Enabel

Social Health Protection,
a path to fight against inequalities

Fact sheet 8

Building universal health insurance that maximises equity: risk analysis and mitigation measures, a decision support tool

Definition of inequality & types of inequalities

The WHO defines equity as "the absence of unfair, avoidable or remediable inequalities between groups of people, whether these groups are defined socially, economically, geographically or demographically or by other dimensions of inequality (e.g. sex, gender, ethnicity or disability)." This definition is related to the definition of Whitehead and Dahlgren (2007): «Three distinguishing features, when combined, turn mere variations or differences in health into a social inequity in health. They are systematic, socially produced (and therefore modifiable) and unfair.» Consequently, inequity is not only about differences, but also about the fact that these differences are unfair, modifiable and systematic.

Inequity is a multi-faceted concept that covers multiple areas of life (health, family life, socio-economic status, etc.). Nevertheless, this note focuses on inequity in the health sector and social protection measures in health.

There are different **types and levels of inequities in the health sector** within a country:

- **between regions**: between rural and urban areas, between regions that are rich and poor in (health care personnel) human resources , but also between economically rich and economically poor regions;
- **between types of schemes**: social protection schemes for civil servants, pensioners, the private sector, the informal sector and the 'indigent' vary between each other;
- **between beneficiaries**: not all beneficiaries have the same income (rich and poor). This is what is known as "vertical inequity".
- **between groups of beneficiaries**: i.e. between men and women, age groups, ethnic groups, types of disabilities, legal status (migration), etc.
- **between medical specialties**: to give an example, there are often many more gynaecologists than urologists in a country, which therefore represents a challenge to meet all the needs of the beneficiaries (supply and accessibility);
- all this plays a part in the inequity **between people**. Moreover, within this inequity between people, we also find the inequity between people living in areas without health insurance and those living in areas covered by health insurance.

Equity is therefore a complex concept. Choices have to be made because it is not possible to achieve absolute equity. You have to go gradually and analyse the context carefully to make deliberate choices. It is **a path that must aim at universality**.

The importance of a focus on inequity

Inequality is recognised worldwide as one of the main factors hindering the harmonious development of countries, generating and maintaining poverty, injustice, lack of credibility and of legitimacy of states in the eyes of citizens and societal instability. As a driver of poverty, inequality and injustice push some people and groups into poverty and at the same time prevent them from getting out. This is therefore a major challenge for all countries in the world.

Universal Health Coverage (UHC) and Social Health Protection (SHP) **may** contribute significantly to the fight against inequalities in a society and thus to social stability, the credibility and legitimacy of the state and social justice. Nevertheless, several social (health) protection measures have, curiously and unintentionally, exacerbated situations of inequity in some countries, despite laudable intentions and real efforts by states to manage problems of inequity in society. This is why decision-makers should take this phenomenon into account at all times.

Reducing inequity is one of the objectives of Universal Health Insurance (UHI) but it is also an objective of Social Health Protection as a whole. Equity is an important value for making real progress on Universal Health Insurance and for achieving all the Sustainable Development Goals (including SDG 10: Reduce inequality within and among countries). If Social Health Protection is well thought out, it becomes a **catalyst for the development of a progressive cycle** of greater equity, following an investment logic.

Nevertheless, societal inequity can be explicit and implicit, and often behaves in unexpected ways or goes unnoticed. Although important, equity is only one of several values in the health sector. Also health outcomes, efficiency, effectiveness and sustainability are among the values that decision-makers must consider. In this context, the choice to focus on another value may be at the relative expense of equity. A certain degree of inequity is therefore probably unavoidable, but being aware of it makes it possible, in a second stage, to remedy it. Thus, we are sometimes too oriented towards the results to be achieved according to the indicators and targets. We lose sight of fairness. We work with the most affluent and easiest to reach people (the 'low-hanging fruit').

Therefore, decisions in the field of Social Health Protection must be preceded by an analysis of the inequity and possible perverse effects of the decision taken. If greater equity is to be achieved in society, then vigilance and decisiveness are required. Examples of this are given later in this note.

