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Debate

Health Insecurity and Social Protection: Pathways, Gaps, and Their Implications on Health Outcomes and Poverty

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Abstract

Health insecurity has emerged as a major concern among health policy-makers particularly in low- and middle-income countries (LMICs). It includes the inability to secure adequate healthcare today and the risk of being unable to do so in the future as well as impoverishing healthcare expenditure. The increasing health insecurity among 150 million of the world's poor has moved social protection in health (SPH) to the top of the agenda among health policy-makers globally. This paper aims to provide a debate on the potential of social protection contribution to addressing health insecurity, poverty, and vulnerability brought by healthcare expenditure in low-income countries, to explore the gaps in current and proposed social protection measures in healthcare and provide suggestions on how social protection intervention aimed at addressing health insecurity, poverty, and vulnerability may be effectively implemented.

Keywords: Health Insecurity, Social Protection for Healthcare, Poverty, Vulnerability

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1. Introduction

Health insecurity has emerged as a major concern among health policy-makers particularly in low- and middle-income countries (LMICs).[1-4] It includes the inability to secure adequate healthcare today and the risk of being unable to do so in the future as well as impoverishing healthcare expenditure. World health statistics reveal that out-of-pocket payments for healthcare represent from one third to three quarters of the total expenditure in low-income countries.[5] However, these payments have a recognised negative impact on low-income households' welfare.[6,7] The observed increasing health insecurity among 150 million of the world's poor[7] has moved social protection in health (SPH) to the top of the agenda among health policy-makers globally.[2] The World Bank describes SPH mechanisms as public interventions that: assist households and communities to better manage financial risks caused by health expenditure as well as provide support to the critical poor. Many such mechanisms aim at removing financial barriers preventing access to uptake of existing healthcare services or providing incentives for their uptake and protecting poor people from the impoverishing effects of medical expenditures.[2,8-11]

Specifically, SPH consists of a menu of policies that addresses health, poverty and vulnerability, through user fee removal, fee waivers, social assistance in healthcare, social health insurance and other similar schemes such as result-based financing mechanisms aimed at increasing access to healthcare among disenfranchised communities.[8-11] Recently, SPH has been reformulated as an essential characteristic of universal health coverage and has attracted greater attention. It has been part of the World Health Assembly agenda[12] and United Nations (UN) General Assembly resolutions[13] and is strongly advocated to become one of the post-2015 millennium development goals.[10]

The proposed sustainable development goals (SDGs) 1 and 3 will concentrate on full implementation of nationally appropriate social protection measures, with a focus on coverage of the poor, in particular the most marginalised and people in vulnerable situations.[11,14-17] Similarly, international development agencies[1,2] and organisations within the UN family have adopted and adapted social protection strategies and policies within the health sector. Furthermore, a growing number of national governments in low-income countries are developing and adapting national social protection strategies in their national (health) plans.[11] There is also a rising interest in social protection among health system researchers, medical research institutes and higher education organisations.[7,18] However, despite global and local interests and adoption of social protection interventions in LMICs, the implementation, uptake, equity and effectiveness of current social protection interventions are limited by various factors.

This paper has three main aims: first, to provide a debate on the potential of social protection contribution to addressing health insecurity, poverty, and vulnerability brought by healthcare expenditure in low-income countries.[19-21] Second, to explore the gaps in current and proposed social protection measures in healthcare, and third, to provide suggestions on how social protection intervention aimed at addressing health insecurity, poverty, and vulnerability may be effectively implemented.

Unlike a standard and structured review paper, in this paper we adopted the approach in debate articles, where a convenience sample of the literature is reviewed and cited accordingly to inform the debate.[22-24] We, therefore, purposively conducted a review of PubMed, EconLit, country report, and UN organization documents to identify gaps in the current SPH mechanisms that specifically examined issues in low-income

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countries.

The paper consists of four main sections. Section 1 provides the introduction and some policy discussion on health insecurity, poverty, vulnerability, and social protection. Section 2 reviews gaps in the existing and proposed social protection measures in the health sector from a low-income country perspective. Section 3 examines different approaches that could bridge the gaps in existing and future social protection mechanisms. Finally, a conclusion gathers together the main points of the paper and concludes on possible approaches linking health insecurity, poverty, vulnerability, and social protection to broader global health agenda.

