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).

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).

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.

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 with contributions from both workers and employers were introduced (Hennock, 2009).

Industrialization created new demands and social expectations among workers. It also generated the need for more and healthier workforces. Laws started being implemented requiring better compensation for workers, improvements to working conditions, and the provision of care after industrial injuries and fatalities (Hennock, 2009). Gradually voluntary sick funds expanded in Prussia, while in England "friendly societies" and trade unions' funds were increasingly created (Breuilly, 2009). To meet labourers' demands for better living and working conditions and in order to prevent social unrest, in 1884, Prussia adopted mandatory accident, invalidity and old-age insurance regimes for all formal workers. This was the beginning of the so-called Bismarck Model. It initially covered short-term sickness; but soon included medical care and rehabilitation, and provided coverage for dependants (Hennock, 2009). The principle 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.

Models and country realities

Although the models mentioned informed social protection regimes, currently there is a consensus that pure forms of these regimes rarely exist and that they are of limited value in explaining how countries can organize social protection. The problems that countries often encounter in the implementation of these models, which limit their effectiveness, are outlined below.

1. A common assumption adopted in the past was that social insurance schemes would gradually expand to become universal. This required the adoption of other public policies to increase formal employment. Yet, in most countries with a large informal sector, expansion was technically and politically unfeasible. In fact, formal workers are currently a minority in labour forces in most low- and middle-income countries. In these countries, social insurance mostly covers formal workers. Despite

commitments to gradually expand social insurance, disparities in rights and benefits between formal and informal workers have widened (WHO, 2010). This is because very often the organized formal sector is better positioned to lobby effectively for the expansion of their entitlements and subsidies rather than for the extension of their benefits to the rest of the population (WHO, 2010).

2. Many countries are experiencing demographic transitions and ageing processes that reduce the size of their workforces. This has impacts on the ability to raise "direct taxes" (payroll taxes for compulsory health insurance or income taxes with revenues supporting general public expenditure, including for health). This often leads to greater reliance on indirect taxes such as value added tax (VAT) to provide revenue that can fund adequate social protection. Also, faced with the challenge of improving their competiveness and attracting foreign firms and investment, countries often relax taxation regimes reducing income taxes and payroll deductions needed to fund social protection.

Policy-makers are exploring new ways to ensure universal social protection and protection from impoverishment due to health costs. They are mixing funding sources and transferring tax revenues to supplement insurance funds. Some explore the extension of social health insurance to "non-contributing" groups by subsidizing contributions with general tax revenues. Low- and middle- income countries are adopting income transfers to address the needs of the poor (OECD, 2009). They are commonly funded from general tax revenues and cover groups without means. These are described in more in detail later. There is increasing consensus that social protection should be delinked from employment status.

Social protection and social policy

Social protection is part of a country's broader social policy framework, which encompasses all policies and interventions to help people to effectively participate in society. It requires the involvement of different government sectors and service providers (OECD, 2009). Social protection comprises a set of public and private policies and programmes aimed at reducing and eliminating economic and social vulnerabilities to poverty and deprivation. As a crucial policy tool, it supports equity and social justice, and delivers specific services and income transfers to help people escape poverty (UNICEF, 2011; ILO, 2011). A country's social policy framework often also includes: 1) social services (education, health care, early childhood development, water and sanitation, or public housing); and 2) social standards (working ages, minimum wages, occupational health and safety rules, working hours and collective labour rights, for example, unionization, collective bargaining and strike action). Policies in other areas are also often components of a social policy framework such as gender policies or initiatives for social inclusion (UNRISD, 2006). In pursuing the principles of *prevention, protection, promotion, and transformation*, countries commonly combine initiatives with other social policies such as cash transfers.

Stakeholders in social protection

Social protection is a public responsibility in most countries, yet many agents are involved. Public or semi-public entities often deliver social protection services. In many countries, private, nongovernmental and community-based entities (under public supervision and regulation) also participate as providers. Approaches depend on national values, past experience and institutional frameworks (ILO, 2010a). Furthermore, most so-called non-contributory schemes in low-income countries (e.g. cash transfers) involve the intervention of public, nongovernmental organizations (NGOs) and international partners, who may offer income and services to individuals, households and communities to overcome the risks and stresses created by poverty and social exclusion (Barrientos, Hulme & Moore, 2006).

The United Nations (UN) system is promoting the adoption of a "social protection floor" to ensure countries implement a minimum level of social rights, services and facilities for all citizens (ILO, 2004). This is seen as a way of contributing to the achievement of Millennium Development Goal 1: to eradicate extreme poverty and hunger (ILO, 2010a). Health and access to health services is a component of the social protection floor. Since the launch of WHO's health systems performance framework in 2000, lowering out-of-pocket spending (OOPs) has been a central component of health systems policy development (WHO, 2000). WHO has been supporting the development of health financing in low- and middle-income countries as part of the social protection floor.

Social protection and the economy

Social protection can stimulate the economy by enhancing involvement in productive activities and employability (Gertler et al. 2005). Improved health, increased school attendance, and reduced hunger facilitate investments in productive activities and human capital generation, which raise productivity and incomes (OECD, 2009). For example, combining social protection and social policies improves the negotiating power of workers and smallholder farmers in the market. Indeed, evidence shows workers have a better fallback position and can search for jobs suited to their capabilities, rather than accepting the first job available. This raises labour market efficiency, reducing underemployment. Furthermore, small-scale producers with social protection benefits are less likely to have to sell produce at a loss in order to survive when food prices are depressed (OECD, 2009).

Entitlement to regular and reliable transfers makes beneficiaries credit worthy. *Mexico's Oportunidades* transfer programme improves consumption and asset accumulation for programme participants and non-participants (Barrientos & Sabates-Wheeler, 2009). Social protection can stimulate demand for local goods and economic growth. For example, In Zambia, 80 per cent of the social transfers are spent on locally purchased goods, supporting enterprises in rural areas (OECD, 2009).
Moreover, social protection increases the positive impact of macroeconomic policies benefiting groups who might otherwise be disadvantaged by economic growth strategies such as lowering import tariffs. Cash transfer initiatives compensated the poor for reduced price subsidies in Indonesia and Mexico. Bolivia established a social pension scheme with the proceeds from the privatization of public enterprises (Birdsall & Nellis, 2002). In South Africa, the redistribution of spending power from upper to lower income groups shifted the composition of national expenditure from imports to local goods, increasing savings by improving the trade balance, and supporting economic growth (Samson et al., 2004).

SCOPE AND LIMITATIONS

The bulk of the burden of disease and the major causes of health inequities in all countries arise from the conditions in which people are born, grow, live, work and age. These conditions are known as the social determinants of health – encompassing the social, economic, political, cultural and environmental determinants of health. The most important determinants are those that produce stratification in societies, namely structural determinants such as the distribution of income, discrimination (e.g. on the basis of gender, class, ethnicity, disability or sexual orientation), and the political and governance structures that reinforce inequalities in economic power. Discrepancies in social position arising from these mechanisms shape individual health status and outcomes through their impact on intermediary determinants such as living conditions, psychosocial factors and the health system.

Recognizing this spectrum of determinants, this briefing takes a largely national perspective of the key challenges facing policy-makers implementing social protection across very different country settings. Although specific social protection initiatives often include evaluation components, evaluation of different types of social welfare regimes as a whole generally requires very careful qualitative and econometric comparisons across countries that specify the nature of the social protection regimes and institutional settings. Some studies of this nature are reported. More recently, the surge of formal evaluations has focussed on integrated social protection schemes and cash transfer schemes mostly from middle-income countries (Brazil, Mexico and South Africa). Evaluation techniques include randomization in the countries mentioned. In other cases, techniques to estimate differences between groups include propensity score matching and regression discontinuity analysis, among others. Many countries employ nongovernmental agencies to evaluate programmes, but very often these documents are not published.

GOAL 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

a) Health services

Social protection challenges and policy responses

Universal access to health care remains elusive for millions. For instance, skilled birth attendance in low-income countries can be as low as 10 per cent of the population, while in high-income countries it is almost universally provided (WHO, 2010). More than 120 national constitutions recognize health as a human right. They also recognize the different roles governments play in delivering, funding, and regulating health services (WHO & OHCHR, 2008). Where constitutions do not include this right, very often laws regulate states' roles in health care. Regardless of this, most countries consider health as a public interest issue and are committed to ensuring universal access. Realizing this right or entitlement (depending on a country's recognition of the right to health) has implications for how to organize the financing of universal health coverage.

Out-of-pocket spending – the direct payment of health services at the point of provision – is considered by policy-makers to be a key lever for policy action. As a major barrier to people's access to health care, OOP is prevalent in less-developed countries but also among low-income groups regardless of the country. Protecting people from a high burden of OOP is essential in achieving universal coverage and preventing financial risk. To work towards universal coverage for health, WHO advises the adoption of policies aimed at enabling all people to use the system without incurring financial hardship (WHO, 2010). The WHO World Health Report of 2010 proposes key policy recommendations in this regard.

1. Reduction of OOPs. Financial barriers deter people from using health services and create financial stress. They accentuate inequities because barriers and stresses disproportionately affect the poor. Furthermore, the fee-for-service incentive arising from this form of payment encourages health providers to over-supply services to those who can pay. This very often reduces the availability of services to the poor and the less financially secure. It also contributes to inefficiencies and widens the utilization gap between the rich and poor.

