Review

TOWARDS SOCIAL PROTECTION FOR HEALTH: AN AGENDA FOR RESEARCH AND POLICY IN EASTERN AND WESTERN EUROPE

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ABSTRACT

Social protection for health moves beyond understanding the social determinants of health to identifying the policies and programmes that can address them. Although social protection has great relevance to health, most of the related discussions are taking place outside the health sector. Thus, to identify areas for strategic partnership, we conducted a semi-structured review of how the World Health Organization (WHO), International Labour Organization (ILO), World Bank, International Monetary Fund (IMF), Organisation for Economic Co-operation and Development (OECD) and the European Union (EU) define social protection and how this relates to health in the WHO European Region. We found several areas of synergy: (i) between the EU, ILO and OECD on social assistance and (ii) between the World Bank and IMF in relation to resilience and social risk management. Building on this analysis, we developed a conceptual framework of the bidirectional linkages between health and social protection. We call on the health sector to lead by example and act on the many social determinants over which it has influence, especially employment, working conditions and income support. We conclude that development of a research and policy agenda could be strengthened through creating WHO Collaborating Centres, launching policy innovation labs and establishing a Commission on Social Protection for Health.

Keywords: SOCIAL PROTECTION, SOCIAL DETERMINANTS, SOCIAL POLICY, EUROPE

INTRODUCTION

Two of the most common mantras at European public health conferences are "health is about more than health care" and "every minister is a health minister". At the heart of these phrases are powerful observations on health promotion in Europe. The first observation is that, despite having some of the world's strongest health care systems, Europe has persistent and large health inequalities between and within countries. For children born in 2010, life expectancy for males ranges from 63 years in the Russian Federation to 80 years in Switzerland; for women, it ranges from 74 years in the Republic of Moldova to 85 years in Spain *(1)*. In 2008, the Commission on Social Determinants of Health called for a closure of these health gaps in a generation *(2)*.

The second observation – as the Commission's work demonstrated – is that the power to address health inequalities lies to a great extent outside the health sector. Action needs to focus on the root causes of health inequalities, which are in the environments where people age, live, work and play *(2, 3)*. In practice this involves the health sector working with partners who may know little about health and may see it as a competing or low political priority *(4)*. Yet by collaborating with ministries of housing, education, agriculture, transportation, social affairs and even defence, the health sector could bring about far greater benefits than by acting alone *(5)*.

This vision of joined-up action across sectors is a guiding theme of the World Health Organization

(WHO) Regional Office for Europe's Health 2020 policy framework and strategy *(6)*. The central aims of Health 2020 are to reduce avoidable health inequalities and to strengthen health governance *(7)*. Historically, such intersectoral action has been difficult to achieve. While there is clear evidence that the people of Europe see improving health as one of the most important goals for policy-makers *(8)*, it is often relegated to a much lower political priority.

To help stimulate joined-up government action, we argue for developing a subspecialty of epidemiology and health policy called "social protection for health". Broadly speaking, social protection refers to a combination of social assistance and insurance programmes designed to "… protect against the risks and needs associated with unemployment, parental and caring responsibilities, sickness and health care, disability, old age, housing and social exclusion" *(9)*. This topic is timely – for example, the global financial crisis has led to deep recessions in many countries, including Greece, Portugal and Spain. As Europe undergoes profound social and economic change, it is important to develop governance systems that protect and promote health and well-being *(10)*.

Much of the discussion about social protection is taking place outside of the health sector. We therefore review how major intergovernmental institutions in Europe define "social protection" and how this relates to health. The overarching goal of this paper is to outline a research agenda and highlight gaps in understanding in the relationship between social protection and health with a view towards enhancing implementation of Health 2020 across the WHO European Region.