In general, if equity is to be addressed, a **holistic and long-term approach** is needed. In particular, four principles of decision-making are considered vital to fostering fairness:

- The beneficiaries must be involved in the development of appropriate policies. To achieve a meaningful participatory logic, it is necessary that the participants are trained and that the process is transformative: **The people have a voice**.
- The measures should focus on the bottom 40% of the income distribution. In doing so, the decisions will call for **solidarity** between the rich and the poor;
- Accountability in implementation is imperative to avoid, for example, corruption and 'under-the-table' payments. It is therefore necessary to build an environment that is conducive to accountability, i.e. to put in place the means, measures and procedures necessary to control and maintain the system in the desired direction.
- A country-wide approach is recommended to avoid creating tensions between regions. Inequities between different regions, between urban centres and rural areas, between rich and poor neighbourhoods, between densely populated and sparsely populated areas need to be addressed.

Areas for developing SHP/UHI and potential unintended adverse effects

The following table illustrates classic and other areas of decision-making, all of which can have perverse implications for equity.

Decision area	Risks of perverse effects on equity
Civil status as a condition for access to social protection measures	Poor and/or rural families find it more difficult to access civil status documents, such as a birth certificate. If such a certificate is a condition of access, the poor and/or rural population will run a high risk of being unable to access social protection measures. Yet, everyone agrees that civil status for the entire population is an important means for increasing the efficiency of all social protection measures.
Human resources in the health sector and in UHI must be evenly distributed over the territory and work in acceptable conditions	An equitable distribution of the health workforce is very difficult to achieve in many countries. Nevertheless, there is room to partly remedy this unequal and unfair situation.
Digital access to social protection measures	Digitisation of healthcare services and UHI almost by definition increases the efficiency of services, for example, by facilitating access. However, there is a strong digital divide in many countries, which consequently disadvantages a large part of the population.
Initiate SHP/UHI	Given the limited financial resources, Social Health Protection sometimes competes with other social protection measures. For this reason, a social protection authority should oversee all initiatives, including SHP.
Non-compulsory health insurance and high membership fees	Voluntary membership carries the very real risk of adverse selection (only high-risk individuals pay the fee). If contributions are too high, poor people cannot pay.
Membership fee that does not take into account household income	Incomes vary between households and families. An identical membership fee for all would then result in low-income households and families not being affiliated to SHP/UHI because they cannot afford to pay the fee. Again, faced with an access barrier, families will be left without protection.
Free access for certain target groups due to age or illness	Widespread practice, but ultimately unequal. Those who do not benefit from the free-of-charge policy do not have access to care, although they may need more substantial care. A 6-year-old child has no protection when he or she is seriously ill. A woman who is not pregnant may die of malaria because she has no financial access to care and cannot leave her children alone.
Direct taxation to finance social protection	VAT is often used to finance Social Health Protection. However, the rich are likely to be much less affected than the poor.
Pilot experiments in favourable areas	Pilots to develop a model SHP system are commendable, but carry the risk of not being followed by scaling up and also raise ethical questions. The populations targeted by pilots will enjoy greater protection than those not targeted. Moreover, if the experience is a failure, people who may have been dependent on protection may find themselves without protection overnight. Firm decisions by the state and alignment of the TFPs are therefore essential to overcome such situation.

This fact sheet is part of a series of 8 fact sheets

1. The role of health-care performance pricing in the organisation of Social Health Protection/Universal Health Insurance
2. Incorporation of free-of-charge policies in a single national system of Social Health Protection/Universal Health Insurance
3. Contracting process
4. The role of advocacy for health service users and the whole population in a SHP/UHI framework
5. Role and engagements of states in SHP
6. Operationalising and professionalising a single national SHP/UHI Insurance system
7. Options for the organisation of Social Health Protection (SHP) and Universal Health Insurance (UHI)
8. Building universal health insurance that maximises equity: risk analysis and mitigation measures, a decision support tool

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