2. Address fragmentation in risk pooling. Pooling is the prepayment, accumulation and management of financial resources in advance of an illness (WHO, 2010). Pooled funds pay for health care once an illness occurs; the pooling allows the financial risk of an illness to be shared ("spread") among all members of the "pool". As noted in the previous section, in many high-income countries, social insurance began by protecting people who were employed. After the Second World War, the idea of universal coverage, inspired by the value of social cohesion, moved many countries to expand coverage to all populations. This led to policy advice that promoted "starting with the formal sector" and gradually extending coverage. Many low- and middle-income countries (LMICs) attempted to follow this policy advice, mostly unsuccessfully. The relatively small formal sector, typically comprising civil servants and private formal sector workers often lobbied for more benefits rather than for the extension of protection to the rest of the population regardless of employment status. Moreover, LMICs were faced with health service rationing decisions that did not exist in the first part of the 20th century. As a result, in most LMICs where "social health insurance" funds were created in the past, there are wide gaps in the level of benefits for scheme members as compared with the rest of the population (which tends to rely on publicly budgeted health services and OOP). This exacerbates social inequalities and results in pooling fragmentation and inefficiencies. For example, as indicated by Tangcharoensathien & Jongudomsuk (2004) in the case of Thailand, in countries with remarkable progress towards universal access, interests entrenched by measures that were initiated in the formal sector make full universal health protection difficult to implement.

3. Contribution must be compulsory. This is based on the recognition that no country achieves universal coverage by relying on voluntary contributions and is supported both by health insurance theory[4] and global evidence. The main approaches involve the use of mandatory "payroll taxes"(compulsory contributions) for health insurance, general government tax revenues, or a combination of the two. In a spirit of solidarity, better off groups (often healthier and younger) are not allowed to take their contributions out of the pool (preventing a potential lack of funding) so as to ensure coverage for the poor and sick (very often the elderly). Evidence shows that voluntary insurance has limited ability to cover a range of services for those too poor to pay. Evidence also shows that pools protecting small populations are not sustainable as episodes of expensive illness easily wipe them out (WHO, 2010). This is another reason to advocate for less fragmentation and larger pools ("bigger pools are better").

4. Equity in finance. The principle of equity in finance, increasingly being adopted by countries, ensures people will contribute to health care according to their capacity to pay, but will access services according to their needs. Governments with relatively large formal sectors and strong tax collection capacity adopt mechanisms for progressive contribution based on income levels (e.g. income taxes, corporate taxes, payroll taxes). For individuals or groups unable or unwilling to contribute, countries provide subsidies from general revenues. Such

4 This is the concept of adverse selection. Those who are aware that they are likely to need care are inclined to prepay at the average cost for the population, while those who are in good health are less inclined to pay. Over time, and without regulation, this leads to ever-rising premiums and those in most need of health coverage dropping out of insurance schemes.

assistance can take the form of direct access to government-financed services or, as noted above, through subsidies to a defined third party pooling agency responsible for purchasing services on their behalf. Other mechanisms that facilitate access to health services among the poor and vulnerable include income transfers (see next sections).

There is no unique model for universal coverage. Countries start from different positions, and organize their health financing systems in different ways based on their preferences and historical inheritance.

Some countries have opted for pool consolidation (e.g. Scandinavian countries). Countries that rely on multiple competing insurers to manage their compulsory health insurance systems have created mechanisms to cross-subsidize pools, compensating for differences in expected risk (e.g. Germany, the Netherlands, Switzerland). Countries with geographically decentralized pools may use equalization formulas to compensate and better align resources with needs. Many countries that rely on contributory-based entitlement but are committed to universal coverage have moved to pool together general revenue transfers on behalf of non-contributors with the payroll taxes of the workers (e.g. Ghana, Moldova). Countries are increasingly combining funds from many sources. This includes "direct taxes" (payroll contributions for compulsory health insurance), and indirect taxes (income and corporate ones and value-added or excise taxes). Most countries use excise taxes on tobacco and alcohol, but only a few specifically earmark these revenues for health. Some countries organize their systems to make the benefits covered by voluntary insurance premiums explicitly complementary to those covered by public funding.

The position adopted by WHO (2010) is that "starting with the formal sector" is not the most appropriate way to protect the poor from financial catastrophe because experience has shown that the political dynamics of this approach exacerbate underlying social inequalities. Instead, the goal of universality should be in the design of the system from the start. To do this, many countries combine funding sources like general budget transfers for the poor and pool them with payroll taxes so as to provide access to health for all irrespective of their labour status (as Moldova has tried to do). The health sector should reach out to key sectors and actors to build political commitment to universalism and address key barriers that prevent people from accessing the health system. This will enhance the redistributive role of health systems and their contribution to greater health equity (Gilson et al., 2007).

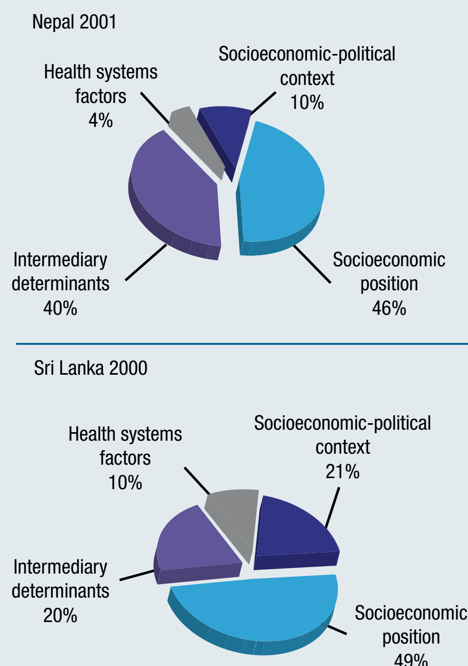
Examples of health impacts and pathways

Access to health services and health outcomes. Most studies predict that access to health care contributes 25–50 per cent to the improvement of health outcomes, depending on which outcome is identified. Lack of available health service and OOP is linked to disturbing trends in mortality. *The World Health Report – health systems financing:* the path to universal coverage (WHO, 2010) shows how various strategies in financing are associated with promoting universal coverage, regardless of employment or citizenship. The CSDH Knowledge Network for Health Systems highlighted the important redistributive role that access to health systems can play (Gilson et al.,2007). Box 1 shows data on the redistributive role of health services relative to other social determinants of health, and how this varies according to different health conditions and the orientation of the universal coverage of the health system.

Box 1a. SOCIAL DETERMINANTS AND EQUITY FOCUS

Evidence shows how more progressive health systems with greater coverage are better positioned to reduce inequities in access. An analysis conducted by WHO described the relative contributions health-systems access and other social determinants of health make to health inequities. Figure 1 shows the "decomposition" of health-systems access and other social determinants in Nepal and in Sri Lanka for malnutrition only. Among factors forming part of "the health system" are user fees and travel distance. While in Nepal, current health system arrangements can reduce health inequities in child malnutrition by 4 per cent, it is estimated that in Sri Lanka the current health system can contribute to a reduction of 10 per cent of inequities in child malnutrition.

Figure 1. Inequities in child malnutrition: factors contributing to its generation.



Source: WHO-SEARO (2007).

Further readings
WHO (2010). *The World Health Report – health systems financing: the path to universal coverage.* Geneva, WHO.
Lundberg O et al. (2008). *The Nordic experience: welfare states and public health.* Stockholm, Centre for Health Equity Studies (CHESS), Stockholm University, Karolinska Institutet (Health Equity Studies No 12).
CSDH Knowledge Networks, Lee J, Sadana R, eds. (2012). *Improving equity in health by addressing social determinants.* Geneva, WHO.

Useful links
WHO's web site on Health Financing Policy. Includes information and resources on country strategies on health financing, mechanisms and functions for equitable health financing and on catastrophic expenditures. The site has a list of country experiences, and tools and training material: http://www.who.int/health_financing/en/index.html.
WHO-CHOICE. *CHOosing Interventions that are Cost Effective:* A WHO tool for health-financing decision-makers to support them in their work and to ensure available resources are used equitably and efficiently: http://www.who.int/choice/en/.

b) Other social insurance schemes and services

Social protection challenges and policy responses

Beyond health-care services, other "traditional" social services aim to safeguard households from the adverse impacts of deprivation. These are specifically targeted at groups who disproportionately bear risks due to existing deprivation or their vulnerability (e.g. low-income groups, homeless people, children, single mothers). Common policy responses are schemes that fund or directly provide social and community services in areas such as day care, protection programmes for vulnerable people including protection services, feeding programmes, foster care for children at risk, shelters for women, counseling services, among others.

Pensions guarantee a minimum of income security to those in old age. They have a fundamentally different purpose to health financing, and therefore, a different administrative logic. Pensions are a savings mechanism that may not involve any inter-personal transfer of income, but rather an inter-temporal transfer e.g. from current contributors (working age people) to retirees. In other systems, contributions are made individually. In both cases, the income received relates directly to the contributions made. While health events are often unpredictable, retirement is an event that is fairly predictable. The fundamental differences between health and pension schemes imply the existence of different management, principles and practices. These differences also underpin the need to avoid putting health coverage and pensions under the same management.

In addition to the schemes mentioned before, countries also ensure income support to the vulnerable, though enacting statutory unemployment insurance, or by enacting employment injury schemes to protect workers and their survivors' (e.g. widows, orphans) from the financial and health risks that disability or accidental death cause. Other schemes are enacted to cover maternity protection (ILO, 2010a).