DEFINING SOCIAL PROTECTION

Social protection is invoked differently in high- and low-income contexts and has different meanings within intergovernmental organizations *(11)*. Social protection is generally defined relative to the labour market, using market-based terminology. When used in reference to or by high-income countries, social protection commonly refers to social assistance and insurance programmes as well as to wider labour market protections *(12)* and may or may not include reference to health programmes. In high-income countries, the majority of the working-age population is employed in the formal sector, and unemployment rates are substantially lower than in many middle- and low-income countries *(13)*. The content of social protection varies and is politically determined but in recent years has tended to favour active labour market policies, which provide job training and placement and invest in job creation *(14)*. These social policies are described as "active" because they connect individuals to opportunities, whereas "passive" policies simply replace or increase income through unemployment insurance, income assistance, wage setting tools (such as minimum wages) and employment laws that make it harder for employers to dismiss workers or make their jobs redundant *(15)*. Furthermore, social assistance and insurance policies centred on formal employment, such as occupational health policies, disability, sick leave and family leave, play a bigger part in providing social protection than they might in middle- or low-income countries *(12)*.

By contrast, in low-income countries where most of the population is not engaged in formal employment, social protection has been synonymous with poverty alleviation, job creation and, presumably, economic growth *(12)*. In low-income countries social protection typically includes reference to the importance of health. Social protection has become a prominent term in discourse on development, since it touches on nearly all of the Millennium Development Goals (MDGs) *(16)*.

Across Europe, there are broad differences in the scale and scope of social protection programmes. Fig. 1 illustrates that spending on components of social protection is broadly lower in eastern than in western Europe in terms of crude expenditure per capita. This difference is also apparent when spending is assessed as a percentage of gross domestic product, suggesting potential for growth.

HOW INTERGOVERNMENTAL INSTITUTIONS IN EUROPE DEFINE SOCIAL PROTECTION

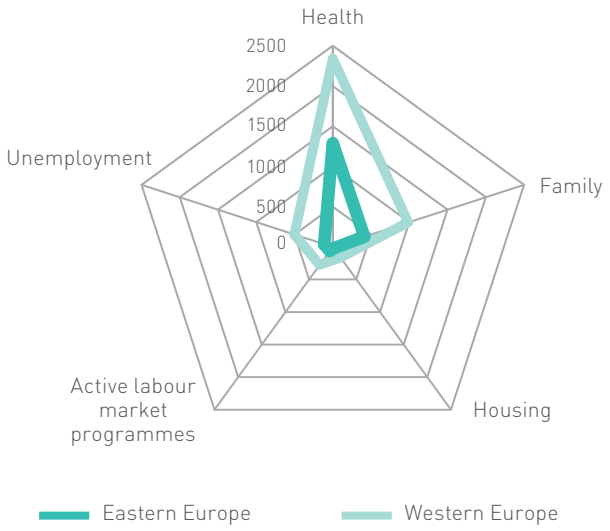
We conducted a semi-structured review to identify the current dominant narratives and understandings of social protection at major intergovernmental institutions in Europe. Organizations were limited to those that: (i) are active in social protection

throughout the WHO European Region and (ii) have health related remits. We therefore excluded, for example, the United Nations Development Programme and the United Nations Children's Fund (UNICEF) since, although active in social protection, these organizations do not, to our knowledge, have widespread activities in western Europe. The organizations included were WHO, the International Labour Organization (ILO), the World Bank, the Organisation for Economic Co-operation and Development (OECD) and the International Monetary Fund (IMF). The European Union (EU) was also included because of its policy importance, agenda-setting role and its interactions with the WHO European Region. We searched the websites of each institution for information on social protection and also the Google search engine with the phrase "[organization] AND [social protection]". Our observations are summarized below.

