy in a Development Context* (ed T Mkandawire) Palgrave, Houndmills, pp. 143–174.

Michielsen J, John D & Chaudhuri L (2009) Researching the transformative dimensions of social protection in health (SHP): transformations in the power relation between providers and female slum dwellers in Mumbai and Pune (India). *ISA-conference Health for all: opportunities and challenges, Jaipur, India*, 21–23 September 2009, University of Antwerp/VLIR-UOS.

Moore C (2009) *Nicaragua's Red de Protección Social: An Exemplary But Short-Lived Conditional Cash Transfer Programme*. Country Study 17, United Nations Development Programme, International Policy Centre for Inclusive Growth, Brasilia.

Ndiaye P, Soors W, Waelkens MP & Criel B (2008) Community health insurance in Africa: one step towards transformative social protection? *International Workshop Primary Health Care in the 21st Century. Which Changes in the Interface Patients/Community Really Do Matter?*, 24 November 2008, Institute for Tropical Medicine, Antwerp, Belgium.

Noirhomme M, Meessen B, Griffiths F *et al.* (2007) Improving access to hospital care for the poor: comparative analysis of four health equity funds in Cambodia. *Health Policy and Planning* **22**, 246–262.

Pal K, Behrendt C, Léger F, Cichon M & Hagemejer K (2005) *Can Low Income Countries Afford Basic Social Protection? First Results of a Modelling Exercise*. Issues in social protection discussion paper 13, International Labour Office, Social Security Department, Geneva.

Sen AK (1999) *Development as Freedom*. Oxford University Press, Oxford.

Soors W & Criel B (2009) L'interface entre mutuelles, qualité de l'offre et demande: résultats de deux études de cas au Mali rural. *Forum 2009 de la Concertation*. 1 October 2009, Institute for Tropical Medicine, Yaoundé, Cameroon.

van Ginneken W (1999) Social security for the informal sector: a new challenge for the developing countries. *International Social Security Review* **52**, 49–69.

Vranken J (2009) From the social to the spatial. stepping stones on my way to a conceptual framework. In: *Between the Social and the Spatial. Exploring the Multiple Dimensions of Poverty and Social Exclusion, Prologue* (eds K De Boyser, C Dewilde, D Dierckx & J Friedrichs) Ashgate, Aldershot, pp. xvii–xxvi.

Whitehead M, Dahlgren G & Evans T (2001) Equity and health sector reforms: can low-income countries escape the medical poverty trap? *The Lancet* **358**, 833–836.

WHO (2004) *Social Health Insurance*. WHO, WHO executive board, 115th session, Geneva.

WHO (2008) *World Health Report 2008: Primary Health Care Now More Then Ever*. WHO, Geneva.

Corresponding Author **Joris J. A. Michielsen**, Research Centre for Longitudinal and Life Course Studies, University of Antwerp, Belgium. E-mail: joris.michielsen@ua.ac.be