Examples of health impacts and pathways

Pensions, poverty and health. During the 1996 pension crisis in Russia, approximately 14 million of the 39 million pensioners were not paid pensions for more than six months. Longitudinal data show that among the affected pensioners, poverty rates doubled, and the intake of calories and protein, and the use of health services and medications declined significantly. Those affected were also 5 per cent more likely to die in the two years following the crisis (Jensen & Richter, 2003).

Unemployment, health outcomes and insurance. Robust evidence suggests that unemployed individuals report higher rates of poor health than employed individuals (Bambra & Eikemo, 2009). Increases in unemployment have also been associated with higher mortality rates (Diderichsen, 2002).

Disability pensions and health outcomes. A recent study in Norway, where disability pensions were established in 1967, suggests that, as in other countries, the risk of not having a disability pension increased with decreasing social class and educational level (Krokstad, Johnsen & Westin, 2003). A study of 15 067 individuals found that it is not health that explains the need for a disability pension, but personal and social contexts (Amundsen Østby et al., 2011). These authors found that the lack of disability pensions impact mainly on those who need them most.

Box 1b. SOCIAL DETERMINANTS AND EQUITY FOCUS

Social protection regimes are an important predictor of population health outcomes. In a research study covering the period 1960–1994, Chung & Muntaner (2007) categorized data from 19 countries into different types of social protection regimes, including among them: Social Democratic Nordic regimes (such as Finland, Norway and Sweden), Christian Democratic or Bismarckian regimes (such as France, Germany and the Netherlands), and Liberal regimes (such as Australia and the United States). While the Scandinavian countries emphasize universal social protection and large pooling regimes, countries with Bismarckian regimes rely on social insurance funds linked to an individual's employment status. Liberal regimes are characterized by the presence of private for-profit insurance entities, multiple pools and higher out-of-pocket payments.

The authors explored health status focusing on infant mortality and low-birth-weight rates for each type of regime analyzed. The Nordic countries had a better population health status as shown by lower infant mortality rates and higher birth-weight rates, compared to the rest of the countries. Among the countries surveyed, the type of welfare state accounted for 20 per cent of the difference in infant mortality rates, and 10 per cent of low birth-weight rates. A comprehensive social protection regime often results in better population health outcomes. This is because welfare services improve key determinants of health, such as education or income, or because resources are committed to improve universal access to health systems.

Source: Chung and Muntaner (2007).

What can both sectors do together?

Designing demand side interventions to increase access to health within community social protection schemes. Out-of-pocket spending comprises two-thirds of health expenditure in Cambodia. In 2000, health equity funds (HEFs) were piloted by a coalition of international health partners (e.g. NGOs and UNICEF). They have since been further adopted as a national social health protection mechanism and included in government health financing policies. They operate as third-party payers to ensure access to priority public health services to impoverished patients (Ir et al., 2010). HEFs have played a positive role in building partnerships between the public sector, civil society and NGOs; they are managed at the district level by independent community organizations. They are under the responsibility of a committee with representatives from communities, pagodas, local health authorities and NGOs. In addition to reimbursing user fees to health facilities, HEFs identify eligible patients, and reimburse costs they incur in transportation and food (Bigdeli & Annear, 2009). The HEFs also engage with communities by identifying needs and disseminating information on services. Although HEFs were initially set up with donor support, there has been progress since 2006 to ensure their financial sustainability as the Government of Cambodia has been allocating state budget funds to subsidize and reimburse patients the cost of user fees. Despite experience from countries showing that micro schemes with small pools are exposed to greater financial risk (WHO, 2010), in the absence of larger nationwide social health protection schemes, HEFs can protect against the impoverishing effects of OOPs as they ensure funds for the poor to purchase services.

Working together to design expanded risk pooling. In 2001, Mexico introduced *Seguro Popular* for more than 50 million informal workers (Marie Knaul et al., 2006). This is a heavily subsidized voluntary scheme that people join at will. It is free for those earning less than one-third of the minimum wage; those over this threshold pay a premium that also covers their families. This scheme covers 1440 conditions and 422 medicines (ISEM, 2011). Both the social protection and health sectors worked together to identify the health risks and their impacts, and to assess the outcomes of planned interventions. The 2008 evaluation of the scheme found that the programme was attaining the goals set in the 2007–2012 National Sectoral Planning for Health (GFM, 2008).

Economic crisis and counter-cyclical policies to prevent catastrophic health expenditures. Contributory unemployment insurance schemes are recognized as being anti-poverty measures. In 2002, the U.S. Temporary Federal Unemployment Insurance Program provided unemployment insurance for a maximum of 26 weeks. In 2010, facing the global financial crisis, the same programme was extended to a maximum of 53 weeks. Estimates suggest that in 2009, this scheme lifted 3.3 million people out of poverty, including 1 million children (Gabe & Whittaker, 2011). In parallel to extending the income transfer component of these schemes and working together with health authorities, 36 states enacted the Medically Needy Program to extend eligibility for health coverage to people who would otherwise be exposed to catastrophic health insurance premiums. This example illustrates the potential opportunities created when unemployment benefits are enlarged and synchronized with expanded health-care coverage.

Increasing portability of social protection benefits. In 2011, The People's Republic of China enacted a new social insurance law introducing changes to current regimes (pensions, medical care, maternity, work injuries and unemployment). The law sets basic principles for a sustainable system. It enables the mobility of pensions and health insurance benefits when workers change employers. Previous regulations linked social protection benefits to a specific employer, which meant that a change of employers could have resulted in the loss of social protection benefits (e.g. pensions, medical care exclusions, etc.). The law regulates the mobility of workers and the portability of benefits gained when changing employers. The law also deals with fragmentation and ensures the specialization of funds. Each pool's coverage will be expanded. In the case of health care, pooling will be expanded from city level (in the urban health regime) and county level (in the rural regime) to integrate pooling at provincial level (Wenliang, 2012).

This example highlights the potential for synergies in administrative transitions that enable both pension and health coverage to be more responsive to the needs of increasingly mobile populations who may also be subject to more frequent changes of employers. While extolling the virtues of lessons and synergies across administrations, it is important to consider that each major protection scheme (e.g. health, pension, employment) often requires specialized knowledge, management principles and, therefore, independent administration.

Further readings

ILO (2010). *World social security report 2010/11: providing coverage in times of crisis and beyond.* Geneva, International Labour Organization.

Useful links

International Labour Organization (ILO). Social Protection Sector: http://www.ilo.org/protection/lang--en/index.htm.

International Social Security Association (ISSA). The ISSA is an international institution bringing together social security agencies and organizations: http://www.issa.int/.

GOAL 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

Social protection challenges and policy responses

Chronically poor people have often fewer assets, less resilience and limited opportunities to escape poverty (Shepherd, 2011). In addition to vulnerability, they mostly operate in the informal sector where there is no form of social protection. When dealing with risks, they many times deepen their poverty by adopting strategies that destroy their assets, for example, by selling household goods and other assets (Barrientos, Hulme & Moore, 2006). Income transfers are an increasing policy response to the challenge of poverty and the lack of formal employment. These include regular non-contributory disbursements in cash or in-kind provided by government directly or through NGOs to individuals or households, with the aim of decreasing chronic or shock-induced poverty and addressing social risk (Samson, 2009). Transfers described in this section refer to those disbursed with no conditions attached.

Transfers can be universal or targeted at poor or vulnerable populations (ILO, 2010a). Research shows that transfers support investments in children's health, nutrition and education, which help break the intergenerational transmission of poverty. They include child allowances, publicly funded old-age pensions, disability pensions, non-conditional cash transfers, temporary subsidies (e.g. energy life-line tariffs), housing subsidies, or price support mechanisms (e.g. supporting the price of staple food). Governments often prefer cash transfers as they are easier to administer and because in-kind transfers incur added costs (e.g. transportation, storage, supervision, infrastructure or equipment). Cash transfers also give households the freedom to decide how to spend funds (Pauw & Mncube, 2007).

In high-income countries, transfers have been in place for many years in the form of "social assistance" as described in Goal 1. In recent years, middle- and low-income countries have adopted these schemes. They are a key component of social protection given the large informal populations living in poverty. Examples include income transfers to poor households, such as the old-age grants in India (31 million beneficiaries) and South Africa (10 million beneficiaries). It also includes child and family allowances that in Argentina reach four million children and in South Africa 10 million children (Barrientos & Niño-Zarazúa, 2011). Some parameters to monitor the effectiveness of social protection measures include:

i) incidence: assess the proportion of potential beneficiaries actually reached (take up) or should be reached (non-take up);
ii) poverty reduction impact: measure effectiveness in reducing poverty among populations targeted (e.g. the elderly, children, people in a specific geographical area, etc.); and
iii) cost effectiveness: assess the effectiveness of delivery ensuring expenditures are reasonable.

A policy implementation problem reported in some countries is the "substitution" effect, by which budgets for health or education services are reallocated to fund income transfers (Pauw & Mncube, 2007). This reduces the effectiveness of the transfers increasing the demand for social services, which is not met by an increase in the supply of social services. In South Africa, social grants funded by public revenues are an important source of income for thousands. It has been estimated that further increases in these grants could imply substitution of budgets unless public revenues are increased (Pauw & Mncube, 2007).