WORLD HEALTH ORGANIZATION

Several parts of WHO invoke the term social protection in their policies and programmes. In a recent Health 2020 policy brief about social protection and health, to which the authors of this paper contributed, the WHO Regional Office for Europe refers to social protection as, "... policies aimed to protect against the risks and needs associated with unemployment, parental and caring responsibilities, sickness and health care" *(9)*. Social protection is integral to at least one of the four priority areas of the Health 2020 framework – creating resilient communities and supportive environments *(7)*. The Commission on Social Determinants of Health defined social protection as covering, "... a broad range of services and benefits, including basic income security, entitlements to non-income transfers such as food and other basic needs, services such as health care and education and labour protection and benefits such as maternity leave, paid leave, and childcare" *(2)*. Several regional programmes are oriented towards social protection. For example, the WHO Regional Office for Africa runs a "health financing for social protection" programme, which offers technical support to Member States to increase social and health sector financing *(17)*. However, although many WHO programmes refer to the importance of social determinants of health, there is scant reference to implementing or monitoring social protection programmes that can address these determinants.

FIG. 1. SOCIAL PROTECTION SPENDING IN EASTERN AND WESTERN EUROPE



Note: Spending per capita in constant 2005 US dollars, in 2011. Eastern Europe includes Czech Republic, Estonia, Hungary, Poland, Slovakia, Slovenia and Turkey. Western Europe includes EU member OECD countries that are not in eastern Europe (14 countries) plus Iceland, Norway and Switzerland. Data are from: Social expenditure – aggregated data [online database]. Paris: Organisation for Economic Co-operation and Development (http://stats.oecd.org/, accessed 25 July 2015).

INTERNATIONAL LABOUR ORGANIZATION

The ILO is one of the most vocal proponents of social protection. At its launch in 2003, the ILO global campaign on social security and coverage for all drew attention to the large gaps in social protection between high- and low-income countries. The ILO directly includes health coverage by defining social protection as, "...access to health care and income security, particularly in cases of old age, unemployment, sickness, invalidity, work injury, maternity or loss of a main income earner" *(18)*. The ILO has also been supportive of efforts to achieve universal health coverage as part of its social health protection strategy *(19, 20)*. Furthermore, the ILO recognizes social protection as a complement to social security, or basic income. In 2009, in the wake of the global financial crisis, the ILO and WHO jointly led the United Nation's social protection floor initiative (SPF-I) that led to the 2012 adoption of a recommendation in support of establishing national social protection floors *(21)*. Social protection floors are nationally defined sets of minimum social security guarantees that include basic income security across the life-course and access to essential health care, including maternity care.

WORLD BANK

The World Bank differs from the ILO in its approach to social protection but also views it as a high priority. The World Bank tends to emphasize risk management through social insurance, rather than social assistance, and also tends to promote market-based approaches for accessing goods essential to poverty reduction, including health. Thus, the World Bank defines social protection as, "… systems, policies, and programs that aim to promote resilience, enhance equity, and build opportunity for all" *(22)*. At the country level, the World Bank recognizes social protection as critical to alleviating poverty, and social protection measures are key elements of their poverty reduction strategy papers *(23)*.

The World Bank regards health both as an outcome of social protection and as an integral feature of social protection depending on the structure of the health care system. In settings where health care is highly commodified (e.g. via out-of-pocket payments or paid for through private health insurance), health is treated as an outcome of social protection, which protects people from catastrophic and impoverishing financial costs of care. However, in settings where health care is acquired as part of meeting the conditions for receiving a cash transfer, the World Bank views health as a complement to their social protection strategies aimed at poverty reduction. A review noted that about half the programmes in the World Bank's safety net portfolio, "… promoted more and better household investments in education and health", on the grounds that investing in human capital is key for exiting cycles of poverty *(22)*. The World Bank's safety net programmes have been criticized for managing the symptoms, rather than the structural determinants, of social insecurity and poverty *(24)*.

In 2012 the World Bank and ILO co-chaired the first Social Protection Inter-agency Co-ordination Board – now the main high-level forum for discussions on social protection – in response to a request by the Group of Twenty (G20) *(25)*. Unlike its SPF-I predecessor, this board focused on both social assistance and insurance programmes, rather than solely on achieving social protection floors *(26)*. In sum, the World Bank's focus on risk management and resilience aligns with its preferred focus on social insurance, although it does recognize that a basic set of inputs, including health, are required for poverty reduction.

ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT

The OECD defines social protection in multiple ways, depending on the context. One is with a focus on poverty alleviation and resilience, or on "…policies and actions which enhance the capacity of poor and vulnerable groups to escape from poverty, and better manage risks and shocks" *(13)*. Similar to the World Bank, there is a focus on social risk management and alleviating poverty, rather than protecting and insuring basic income alone. When referring to wider developmental objectives, such as the MDGs, the OECD includes better nutrition, health and education outcomes within the remit of social protection *(13)*. In this sense, the OECD's conceptual understanding of social protection does the most to bring the relationship between social protection and health into focus. Finally in its broadest terms, the OECD Development Assistance Committee defines social protection policies as public actions, "… that enhance the capacity of poor people to participate in, contribute to and benefit from economic, social and political life of their communities and societies" *(13)*. The OECD describes these participatory economic policies as promoting "pro-poor growth", which many view as a compromise between pro-market policies and commitments to universal social security *(27–29)*.

INTERNATIONAL MONETARY FUND

To our knowledge, the IMF lacks a direct policy on social protection. However this is not to say that its programmes do not have implications for social protection systems. Indirectly, the IMF affects social protection through the conditions it places on its loans. These conditions often include wage bill ceilings, cuts in government spending and the prioritization of debt repayments. As a result, IMF lending policies have been criticized for obstructing the development of social protection programmes – including those concurrently promoted by the OECD and the World Bank – in countries that are experiencing shocks and risks *(30)*.

While we were unable to find any official policy reports on the theme of social protection from the IMF, we identified a factsheet from their website on protecting the most vulnerable under IMF-supported programmes *(31)*, and several IMF economists have referred to social protection in public policy presentations. For example, the IMF Uganda country-

team economist recently defined social protection as, "... public and private interventions to address risks and vulnerabilities that expose individuals to income insecurity and social deprivation" *(32)*. Preceding this, the IMF along with the World Bank, ILO and UNICEF joined forces to support a pilot programme of the SPF-I in Mozambique, where the IMF's primary role was to analyse the fiscal space available to implement the programme *(33)*. During the project, the IMF resident representative recognized social protection systems as important because they: (i) act as automatic stabilizers, thereby providing a cushion against external shocks; (ii) promote labour productivity, leading to inclusive growth; and (iii) consolidate social stability and peace, which are essential to attracting private investment and achieving sustainable growth *(33)*. As these definitions suggest, the IMF focuses primarily on the fiscal space and sustainability of social protection policies and programmes, and health would likely be treated similarly to sectors such as education or agriculture in this regard.

EUROPEAN UNION

The European Commission closely links social protection with the labour market, seeing it as providing, "... protection against the risks and needs associated with unemployment, parental responsibilities, sickness and health care, invalidity, loss of a spouse or parent, old age, housing, and social exclusion" *(34)*. This view is concordant with that currently featured in the WHO European Region policy briefs.

Europe 2020 is the EU's ten-year growth strategy; of the seven flagship initiatives, two relate directly to social protection: the platform against poverty and social exclusion and the agenda for new skills and jobs. The platform against poverty and social exclusion identifies five areas for action and targets for Europe 2020: delivering actions across the whole policy spectrum; better use of EU funds to support social inclusion; promoting robust evidence of what does and does not work in social policy innovations; working in partnership with civil society to better implement reforms; and enhancing policy coordination among EU Member States through the open method of coordination for social protection and social inclusion *(35)*. EU Member States are translating these Europe 2020 targets into national targets and policies, and the European Commission publishes regular reports to track country progress. The agenda for new skills and jobs is focused on achieving its employment target of 75% of the working-age population in paid work, in addition to reducing the number of people in or at risk of being in poverty to fewer than 20 million across the region *(36)*. In addition, through the social investment package, EU Member States are encouraged to modernize their social policies and welfare systems to help cope with the challenges of demographic change and economic crises *(37)*.