2. The Pathways and Gaps in Current Social Protection Mechanisms in Health

Literature on social protection in healthcare suggests that social protection measures will follow a range of pathways in different countries, depending on the nature of their existing institutions, the level of their economic development and the features of their economic transformation, particularly the interaction between short-term and longer-term changes in the global health agenda,[10,25-27] as well as demand and supply side factors. Demand factors include information on healthcare choices/providers, education, direct and indirect costs, price and availability of substitute services. In contrast, supply side factors are elements (resources) that interact to produce healthcare service and are derived from the healthcare production function.[28]

In this regards, the performance of SPH can be assessed in terms of different evaluation criteria, including health security, poverty reduction, and non-vulnerability state. At the root of much of these outcomes is the simple interactions between the consumer and the provider of healthcare services, in which demand for healthcare services is met by the provision of that service. Consumers are linked to demand side factors (pattern of usage and demand of the population, and the resulting potential workload) while providers are linked to supply side factor (human, physical, and other resources required to provide services). The literature has highlighted four supply side factors that constitute constraints in SPH namely; institutions, human resources, infrastructure, and funding.[28-32]

SPH role is, therefore, to balance demand and supply through the mechanism of purchasing and contracting as well as deployment of resources.[28] Effective balancing in this context requires significant data and information resources. Contrary to these pathways, much discussion within social protection in the health sector has focused on demand side strategies, particularly on instruments such as user fee removals and social insurance schemes.[33-35] While these mechanisms have a number of advantages relative to alternative healthcare financing mechanisms, it is highly unlikely that social protection measures focused only on user fee removal and social insurance schemes could achieve the diverse objectives of protecting households from health insecurity, promoting asset accumulation, strengthening productive capacity, and inclusion as well as reducing poverty, vulnerability, and inequality.

Furthermore, it is important to caution that balancing demand and supply factors may not guarantee health security, poverty reduction, and non-vulnerability state as other factors may be at play, for instance macroeconomic and political instability as well as governance and corruption in the healthcare system.[1,2,10,14,17] It is, therefore, crucial that discussions around social protection in healthcare shift from the current focus on single instruments to broader integrated interventions or a mix of interventions, capable of addressing these diverse objectives.[36-39]

Integrated social protection programs[39,40] play a central role in mitigating against the impact of health insecurity, poverty, and vulnerability due to healthcare expenditure.[17,35,38] The combined effects of worsening health insecurity, poverty, and vulnerability as a result of out-of-pocket healthcare expenditure and a weak social protection response set the scene, not only for severe poverty and inequality in the medium and long term, but also for stifled economic development.[12,13,36] Important to all policy-makers in the health sector is an understanding of what determines the success of SPH in reducing health insecurity, poverty, vulnerability, inequality, and promoting productivity.

Depending on their financing mechanism, design and implementation, SPH interventions affect a country's economic performance in different ways. This is so, as poor health significantly hinders the social and economic development of a country: beyond affecting household's well-being (reduced life expectancy, higher infant mortality, spread of infectious diseases, etc.), poor health also lowers the productivity of the labour force and threatens the entire economy.[2,18] The underlying hypothesis here is that SPH can reduce the disease burden but enhance economic activities that lead to greater economic output and growth: hence, spending in SPH is an investment rather than expenditure. However, this hypothesis only holds when the SPH mechanism has a supportive external environment.[7,22]

The external environment among other factors includes the characteristics of the healthcare sector, institutional arrangements, financial sector, and the political state of the country. Most of these external factors are likely to influence health sector policy and can potentially be key determinants of the success or failure of SPH mechanisms to achieve their objective of health security, poverty reduction, and non-vulnerability state in the long term.[14-17,22,41]

For instance, in situations where the legal system is weak, contractual agreements between funders of health services and healthcare providers are less likely to be binding, reducing the potency of the contract. Similarly, lack of functioning regulatory mechanisms can influence the state's ability to both monitor the action of the healthcare providers and to place sanctions on them if they are not meeting minimum standards. In addition, the absence of a sophisticated financial system may potentially affect financial audit and accountability of social protection mechanisms. The foregoing suggests that weak institutions, financial systems and political structure together provide an opportunity for corruption and may impede SPH effectiveness.[14-17,22,41]

In addition to the external environment, it is also important to highlight the interaction of demand and supply side factors in SPH mechanisms. In this paper, demand side factors are defined as elements that influence the response of health service users and that operate at the individual, household

or community level. Although demand side factors are the prominent features of SPH, there is need to consider the joint effect of demand and supply side changes in formulating predictions about usage change due to SPH mechanisms. Specifically, how supply factors limit social protection mechanism's ability to significantly improve utilisation and access to essential healthcare services as well as financial protection.[8,38]

To date, evidence suggests that SPH has mainly focused on demand side factors, while supply side factors related to resources, capacity , institutions and incentives have received less attention.[15-17] However, for SPH to function as intended, there is need for micro approaches to analyse the delivery of healthcare services from the supply side as well, and determine ways to strengthen the supply side in order to maximise the benefits of SPH. This implies that approaches to strengthen supply side factors in SPH warrant further research, as these may be potent alternatives to the dominant demand side approaches.[22,23,33,37]

While there is not a single definition to institutions that can be applied in all contexts, several messages emerge from the experiences of the global health community on how institutions impact SPH and the health system in general.[39,41] In terms of SHP, institutions refer to the recognized structures of rules and principles within which purchasers, providers, and government agencies operate, including such concepts as enforcement, governance, and accountability.[37] There are indications in the literature that current SPH policies rely on institutional arrangements that do not fully support them. Thus, there are no functional enforcement and accountability mechanisms to deter stakeholders from deviating from SHP objectives.