The targeting of transfer programmes has political, social and economic dimensions. Its aim is to define where to allocate limited public resources most efficiently; but it is costly (Samson, 2009). It entails bureaucratic costs to assess applicants' means and reassess them on a regular basis (Samson, 2009; SEKN, 2008); private costs when people apply for benefits covering transportation, travel time and other outlays; and social costs arising from stigma and the potential erosion of social cohesion, which reinforces the marginalization of recipients (Samson, 2009).

Means testing mechanisms can be expensive and time consuming (SEKN, 2008). Some countries adopt "categorical" approaches that define population groups that are very often in more need or vulnerable (e.g. the elderly, children). Other approaches include covering people living in a specific geographical location with a social protection scheme (Samson, 2009). Other countries adopt community-based mechanisms for the identification of beneficiaries, where it is assumed that the communities themselves are in a better position to assess their needs (Hanlon, Barrientos & Hulme, 2010). However, it is understood that local elites may skew the allocation of transfers away from the poorest (Samson, 2009). Self-selection is a targeting mechanism largely used in employment guarantee schemes, such as public works programmes, where people are guaranteed the right to work and are free to choose whether or not to accept the offer (Hanlon, Barrientos & Hulme, 2010).

There is no single approach and often different targeting methods are used together. In South Africa, income transfers go first to a group of people that share similar characteristics (a "category" such as the elderly, children and pregnant women). Then a means test is applied so that better off people are excluded and the focus put on those below a previously defined minimum income. In China, a targeting criterion is related to geographical location, people living in rural or urban areas receive different income transfers (Hanlon, Barrientos & Hulme, 2010). Decisions on how to target populations and their entitlements often consider the direct and indirect costs of implementation. Overall, the less stringent the conditions, the lower the cost of targeting. However, flexible inclusion mechanisms (and therefore a more universal scheme) imply greater public funding (Samson, 2009; SEKN, 2008).

Examples of health impacts and pathways

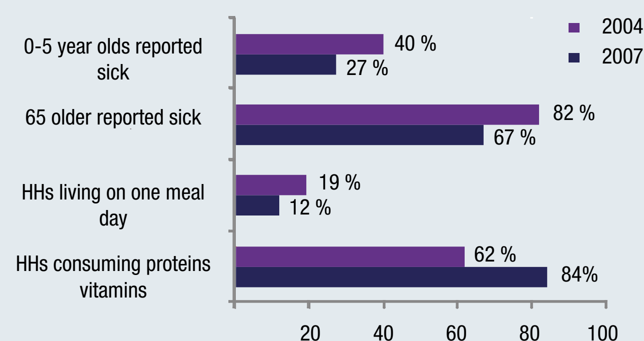
Non-conditional child transfers, nutrition and height. South Africa's Child support Grant (CSG) is an income transfer scheme that provides a monthly amount equal to US$ 35 to caregivers of children less than 18 years old. It is paid to households that have a monthly income that is less than US$ 700. Currently, around 10 million children benefit from the grant. Research shows a positive impact in height, which is used as an indicator of nutritional status. Using data from a 1998 national survey that measured the nutritional impact of CSG on children, Aguero, Carter and Woolard (2007) extrapolated the results to adult males aged 25–35 and determined that adults would have been 3.5 cm taller.

Unconditional old-age transfers, education and height. South Africa's Old Age Grant (OAG) is a non-contributory and unconditional transfer that is provided to all low-income citizens or residents in the country who are 60 years or more. The current benefit amounts to the equivalent of around US$ 160. About 80 per cent of Black African females and 75 per cent of males benefit from the grant. In 2000, the OAG was the only income source in the median recipient Black African household in rural areas, and represented about two-thirds of the total income in the average Black African household in urban areas of the country. There are documented impacts of the OAG on education and the health of children living in the same household as pensioners. Indeed, it has been found that the old age grant is associated with improved school attainment among boys, with a significant impact among girls (Hamoudi & Thomas, 2005). Moreover, Duflo (2003) found that children in households with one pensioner have better height-for-age and weight-for-age indicators than children in a similar household without a pensioner.

Box 2. SOCIAL DETERMINANTS AND EQUITY FOCUS

In Zambia, a cash transfer scheme was launched in 2004 for 1000 households (7000 people) in Kalomo District. Households benefited from a non-conditional monthly grant equivalent to US$ 7.52. The targeted population was under the poverty line; 70 per cent of whom had HIV/AIDS. The district's population was characterized by a marked under representation of adults due to the impact of HIV/AIDS mortality and urban migration. The rate of orphans was double the national average at 17 per cent. Around 55 per cent of heads of households were aged 65 years or more. By 2007, the programme had enabled an increase in the consumption of nutritious food. The cash transfer scheme was instrumental in reducing illness, as shown below. This evaluation did not have a control group as it was deemed unethical to monitor the suffering of families not benefiting from the scheme.Despite these limitations, the study provided data on the potential to replicate such programmes in low-income settings (Figure 2).

Figure 2. Pre- and post-analysis of the Kalomo District cash transfer scheme, 2004–2007



Source: Adapted from MCDSS and GTZ (2007).

Recently, the results of one of the first randomized evaluations of a cash transfer programme in sub-Saharan Africa was reported by Baird, McIntosh and Özler (2009). The study compares the impact of a non-conditional and a conditional cash transfer scheme in Zomba District, Malawi. In this case, transfers improved key social determinants of health and were associated with a 60 per cent reduction in risk of HIV infection among beneficiaries, against a prevalence of 22 per cent. Mechanisms that influenced this impact were a reduction in early marriage and transactional sex, improved nutrition and health-care access, and increased school attendance.

What can both sectors do together?

Supporting access to other social assistance schemes. Non-contributory income transfer schemes have demonstrated positive impacts on poverty, health and well-being. *The Beneficio de Prestaçao Continuada in Brazil* provides non-conditional income transfers to 3.5 million people. In South Africa, the Child Support Grant provides non-conditional income transfers to 10 million children. Evaluations of both schemes show positive impacts improving nutrition, health and education (UNICEF, 2008). These transfer programmes act as "gateways" to other services. Since 2008, health authorities in Brazil and South Africa have undertaken actions to improve local level cooperation to ensure beneficiaries are informed and can access other social services including early childhood centres, community centres, and feeding and immunization programmes (UNICEF, 2008). Similarly, in India, health authorities operate outreach activities to engage with local communities benefiting from income transfer schemes. They provide orientation, and organize awareness campaigns and women's meetings to disseminate knowledge about different services and poverty reduction schemes (Ministry of Rural Development, 2010). In South Africa, health and local authorities cooperate to extend the population's access to public works programmes, housing subsidies and adult education programmes.

Collaborating to identify new beneficiaries of income transfer programmes. In Argentina and India, local health authorities have adopted mechanisms to identify and cross check information with social protection programmes on people who qualify for social protection schemes. In Brazil, health authorities share their databases with the Ministry of Social Development facilitating the identification of new beneficiaries of *the Beneficio de Prestaçao Continuada.* This allows for the inclusion of new beneficiaries and the updating of information on beneficiaries that do not qualify anymore for the income transfer (TCU, 2009).

Technical assistance on nutrition in the context of in-kind transfers. Health authorities can contribute to the implementation of in-kind transfers to ensure adequate living conditions. In India, the Indira Ghandi National Widow Pension Scheme provides income transfers combined with a daily free meal and a specific amount of food for each household. This programme benefits 2 million women in vulnerable situations (e.g. landless, widows, abandoned women or those suffering from intimate partner violence). Health and nutrition practitioners work with social protection authorities at state and local levels providing guidelines on the recommended caloric intake for meals, and the dietary content of food to be distributed among the beneficiaries. In Mexico, the Programa de Apoyo Alimentario provides nutritional supplements to children aged six months to two years and distributes milk to low-income households. The health sector formulates nutritional guidelines and supervises the quality of in-kind transfers (Rodriguez, 2001).

Further readings

World Bank (2008). *For protection and promotion. The design and implementation of effective safety nets.* Washington DC.

Barrientos A, Hulme D (2008). *Social protection of the poor and poorest.* Basingstoke, Palgrave, Macmillan.

Useful links

Global Extension of Social Security (GESS). A global knowledge sharing platform on the extension of social security; aims to facilitate the exchange of information and ideas, capture and document experiences, identify knowledge gaps, create new knowledge and promote innovation: http://www.ilo.org/gimi/gess/ShowMainPage.do.

Chronic Poverty Research Centre (CPRC). International partnership of universities, research institutes and NGOs focusing on research on insecurity, risk and vulnerability: http://www.chronicpoverty.org.