The EU's open method of coordination (OMC) around social protection and social inclusion policies was developed in 2000 since these policy areas are not codified in EU law. The OMC allowed countries to tailor the definition, implementation and evaluation of social policies to their particular needs in an effort to encourage mutual cooperation between the EU and its Member States. While this may have been the most practical approach given the diversity among EU Member States, it also led to a multitude of strategies that were difficult to track and compare. As a result, the EU introduced the single social OMC for social protection and social inclusion in 2005 focusing on: the eradication of poverty and social exclusion; guaranteeing adequate and sustainable pension systems; and providing accessible, high-quality and sustainable health care and long-term care *(38)*. The EU renewed its commitment to this style of engagement in 2008 which, like the ILO, recognizes health care, and also poverty alleviation as critical to social protection *(38)*.

To conclude, these intergovernmental institutions clearly recognize the central importance of social protection. However, what they mean by social protection often differs. Some, such as the ILO, see health care as integral to social protection, while the World Bank often sees health as an outcome of social protection. Others, such as the IMF, give the topic much less attention altogether. However, none of these actors has clearly identified areas of strategic overlap and synergy, whereby health and social protection can be mutually reinforcing and jointly pursued. For example, while the EU has Europe 2020 goals for social protection and exclusion, which health activities may contribute to and benefit from, these are not directly operationalized in the EU's social protection and inclusion goals.

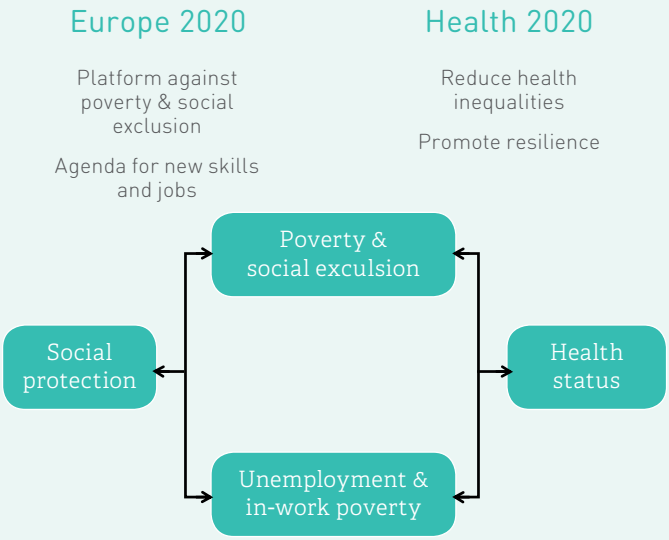
Below we outline evidence that supports a bidirectional relationship between social protection and health programmes, which is then used to identify potential entry points for further research and cross-sectoral collaboration.

FROM SOCIAL DETERMINANTS TO SOCIAL PROTECTION

There is now an extensive body of literature that highlights the important roles of individual social determinants of health. The most prominent of these include education, employment, income, housing and transportation. Additionally studies show the important role of social capital, in various forms such as bridging and bonding capital *(39)*, as well as the significance of neighbourhoods and built environments *(40)*. A critical gap in this evidence, however, is an understanding of how the health sector should engage with other sectors that affect the social determinants of health *(41)*. More studies that document the importance of individual social determinants of health, however epidemiologically important, will likely do little to advance European public health if they cannot inform the design of the social policies that shape them *(41, 42)*. One example is the current debate on how to cope with ageing populations in Europe. Linked to this debate is a discussion on the appropriate structure of pensions to ensure support for individuals in old age *(43)*. Many nations are switching from defined benefit to defined contribution schemes, drawing on a variety of investment structures *(44, 45)*. But which of these pension systems would be most beneficial to healthy ageing? Currently, the literature is relatively silent on this point; as a result, health policy-makers have little evidence and advice to offer the OECD, ILO, EU and others on pension policies – a major social determinant of health for older persons. This is a missed opportunity, for there is clear evidence of a bidirectional relationship between social protection and health. For example, there is scope to link Health 2020 directly to Europe 2020 targets, acting jointly via social protection schemes. Fig. 2 summarizes a conceptual framework of this bidirectional relationship as it applies to employment and poverty reduction.