In addition, it is important to understand that the apparent absence of SHP supportive institutional structure has an impact on the functionality of other policy strategies. The impact is mostly due to the additional administrative burden created by the SPH policy strategy, by assigning the already scarce skilled health personnel, enforcement, governance and accountability roles, instead of leaving them to concentrate on core healthcare issues.[41]

Similarly, the health sector in most low-income countries has experienced a chronic shortage of healthcare workforce mainly due to low numbers of people being trained, very high attrition rates of existing staff migrating to the private sector and overseas[29,30,32] and the loss of skilled health workers to HIV and AIDS.[24] Considering that SPH mechanisms are implemented in an environment of human resource shortages, and that human resource numbers will not keep pace with the policy, it is not surprising that human resources shortage have resurfaced as one of the challenges impeding successful implementation of the policy.

Furthermore, some reports and evaluation studies on SPH have claimed a lack of essential items that make up a functional infrastructure including basic medical equipment, improper functioning equipment, poor and absent equipment repair, lack of complementary utilities such as running water, electricity and electricity backups and fridges for vaccines.[10,31,34,37,40] Given these problems, the quality of services in general can be no better than the infrastructure. However, this has implications for utilisation of services at these facilities, implying that without newly strengthened infrastructure, SHP cannot be sustained.

Importantly, the health sector in most low-income countries is financed through general taxation and donor support. This being the case, there are concerns about instability owing to the small tax base, lack of effective taxation mechanisms and unpredictability of international aid.[10,24,39,43-45] These concerns have been exacerbated by the emergency of SHP in the health system and further compounded by greater demand for healthcare services offered, implying greater need for more financial resources in the health sector.

The need for more financial resources is partly demonstrated by inadequate infrastructure and shortage of skilled healthcare personnel as illustrated earlier. Paradoxically, this is related to financial sustainability or the extent to which national expenditures are funded from domestic resources or provide long term stability based on a mix of funding sources.[10,24,39,42-44] Unfortunately, the analysis of SHP funding mechanisms suggests that the current financial arrangements do not fully support, and would not guarantee the continuity of funding for SPH in the absence of development partners.

3. Closing the Gap

The discussion on pathways and gaps show a potential for doing harm if SHP are not well-designed, implemented, and supported by the external environment as well as corresponding demand and supply side interventions. This implies that SHP should address both demand and supply side factors in order to achieve meaningful benefits from this policy instrument.[10,14,17,24,40,43] However, it also entails considerable improvement in the capacity, financing, and institutional arrangements.

Similarly, SPH initiatives in most low-income countries are constrained by historically and socially determined institutions and organizations.[38] However, for SPH to work better there is need to alter or adapt institutions and organizations that govern them. Nonetheless, given the environment in which social protection mechanisms are implemented, in which high levels of organizational fragmentation are combined with multiple agency relations and plural modes of governance, it may require application of significant resources to negotiate, implement and manage delivery of public health programmes through SPH.[10,17,24,40] This suggest that there is need for institutional reforms to support SPH policies. Specifically, the reforms should focus on how various stakeholders will interact and support social protection mechanisms.

Furthermore, the analysis in this paper has highlighted that the current SPH financial arrangements do not fully support, and may not guarantee the continuity of social protection mechanisms in the absence of development partners who contribute to the national health sector budget.[46,47] Achieving continuity entails that domestic financial resources are able to fund recurrent operational costs beyond development partner's support. However, this implies that government should find alternative sources of funding to ensure the continuity of SPH mechanisms.

The foregoing suggest that, SHP policies should, therefore, ensure continuity of funding for social protection and increase public social spending in order to sustain the availability of

drugs, equipment and medical supplies, and qualified health personnel in health facilities, given that these factors pose a key constraint for the poor to access quality healthcare.

4. Conclusions

This paper has sought to contribute to the debate and better understanding of the relationship between health insecurity, poverty, vulnerability, and SPH. Notably, it aimed at assessing the pathways and gaps in SPH mechanisms and how they have impacted access to essential healthcare services, poverty, and vulnerability.

In general, SPH mechanisms have been constrained by the mismatch between the demand and supply side factors. These constrains are mainly related to lack of supportive institutions, shortage of skilled labour force, inadequate healthcare infrastructure, and limited/unpredictable financial resources. The existence of these constraints imply that SPH have not adequately supported the provision of appropriate health services that meet the health needs of the intended beneficiaries. Hence health insecurity, poverty, and vulnerability may still persist in the presence of SPH.

The current constraint in SPH mechanisms suggest that there is need for further research on how SPH mechanisms may be adequately structured to incorporate both supply and demand side factors as well as include broader integrated interventions or a mix of interventions and institutional reforms capable of addressing diverse health security, poverty reduction, and non-vulnerability related objectives.

Ethical issues

Not applicable.

Competing interests

The author declares that he has no competing interests.

Author's contribution

EG is the single author of the manuscript.

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