GOAL 3. INCOME TRANSFERS PLUS SERVICES

SOCIAL PROTECTION MEASURES AIM TO ENHANCE PEOPLE'S ASSETS AND CAPABILITY, AND ENSURE ECONOMIC AND SOCIAL INCLUSION

Social protection challenges and policy responses. Pure income measures in the form of cash or in-kind transfers, as discussed under Goal 2, provide immediate relief to households, enabling them to secure their basic needs and prevent chronic poverty. However, these protective measures alone are not sufficient because they may not address the root causes of poverty and often do not break its intergenerational transmission. The challenge faced by policy-makers is that low capability is often at the origin of poverty and needs to be addressed directly. Children who grow up in poor households tend to remain poor. Malnutrition, combined with poor quality schooling and low educational levels, mean they lack the capabilities required to escape poverty (Pauw & Mncube, 2007). Interventions can be categorized into three types as outlined below.

i) Asset protection. In the absence of social protection, when those living in poverty are faced with social risks they very often have no other option than to adopt counter-productive coping strategies (Barrientos & Niño-Zarazúa, 2011). They may dispose productive assets they have to escape poverty such as cattle, land, tools, machinery or their dwellings (Samson, 2009). This undermines their productive capacity and heightens the risk of a poverty trap. Protection measures prevent the depletion of assets and help rebuild them (Barrientos & Niño-Zarazúa, 2011). For example, Ethiopia's Productive Safety Net Programme provides income transfers to households affected by droughts so that they do not have to sell their assets. The programme also has a public works component. People participate in activities, such as the construction of roads, local infrastructure and public facilities, which promote well-being and provide local assets. Research shows that this programme, which covers 1.8 million households (10 million people), has been key in counteracting these desperate coping measures and in reducing future vulnerability.

ii) Asset accumulation and investment. Very often the poor cannot start income-generating activities or take advantage of economic opportunities as they have very low capital or collateral resources. Living under the constant threat of a sudden drop in income makes poor families more risk averse than non-poor families (Hanlon, Barrientos & Hulme, 2010). Most people living in poverty also have no access to credit. Interventions in this area include increasing preferential access to microfinance, microcredit and employment guarantee schemes, or addressing bank lending practices. Reducing uncertainty increases the probability of engaging in productive investments (Hanlon, Barrientos, and Hulme, 2010). For example, farmers under the Employment Guarantee Scheme in Maharashtra, India, invest in higher yielding varieties than farmers in neighbouring states (Samson, 2009; DFID, 2005). Finally, job searching is often expensive and risky particularly for those with less income. In South Africa, people receiving cash transfers have more time to engage in job searching and are more successful than those in households not receiving grants. (Samson et al., 2004; Samson & Williams, 2007). Yet, there are also potential unintended consequences, especially for microcredit schemes that have no other developmental interventions attached. Research shows that they can exacerbate poverty: 1) by self-exclusion where community members (often the poorest) decide not to enrol; and 2) because of the high costs involved as, to stay viable, many schemes have to charge high interest rates, and if the borrower defaults the escalating debt increases poverty (Hanlon, Barrientos & Hulme, 2011)

iii) Investments in human capital development: Poor people's coping strategies include withdrawing children from school, reducing spending on health care, and slashing expenditure on food and seeds. This is where income transfers combine to become investments in human capital (Devereux & Sabates-Wheeler, 2004). Human capital interventions aim to overcome poor households inability to invest in health and education, which are the foundations of productivity and better income (Niño-Zarazúa & Barrientos, 2011). These transfers are often conditional on beneficiaries' enrolment and minimum attendance at primary or secondary school, use of preventive health services (e.g. expectant mothers and children from birth to age five or six), or use of early childhood development services. Other interventions consist of training for income-generating ventures and active labour policies (e.g. workers' training). Income transfers are provided to targeted households on the condition that they invest in human capital, thus combining the short-term objectives of safety nets with the long-term goals of breaking intergenerational poverty traps (Britto, 2006). Yet, it is critical for governments to ensure that increased demand for education and health services is accompanied by increases in the numbers of service providers and high quality maintenance.

Very often the three types of interventions described above are mixed. Many interventions that aim to protect or increase assets are combined with human capital interventions. Another essential aspect of interventions grouped in this category is the existence of conditionalities in programme design. These are behavioural requirements that participants must satisfy in order to regularly receive the cash benefit. For example, households may be required to ensure 85 per cent school attendance or prove that their children have received appropriate immunizations (Samson, 2009). The aim is to increase human capital and break intergenerational poverty by positively influencing children's early years. However, there is a debate on the pertinence of conditionalities as, unless they are assessed correctly, they can penalize participants by reducing their benefits unfairly. There is also a gender dimension as compliance very often falls disproportionately on women. An argument in favour of conditionalities is that it changes intra-household decision-making on the allocation of resources if the benefits are paid to the women.

There is no single prescription on conditional versus non-conditional schemes. In Kenya, Malawi, Pakistan and Zambia, governments and partners are implementing conditional and unconditional schemes to explore the pertinence of conditionalities (Pauw & Mncube, 2007). Measuring the impact of schemes usually involves monitoring issues such as increases of schooling years, gender equity at school, health-care access, or the expansion of income-generating activities.

Examples of health impacts and pathways

Human development schemes, and maternal and newborn health. In 2005, with the goal of reducing maternal and neonatal deaths, the Government of India launched the Janani Suraksha Yojana (JSY). This is a conditional cash transfer that tries to contribute to increasing the number of pregnant women delivering at health facilities. After a delivery in a public or private health facility, women living in both urban and rural areas receive an income transfer of the equivalent of US$ 13.3 and US$ 15.6, respectively. This transfer is conditional on the women following up with neonatal care services. This is the largest conditional cash transfer programme in the world in terms of the number of beneficiaries being reached. It has significantly increased antenatal care and in-facility births. As a result, postnatal care coverage has reached more than 80 per cent in low-income states such as Orissa, Rajasthan and Uttar Pradesh (Lim et al., 2010).

Cash transfers and child development. Mexico's *Oportunidades* conditional cash transfer programme (CCT) started in 1997 and currently benefits 25 million people. Its goal is to break the intergenerational transmission of poverty. The scheme provides a monthly stipend on condition that parents bring children to preventive medical care services and buy food to improve their nutrition. *Oportunidades* also provides an educational scholarship for children on condition that they attend at least 85 per cent of the school year. All children receive regular medical check-ups. In a randomized controlled trial evaluating the impact of the programme, it was found that participation is associated with children's higher height-for-age, lower prevalence of stunting, lower body-mass index for age percentile, and lower prevalence of overweight. In other cases, the cash transfer was also associated with children doing better on a scale of motor development and receptive language. It was found that, at two years old, children's growth differed by about 1 cm between programme participants and non-participants (Fernald, Gertler & Neufeld, 2008).

CCTs and early childhood development. Ecuador's Bono de Desarrollo Humano has been implemented since 2003 and covers around 250 000 households. It provides a conditional cash transfer for female heads of households with children and a non-conditional cash transfer for senior citizens and people with disabilities. The benefit is equivalent to US$ 15 per month per family, or US$ 11.50 per month to senior and disabled heads. Fernald and Hidrobo (2011) have documented the impact of the scheme on child development in a randomized control trial that found that infants and toddlers living in the rural areas who were benefiting from the grant had significantly greater vocabularies than the children who were not benefiting. Moreover, compared to children in the control areas, rural children in treatment areas were more likely to have received vitamin A or iron supplementation in the past 6 months and were also more likely to have been bought a toy in the same period.

Box 3. SOCIAL DETERMINANTS AND EQUITY FOCUS

In 2003, Brazil had three conditional cash transfer programmes in place and an unconditional transfer for gas subsidies. These were merged to create the *Bolsa Familia* cash transfer programme avoiding duplication of efforts. *Bolsa Familia* aims to: i) reduce poverty by providing a basic income; and ii) strengthen human development with education, health and nutrition components. The programme does not use means testing. Eligibility is decided by self-reported information on income and children. The maximum benefit is equal to US$ 153 if a family is in extreme poverty. The average benefit is US$ 73. Information is recorded in a single registry (Cadastro Único). *Bolsa Família* relies on municipal managers and social workers who look for people in the communities to be registered. Conditionalities are 85 per cent school attendance per month and regular visits to health centres. Children also have to follow an immunization calendar according to a protocol. Municipalities verify compliance with conditionalities and report to the health and education ministries.

An evaluation published in 2010 showed health improvements: pregnant beneficiaries had longer gestation periods (14.1 percentage points) than non-beneficiaries; body mass index was better among children benefiting from the programme, with the well-nourished among them being 39.4 percentage points better nourished than non-beneficiary children. The proportion of immunized children was higher among beneficiaries. *Bolsa Familia* also had a positive impact on key determinants of health. There was higher school attendance by beneficiary children between the ages of six and 17 (4.4 percentage points) than by non-enrolled ones. In the poorest region of Brazil, the impact was higher at 11.7 percentage points. School progression rates were higher for girls aged 15 years (19 percentage points) and for girls aged 17 years (28 percentage points). *Bolsa Família* was responsible for a 16 per cent fall in income inequality between 1999 and 2009. This is remarkable as the transfer represents 0.7 per cent of family income. Finally, studies show that *Bolsa Família* was responsible for a 16 per cent fall in poverty and a 33 per cent fall in extreme poverty in Brazil between 1999 and 2009.

Source: Veras Soares & Silva, 2010; Tapajos et al., 2010; Veras Soares, 2011.

What can both sectors do together?

Contribute to the design of social protection schemes and report on compliance. Brazil's *Bolsa Familia* provides eligible households with a monthly transfer that varies depending on the number of beneficiaries and the household's poverty level. Beneficiaries have to commit to a "Charter of Responsibilities", which outlines attendance at antenatal care, health and nutrition education and child growth monitoring sessions, as well as compliance with vaccination schedules, among other activities (Basset, 2008). The health sector participated in the development of the Charter and reports social workers on compliance with health-related conditionalities. Co-operation between sectors is key. Panama's *Red de Oportunidades* is a cash transfer scheme that provides a package of health interventions. The Ministry of Health prepared the guidelines for local authorities, training materials and software to central and regional staff to plan, coordinate and supervise activities. A monitoring and evaluation system was also

jointly designed to track the expansion of the package and measure the impact of nutrition interventions (World Bank, 2007).