As shown in the figure, and using employment as an example, there is a well-known "healthy worker effect", whereby those in employment are healthier than those who are unemployed *(46, 47)*. People who are healthier tend to work more hours and be more productive in those hours *(48)*. Thus, good employment and good health go hand-in-hand, creating a virtuous cycle. Box 1 highlights examples of how social protection can improve health and vice versa.

FIG. 2. RELATIONSHIP BETWEEN SOCIAL PROTECTION AND HEALTH PROGRAMMES



BOX 1. EXAMPLES OF THE BIDIRECTIONAL LINK BETWEEN SOCIAL PROTECTION AND HEALTH

How social protection improves health

As indicated in Health 2020, there is an untapped opportunity to use social protection programmes more effectively to prevent sickness and disability, improve health and reduce health inequalities. A classic example is paid sick leave. The economic costs of working while sick exceed the costs of paid sick leave *(61)*. Furthermore, paid sick leave reduces the number of people showing signs of ill-health, increases recovery rates, reduces health care costs, increases worker productivity and reduces worker presenteeism and absenteeism *(61)*. Such programmes – if carefully designed – have the potential to reduce health inequalities according to age, gender, education, ethnicity and sexual orientation. However, while social protection programmes are explicitly intended to help the most vulnerable, they are also forms of stratification in and of themselves *(62)*. Paid sick leave applies only to workers engaged in the formal labour market, potentially excluding those engaged in unpaid work from such protection.

How health improves social protection

There is also an untapped opportunity to leverage Health 2020 to achieve the goals of social protection. Ill-health reduces employment prospects and working hours, increases the likelihood of premature retirement and also increases the risk of poverty in old age *(9)*. For example, mental illness is the leading cause of disability and the largest contributor to missed work-days in the WHO European Region. When left untreated, it increases the risks of unemployment, exit from the workforce and premature retirement *(63)*. However, cost-effective, preventive interventions improve mental health, increase job search motivation and promote faster re-employment into higher-quality jobs for the unemployed *(64)*. In this way, health is an important catalyst that helps individuals re-connect to the labour market, thereby stopping cycles of poverty and unemployment before they start.

While this framework is not intended to be comprehensive, it highlights some initial areas of overlap with the EU's programmes on social protection, focusing on two themes for which there are Europe 2020 targets: poverty and social exclusion and unemployment and in-work poverty. A powerful research agenda would link the policy initiatives in this area to health outcomes, and conversely document the contribution that investing in health makes to social protection.

HOW THE HEALTH SECTOR CAN LEAD BY EXAMPLE

While health ministers may not be engaging enough with the social determinants of health through intersectoral policy-making, their own sector can provide a strong platform from which to address these determinants. By taking action from within, the health sector can use its influence to impact positively the living and working conditions of its employees and the neighbourhoods in which clinics and hospitals operate, as well as the transport systems that connect them. We argue that the health sector can lead by example by promoting social protection and occupational health policies for health care workers and their families *(9)*.

The health sector can lead by example in both the clinical environment and the wider community. Health care facilities employ over 59 million people globally, making the health sector an influential employer *(49)*. Health care sector policies can help spur the development of employment protection legislation, as called for by the OECD and EU. Such legislation and protections could make a large impact in a national health system, such as the National Health Service – the largest employer in the United Kingdom of Great Britain and Northern Ireland and one of the largest employers in the world *(50)*. Also, managers and leaders of health care organizations could bring a scientific approach to promoting worker's health, for example, by testing innovative occupational health programmes, such as those designed to increase physical activity and safety in the workplace *(51)*.