Support in tailoring health and nutrition interventions adapted to local needs in the context of social protection schemes. *Juntos* is an income transfer programme in Peru that aims to improve human development. It targets the poorest rural households with children under the age of 14. It benefits around 4 million people. Together with an income transfer equal to US$ 35, the programme provides households with nutritional support, health-care interventions, educational opportunities and training. It also supports household members to obtain identification documents. Evaluations show positive impacts. There was a 30 per cent increase in immunizations among children under the age of one within the first year of operations. Another evaluation found that the scheme had led to a 61 per cent increase in immunizations of children aged 1–5 years (Barrientos, Niño-Zarazúa, Maitrot, 2010). Another study reported an increase of 65 per cent in pre- and postnatal visits to health-care facilities and a reduction in home births. This was a significant achievement, given the high levels of maternal mortality in the areas targeted by the programme (Barrientos & Niño-Zarazúa, 2011). *Juntos* is led by the Ministry of Social Development and Inclusion, which coordinates the work of several agencies and ministries. The health sector contributed in the design of an essential health plan that includes a package of interventions emphasizing maternal and child interventions as well as nutrition interventions. The Ministry of Health establishes mechanisms for the funding and purchase of these services, monitors their delivery, and identifies areas for improvement in the implementation of the package. The Ministry takes part in the joint work to design the targeting mechanisms of *Juntos.* It adjusts the content of the package of health interventions and proposes costing changes. Other areas of collaborative work include the design of a targeting tool based on the concept of multi-dimensional poverty. The Ministry of Health also supports the Ministry of Social Development and Inclusion in the creation, adoption, and maintenance of a beneficiary registry. Moreover, the Ministry of Health contributed micro-simulations of potential health and nutritional impacts that inform the expansion of the programme to new areas and populations.

Joint impact evaluations. In 2005, Brazil implemented the *Chamada Nutricional* as an evaluation component of the *Bolsa Familia* programme. It sampled 22 927 children, who attended health centres on a specific day and screened various health and nutritional aspects among children and mothers (Paes de Souza et al., 2011). This evaluation included measurements related to nutritional status, haemoglobin, breastfeeding status, compliance with prenatal care conditions, child growth, recent illness, and participation in food support programmes. This was a joint effort to monitor the effects of shared interventions and provided lessons for future policy developments (Basset, 2008).

Addressing increased health-care demand. *Familias en Acción* was introduced in Colombia in 2001 to assist poor families with children in rural and urban areas. The programme provides a nutritional subsidy of US $15 per month for children under the age of six. Children must attend growth check-ups and be vaccinated in preventive health visits prepared by health authorities. Attendance for check-ups by children under 24 months began at about 40 per cent and currently reaches 70 per cent (Attanasio et al., 2005a). The impact on anthropometric indicators translates to a 6.9 percentage point decrease in stunting (Attanasio et al., 2005b). The health sector funds health centres run by local communities, which carry out the activities related to the programme. The centres train local residents on health-related issues. The health sector monitors compliance of conditionalities together with local authorities.

Designing interventions and monitoring impact in the context of HIV programmes. The scheme implemented in Zomba District, Malawi, which included conditional and non-conditional cash transfer components, was instrumental in increasing school attendance and retention, and in decreasing early marriage, pregnancy and HIV infection rates (see Box 2). Although not a government intervention, it showed the potential for collaboration between health, education and social protection actors. Health practitioners contributed to the design of the conditional cash transfer component and prepared baseline and monitoring surveys. Other potential interventions to which the health sector could contribute include behavioural change communication strategies to promote safer sexual behaviours, campaigns to reduce the onset of sexual activity, as well as condom distribution.

Rethinking conditionalities, working with families. In Brazil, a new feature implemented since 2009 by *Bolsa Família* shows how the concept of conditionalities has evolved. Non-compliance of conditionalities (known as co-responsibilities) is now understood as a sign that a family is facing additional vulnerabilities that prevent them from complying (Veras Soares, 2011). Rather than penalizing families with the termination of the cash transfer, a social worker verifies the reasons why a family is failing to comply with the co-responsibilities and helps them to overcome them. Social workers work with families and coordinate with Social Assistance Reference Centres. These reference centres organize and supply basic social protection services in 80 per cent of the municipalities (Curralero et al., 2010). This is an opportunity for local health authorities to contribute to the work of social workers and the Social Assistance Reference Centres, in exploring ways to further support vulnerable families.

Working with other sectors to monitor compliance. Brazil recently created an intergovernmental and intersectoral forum that monitors co-responsibilities at aggregated level. This forum brings together representatives of federal, state and municipal governments. It includes participants from the education, health and social protection sectors (Veras Soares, 2011). This coordinating entity aims to inform the policy-making process of *Bolsa Familia.* The forum is charged with analyzing and proposing ways to increase the proportion of families with health co-responsibilities that are monitored every six months (the rate currently stands at 67.5 per cent) (Curralero et al., 2010), and to increase the number of families assisted by the Social Assistance Reference Centres when they fail to comply with co-responsibilities. Coordinating forums, such as this are common in many countries implementing social protection schemes. They provide an opportunity to explore ways of contributing to the achievement of social protection goals.

Contributing to the design, implementation and evaluation of active labour policies. Evidence shows that, during times of unemployment, active labour policies that provide the unemployed with opportunities for retraining and job seeking support as well as schemes for income security, have had a positive impact on health equity (EMCONET, 2007). Denmark and the Netherlands are two countries that are recognized as having a wide range of active labour policies, which have resulted in stable labour markets and relatively small health inequities among the population (both among the employed and the unemployed) (Diderichsen

et al., 2011). Health professionals play a crucial role in dealing with the health consequences of people who are unemployed or underemployed. They provide evidence on the health effects of unemployment and can also advocate for governments to adopt effective labour market and social policies that support the retraining of the unemployed and their effective reinsertion in the labour market (Benach, 2011). The health sector can also support these initiatives by measuring their impact on health equity.

Further readings

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Lagarde M, Haines A, Palmer N (2011). *Conditional cash transfers for improving uptake of health interventions in low- and middle-income countries. A systematic review.* JAMA, 298:1900–1910.

Forde I, Rasanathan K, Krech R (2011). *Public health agencies and cash transfer programmes: making the case for greater involvement.* Geneva, World Health Organization (Social Determinants of Health Discussion Paper No. 4).

Useful links

Sistema de Gestão do Programa Bolsa Família (SIGPBF). Programme of the Government of Brazil on conditional cash transfers for extreme poverty households: www.mds.gov.br/bolsafamilia.

Familias en Acción. Programme of the Government of Colombia on conditional cash transfers aimed at providing assistance to children and their families: http://www.accionsocial.gov.co/contenido/contenido.aspx?catID=204&conID=157.

International Policy Centre for Inclusive Growth (IPC-IG). A UNDP global forum for policy dialogue and South-South learning on development innovations. It equips policy-makers with the skills to design, implement and evaluate policies and programmes for high inclusive growth: http://www.ipc-undp.org.

GOAL 4. INTEGRATED AND TRANSFORMATIVE APPROACHES

SOCIAL PROTECTION MEASURES PROMOTE EQUITY AND SOCIAL CHANGE, AND ADDRESS THE STRUCTURAL CAUSES OF DEPRIVATION

Social protection challenges and policy responses

Structural forces (or determinants) can prevent poor, stigmatized and otherwise vulnerable households from accumulating assets, investing in human capital and maintaining a basic standard of living in spite of income transfer programmes. Structural determinants include issues such as social discrimination due to ethnicity, race, caste, gender, religion and class preventing employment or relegating individuals to specific types of employment. Many times, geographical location and under-investment in public infrastructure, conflict or social unrest may combine to reduce people's opportunities to break away from chronic poverty (CPRC, 2006). The lack of empowerment is a key factor that perpetuates disadvantage in society and poverty across generations (CPRC, 2009). Adopting integrated approaches to stimulate social actors to take on economic interests, and to implement interventions to change discriminatory practices are key strategies in addressing poverty and its structural causes. These approaches are referred to as transformative as they aim to address underlying inequalities that fuel chronic poverty (Devereux & Sabates-Wheeler, 2004). Interventions that are deemed as "technically" feasible very often have little impact on poverty reduction as they are adopted with no consideration for the structural forces that shape disadvantage (CSDH, 2008). These forces interact across four dimensions: economic, political, social and cultural. They are characterized by the unfair distribution of resources, and unequal access to capability required to meet basic needs and build cohesive societies (SEKN, 2008).

When confronting the structural forces that cause vulnerability, social protection needs to be implemented in conjunction with other social policies. In fact, initiatives to promote universal health coverage can often be transformative and provide windows of opportunity for social dialogue. The dialogue surrounding South Africa's National Health Insurance proposal is indicative of how dialogue in one area of social protection has initiated broader social debate around solidarity and addressing racial discrimination (McIntyre, 2011). Integrated approaches may be social protection initiatives that combine social services, such as health, education and food supplements, income transfers and legislative amendments.

Legislation is a common intervention used to address exclusion or discrimination. Although it does not guarantee change, it can help excluded groups to take advantage of specific interventions. These include, for example, legislation for the protection of minority groups (e.g. affirmative action for racial minorities, indigenous groups, employment or education quotas), regulations that promote gender empowerment or the protection of peoples with disabilities or vulnerable groups (e.g. child labourers, sex workers). These interventions aim to increase people's ability to effectively claim their rights and promote social mobility. Countries also implement awareness campaigns to promote inclusion. Another area of intervention is gender equity with programmes for women's employment and income-generating activities, such as microcredit, that address intra-household and community decision-making processes (CPRC, 2009). Social participation is also an area of policy work (CPRC, 2009). Similarly, with the design and implementation of integrative and transformative approaches, work with the private sector to address conflicting private and public interests is often required.

Integrated strategies are increasingly transforming governments. Often interventions that address poverty in its multiple dimensions require different government agencies, and social actors. Integrated interventions have often evolved from programmes that focus on material deficits to address human capital needs, to ultimately include sectors that address the structural forces of inequality. This is the case of India's National Rural Employment Guarantee Act. It was created to guarantee 100 paid workdays to all workers living in poverty who meet specific targeting criteria. Although not intended to promote gender equity, experience shows that women's participation had a positive impact on intra-household decision-making (Pankaj & Tankha, 2010). This led to legislative changes that now mandate equal wages and working conditions for women and men enrolled in the programme. Further changes will ensure quotas for women in the programme. Similar impacts on gender equity, and on the education and health of children living at home have been documented in *Mexico's Progresa* (now *Oportunidades*) (Skoufias & McClafferty, 2001).

Examples of health impacts and pathways

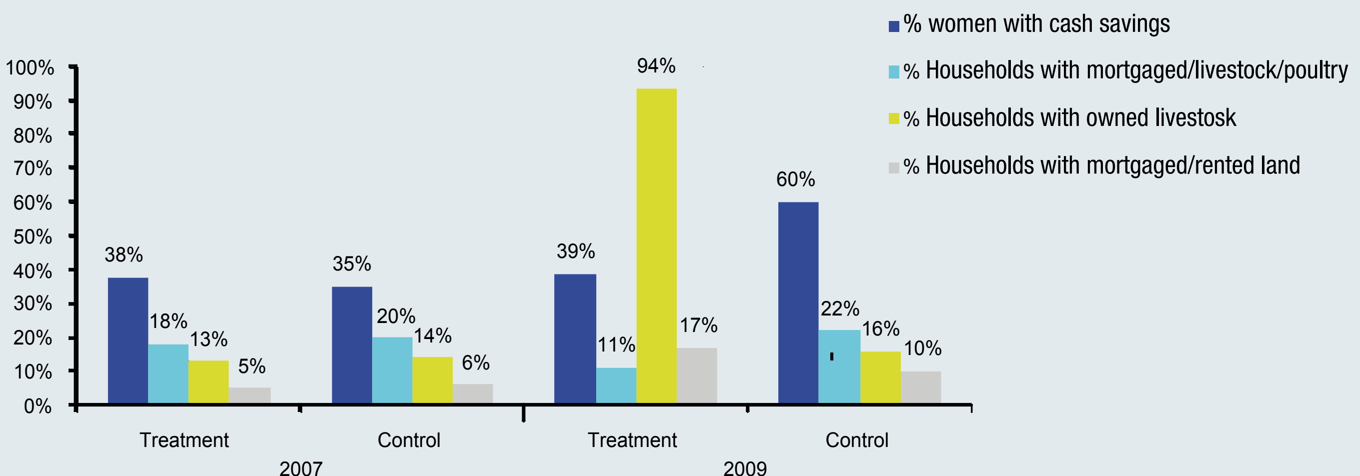
Integrated action to improve early childhood development. The path from interventions in childhood development to health impacts is complex. Frequently, interventions are implemented with little health sector involvement, and with little understanding of the links between determinants and health and, therefore, evaluations often do not document their health impacts systematically. Yet, there are some cases where impacts on determinants strongly linked with health, such as discrimination, gender norms or social participation, have been documented. For example, *Chile Solidario*, a social protection system to eradicate extreme poverty which supports 225 000 households in Chile was instrumental in increasing the rate of enrolment of children in early childhood services by 6 per cent between 2004 and 2006. The programme boosted school enrolment of children aged 6–15 years by 9 per cent and increased the use of the public health system by 8 per cent overall. Health visits for preventive care were increased by 6 per cent for children under six years old and by 7 per cent for women (Galasso, 2006). Evaluations also found an increase in the share of employed adults. In terms of well-being, the evaluation found an increased optimism about the future among the beneficiaries (Veras Soares & Silva, 2010).

Box 4. SOCIAL DETERMINANTS AND EQUITY FOCUS

Bangladesh has a population of 145 million. It is estimated that 70 million people (almost 50 per cent of the population) live in extreme poverty (earning less than the equivalent of US$ 1.25 a day). According to World Bank data, approximately 55 per cent of the population over the age of seven cannot read or write. It is estimated that people living in extreme poverty in the country spend 80 per cent of their income on food and very often they fail to reach a minimum level of caloric intake. Challenging the Frontiers of Poverty Reduction – Targeting the Ultra Poor (CFPR/TUP) is a programme addressing extreme poverty. It evolved from previous income support schemes that for more than 30 years had tried to help people escape from poverty. Yet, despite the vast amounts of development assistance invested, in many cases, they failed to reach poverty reduction goals.

In addition to the traditional income transfer components, the programme includes several transformative elements to assist people in escaping from poverty. These include social awareness interventions, gender empowerment activities, access to education opportunities, and community mobilization components. A recent evaluation comparing control versus treatment groups showed how individuals benefiting from the transformative elements were more easily able to translate cash benefits into productive assets than the group receiving income transfers alone. Figure 3 shows the results of the evaluation. Starting from a similar base for both treatment and control groups in 2007, in 2009 the treatment group had a higher rate of conversion of cash savings into a variety of productive assets and reduced mortgaging of livestock. The treatment group ownership of livestock or poultry (yellow) increased from 13 % to 94% as compared with the control group's increase of 14% to 16%. Mortgaged livestock or poultry (light blue) decreased in the treatment group from 18% to 11% compared with a rise in the control group from 20% to 22%. Finally, mortgaged or rented land increased in the treatment group from 5 % to 17% compared with a lower increase, from 6 % to 10%, in the control group.

Figure 3. Pre- and post-analysis of CFPR household interventions, Bangladesh, 2007–2009



Source: Das and Shams (2011).

What can both sectors do together?

Gender empowerment and social protection. Colombia's *Juntos* is an integrated strategy of several ministries to complement the *Familias en Acción* programme. It focuses on 1.5 million households in extreme poverty. The programme has set 45 targets to reduce poverty in areas such as civil registration, income transfers, education, health, nutrition, housing, families, and access to credit lines and the judicial system. It combines income transfers and gender empowerment. The health sector runs public health campaigns and advocacy activities to prevent gender violence. The programme includes health interventions according to a protocol prepared with the Ministry of Social Protection focusing on family health, reproductive rights and health education. A key element of *Juntos* is its work with mothers (Veras Soares & Silva, 2010). The health sector organizes care meetings and family meetings to discuss and interact with so-called "mother leaders". They are elected by beneficiaries to represent them and check compliance of conditionalities. They also undertake community work and deal with the different public agencies and local governments. Forums are held for women to discuss their needs and improvements to the interventions with managers.

Supporting eradication of discrimination. Societal norms can strongly contribute to chronic poverty and the reinforcement of social attitudes that keep the poor vulnerable to social risks. In addition to economic impacts, social attitudes, such as discrimination, put people affected by disease (e.g. HIV/AIDS, tuberculosis) under pressure making it difficult for them to secure employment, increasing social exclusion and stigma, decreasing access or use of health services, and deepening vulnerability (e.g. widows or orphans). The health sector has successfully participated in campaigns against discrimination improving the impact of social protection initiatives and access to health services (e.g. treatment action campaign in South Africa). Also, the Red Cross Society in Uganda launched a two-year anti-stigma campaign in 2002 for people living with HIV/AIDS by challenging pre-employment HIV tests and employers' dismissal of HIV-positive workers (Devereux & Sabates-Wheeler, 2004).

Health interventions as a gateway for broader empowerment. The Sonagachi Project in Kolkata, India, started in 1992 as an initiative focusing on medical interventions to prevent HIV/AIDS among sex workers.

The project, which was launched by the All India Institute of Hygiene and Public Health (AIIHPH) evolved over the years as it was recognized that in order to improve health it was critical to improve the living and social conditions of the targeted population. The agency implementing the project partnered with different ministries and local NGOs in order to move beyond traditional prevention and medical approaches. Initially, interventions included vaccination and treatment, and later included literacy campaigns, political activism, advocacy, microcredit schemes and cultural programmes. Over time, members created their own organization, the Durbar Mahila Samanwaya Committee (Durbar) that was able to negotiate better treatment by madams, landlords and local authorities (WHO & PHAC, 2008). In 1999, Durbar took over management of the project and expanded it to 40 red-light districts. Currently, it has a membership of 2 000 sex workers and the informal participation of 65 000 people (Durbar, 2007). The empowering effects of the project were further increased when participants established a social protection mechanism comprising a financial cooperative to facilitate access to material and human capital assets by funding productive undertakings including small businesses and micro enterprises. This group had lower rates of HIV and other sexually transmitted diseases, when compared to similar groups in the rest of the country (Durbar, 2008).