In the community, health employers also influence pensions and have an incentive to understand which pension systems best promote health. The large pension holdings across the health care sector could be leveraged to stimulate investments in health- and employment-generating areas and withdraw from industries that pose a threat to public health, such as tobacco companies, which still receive investment from several large health system pension funds in Europe *(52)*. Additionally, hospitals are often located in deprived urban areas *(53)*. By large-scale purchasing of nutritious food, hospitals may be able to drive local market changes, reduce prices and increase availability in these areas.

These examples illustrate the way in which policies acting on the social determinants of health can be promoted from within the health sector. It would be premature to determine the appropriate way in which such action could be taken, for who leads in the health sector and what policies they promote will likely differ across Member States. These differences arise from important structural factors, including the public-private split in health care delivery, which shapes the relative influence of health ministers *(54)*. For example, the NHS in the nations comprising the United Kingdom of Great Britain and Northern Ireland has greater leverage when negotiating labour contracts than a minister of health might in a federalized system with a larger number of private sector providers, such as Germany's. WHO's Health Promoting Hospitals project, which was designed largely to promote the health of hospital staff and the links between the hospital and its community *(55)*, is an important starting-point for understanding how best to promote health from within the sector. Although the design and implementation of social protection strategies within the health sector may differ, these policies should be monitored and evaluated so that where success occurs, it can be transferred to other sectors and country contexts where appropriate *(56)*.

SOCIAL PROTECTION FOR HEALTH: TOWARDS A RESEARCH AND POLICY AGENDA

Our paper has documented several critical areas of synergy in social protection for health between the WHO European Region and partner institutions in Europe. As outlined by the WHO European Region, intersectoral action on the social determinants of health through the promotion of social protection for health can be strengthened by: developing joined-up

responses to support target populations; developing joint regulatory frameworks that are flexible, enabling specificities and social innovation and change at the local level; adopting common systems for monitoring policy implementation and outcomes across sectors, including indicators; and making better use of existing resources to ensure that populations have adequate care and support *(9)*.

Understanding these intersectoral opportunities requires a better appreciation of the bidirectional relationship between these two policy areas. For epidemiology, this will mean moving beyond studies of individual social determinants of health to policies that can address these determinants *(57)*. We propose three steps to take this agenda forward.

CREATING WHO COLLABORATING CENTRES

Stimulating a social protection for health research and policy agenda will require working not only with experts such as nurses, doctors, health workers and epidemiologists but also with sociologists, anthropologists, economists and political scientists. The creation of WHO Collaborating Centres focused on strengthening the evidence base for social protection for health would raise awareness of the importance of the social determinants of health and create entry points for social scientists. A new generation of political epidemiologists could be trained in social science departments and more closely linked to policy-makers through such centres.

LAUNCHING POLICY INNOVATION LABS

High-quality evidence is critical to advocacy but large-scale randomized trials of social determinants of health are difficult to implement. While there are examples from cash transfer programmes and insurance schemes, such as Seguro Popular in Mexico *(58)*, these are relatively few and expensive to implement. Some exist within Europe, including randomized impact evaluations of active labour market policies *(59, 60)*, but health impact evaluation is not usually part of the research design. Through policy innovation labs that link researchers and policy-makers in Europe, there is potential to implement low-cost, natural experiments by modifying the scope, location or eligibility criteria of current policy interventions. Use of entrepreneurial language, such as innovation and solutions platforms, may also help politicians overcome their fears that results will not accord with political ideology – a major impediment to introducing randomized trials. Innovation labs would enable policy ideas to be tested in real time, using existing political support in Europe. Such labs would encourage the development of new ideas and enhance the predictive capabilities available to policy-makers.

ESTABLISHING A COMMISSION ON SOCIAL PROTECTION FOR HEALTH

A next logical step in the work of the Commission on Social Determinants of Health would be a Commission on Social Protection for Health. This initiative would address two criticisms of the Commission – that it did not identify specific policies that act on social determinants of health and that it did not engage with those who determine the social determinants of health. One starting-point would be to identify a minimum package of resources to achieve and sustain good health and social protection.

Taken together, these actions would be the start on a long road towards social protection for health in Europe.

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