Promoting participation in public policy-making. Brazil's constitution has adopted principles for social participation in all phases of public policy-making. A mechanism to implement these principles is public councils, where civil society and government departments participate. These councils have the capacity to define, implement and ensure social control of specific public policies (Cicconello, 2008). Consultative councils are established on issues such as health, gender, youth, food security, urbanism, racial inequality and public transparency. There are 35 councils at the federal level, while at the local level 20 000 councils operate in Brazil's 5 564 municipalities. These councils discuss social issues, health care, children and adolescent well-being, rural development, housing, etc. Other councils deal with policy issues related to education, labour and income, food security, culture and cities, which could increase this figure to approximately 40 000 (Cicconello, 2008). Moreover, in 2004, Brazil created the Economic and Social Development Council (CDES) to advise the president when formulating major policies ("social pacts") on development issues, taxation, social security reform, investments in infrastructure and social issues. All these are important spaces for political debate and dialogue where future legislative propositions are often discussed and where health, as a key driver in social protection, should be present.

Engaging the private sector when addressing structural drivers of poverty. The private sector has a key role in influencing working conditions. Although conflicts of interest often prevent joint action, some collaborative initiatives have shown the potential for working jointly to successfully address chronic poverty. Recently, eight international corporations in the chocolate industry have pledged funds to a groundbreaking public-private partnership (PPP) with the ILO to combat child labour in cocoa growing communities in Côte d'Ivoire and Ghana. Both of these countries account for 60 per cent of the global production of cocoa with large numbers of children performing farming tasks. The focus will be on strengthening the capacity of governments, social partners and cocoa farmers to combat the worst forms of child labour, supporting the development and extension of community-based monitoring systems and enhancing coordination with national child labour committees. Although it remains to be implemented, it has the potential to show how the concerted action of the stakeholders, who often have opposing interests, can address an issue that perpetuates chronic poverty. Child labour is a key area for the health sector to promote health equity.

Shaping social protection programmes and government collaboration. The conceptualization of poverty as a multidimensional problem is influencing the way governments organize their operations and, in this sense, is having an impact on "structural determinants". *Chile Solidario* provides benefits to chronically poor families, the elderly, homeless people and children with one parent in prison. It coordinates several other programmes including housing and food security, and for the first two years in the programme provides subsidies to families for water and sewage services, ID cards, child allowances, social pensions and disability grants (Veras Soares & Silva, 2010). In providing the integrated services of *Chile Solidario*, the Government of Chile created a "social cabinet" under the direction of the Ministry of Planning, and several other ministries and public agencies. The social cabinet reports progress to the president. The Ministry of Planning coordinates the budget and strategic planning, and negotiates the design of delivery models with participating ministries and local agencies. It also coordinates with funding and management entities. This integrated programme requires the joint efforts of 10 ministries, institutions and public entities from health, education, employment, housing and justice with a common mandate. These structures, coupled with "supply side" interventions (e.g. income transfers) have broken the traditional silo cultures in public administration that often result in uncoordinated responses. While the Ministry of Planning leads the programme, the health sector cooperates in assessing the needs of the targeted populations, and ensures collaboration between the health services and local governments.

Further readings

Sabates-Wheeler R, Devereux S (2007). Social protection for transformation. *IDS Bulletin,* 38:23–28.

UNICEF (2011). *Integrated social protection systems: enhancing equity for children.* New York, NY.

Useful links

Governance and Social Development Resource Centre (GSDRC). The GSDRC provides cutting-edge knowledge services on demand and online. It aims to help reduce poverty by informing policy and practice in relation to governance, conflict and social development: http://www.gsdrc.org/.

Surfer

SUMMARY MESSAGES

Reducing vulnerabilities is key to addressing the social gradient in health and to ensuring social protection for all

- A country health policy is key for universal social protection. The more equitable a health policy, the more it will ensure financial protection from catastrophic health expenditures. This will prevent impoverishment, and create resilience against external shocks, improving living conditions and health.

- Poverty and vulnerability are multidimensional. Their causes go beyond material circumstances to include deficits in human capability (e.g. health or education) as well as social, political and cultural factors. Different from past approaches that focused on the current material causes of poverty, there is a broad consensus that social protection should address all these dimensions and break intergenerational cycles of poverty.

- Traditional social protection models are limited in providing information on how countries can organize protection regimes, in particular with reference to health. Policy-makers are exploring new ways to ensure all people are protected from impoverishment due to health expenditures and other shocks. There is an increasing consensus that social protection entitlement should be detached from employment status. A key challenge in developing sustainable social protection systems is to find ways of ensuring solidarity between formal and informal workers.

- Social protection policies play an important role in economic growth and development. They enhance productive capacity and employability. By improving access to health, education and other training opportunities, they improve human capital by raising income levels. They also raise labour market efficiency, reducing underemployment. Income transfers make beneficiaries credit-worthy and have an impact on the dynamics of financial markets, and social and income redistribution.

- Social protection can contribute to government-wide measures to create enabling environments through legislation to reduce stigma or exclusion, which can improve the health of the most vulnerable across a range of communicable and non-communicable diseases.

There is a new role for health in working with the social protection sector: cross-cutting functions

The health equity imperative and the intersectoral actions described above provide specific examples of a new role for public health, which were outlined in the Adelaide Statement on Health in All Policies (WHO & Government of South Australia, 2010). Yet the health sector's pivotal role within a robust social protection system is gaining renewed acknowledgement through WHO's promotion of a clear position on the principles for a progressive realization of universal coverage. Beyond health services, the health sector can also contribute more systematically to the development of innovative tools being developed by the social protection sector to address other health determinants. Some notable areas include:

- monitoring trends and outcomes for both populations and specific groups through disaggregated data that uncover the equity impacts of social protection and health policies;

- encouraging needs-based assessment of disadvantaged populations and specific groups in order to better design actions that increase transformative social protection and improved health outcomes of hard-to-impact segments of the public;

- developing guidelines, standards and recommendations on social protection-related risk factors, and disseminating technical guidance as a shared responsibility for both health and social protection actors;

- supporting the participation and empowerment of the different actors in the social protection community to address both social protection and health challenges.

There are many entry points for health stakeholders to work with social protection stakeholders.

There are many entry points for better synergy across health and other social protection stakeholders. Table 2 summarizes shared interests and provides examples of areas for collaboration.

Table 2. Summary of areas for collaboration between health and other areas of social protection

SOCIAL PROTECTION ISSUE	AREAS OF COLLABORATION
Health, social services and insurance schemes	• Health and other social services and insurance share a common interest in both protecting the vulnerable in society and in ensuring the realization of the rights of all to social security, as described in the United Nations' Universal Declaration of Human Rights. Having health services oriented towards pooling risk and reducing out-of-pocket health-care costs for individuals contributes to ensuring more predictable levels of household income, enabling better planning for asset investment and human capital development. Old-age pensions, disability and unemployment benefits also serve to stabilize income in the face of adverse economic, environmental or health changes. • Health and other areas of social protection can collaborate on the development and promotion of universal social protection policy frameworks that are resilient to changes in economy prosperity. The health sector has an important role to play in promoting the sustainable financing of universal health care and in making a more broad case for counter-cyclical social policies. Health can also contribute to other social services by designing health service responses within community social protection schemes and by helping to target vulnerable groups. Pension transfers and health services can benefit from legislation that supports greater flexibility or responsiveness in the administration of entitlements for the population in terms of portability.
Income-only transfers (in cash or in-kind)	• In the context of pure income transfer programmes addressing poverty, both sectors have an interest in ensuring all households have a minimum level of income, shelter, nutritious food and transport. • Social protection and health authorities can work together to ensure that: 1) people are aware that they can access health services and are referred appropriately to other social services; and 2) beneficiaries of social services are reached through health promotion and public health campaigns. Health can also contribute to the implementation of in-kind income transfers. Examples include providing feeding programmes, or developing guidelines on recommended daily caloric intake and dietary content of food.
Income transfers plus services	• Adding training and other services to income transfers for households vulnerable to poverty is feasible in many different country settings. These types of social protection initiatives cause poorer and disadvantaged households and individuals to make greater investments in human capital and to retain assets, which are important for health. • Cash transfers coupled with training, health-related interventions, and income-generating opportunities provide both health and other social protection agencies with a wide field of win-win actions. The health sector can contribute to the design of these schemes, follow up on compliance with conditionalities, if necessary, and support evaluations. Evaluations are key in learning how to improve the effectiveness of programmes and to support individuals and communities in overcoming barriers to services.
Integrated and transformative approaches	• Structural determinants prevent poorer, stigmatized and otherwise vulnerable people from accumulating assets, investing in human capital or participating in society. Tackling them is key when addressing health inequities and ensuring a resilient society where empowered individuals are protected from negative life shocks. • Action should link social protection to broader social policy issues. Common areas of action include campaigns promoting gender equality backed by appropriate legal measures, access to housing services, affordable access to capital goods for self-employment or banking services, removal of discriminatory employment practices in the private sector and comprehensive social services, such as education and health. In addressing the processes required to shape the structural forces of society to the benefit of the disadvantaged, provisions should include the active involvement of the most discriminated and vulnerable population groups in formulating public policies and interventions.

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