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The role of social health protection in reducing poverty: the case of Africa

Maria-Pia Waelkens, Werner Soors and Bart Criel

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Contents

List of Boxes

List of Tables

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Strategies and Tools against social Exclusion and Poverty (STEP)

The Strategies and Tools against social Exclusion and Poverty global programme (STEP) of the International Labour Organization (ILO) is active in two interdependent thematic areas: the extension of social protection to the excluded and integrated approaches to social inclusion.

STEP supports the design and dissemination of innovative systems intended to extend social protection to excluded populations, particularly in the informal economy. It focuses in particular on systems based on the participation and organization of the excluded. STEP also contributes to strengthening links between these systems and other social protection mechanisms. In this way, STEP supports the establishment of coherent national social protection systems, based on the values of efficiency, equity and solidarity.

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STEP combines different types of activities: studies and research; the development of methodological tools and reference documents, training, the execution of field projects, technical assistance for the definition and implementation of policies and the development of networking between the various actors.

The programme's activities are carried out within the Social Security Policy and Development Branch of the ILO, and particularly its Global Campaign on Social Security and Coverage for All.

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Summary

This literature review aims to increase our knowledge of the potential that social health protection has in reducing poverty in sub-Saharan Africa. Of all regions in the world, sub-Saharan Africa ranks lowest in income per capita, life expectancy at birth, and highest in mortality. It is the only region with a negative growth for the period 1980-2000. Trapped in poverty and excluded from decent health care, the African poor have to face both the catastrophic costs of seeking health care and bear the burden of lost productivity. Evidence for the link between illness and poverty is particularly striking in the case of malaria and AIDS.

Social protection is increasingly seen as a key strategy to contribute to poverty reduction and to sustainable development. But in Africa, where the informal economy sector remains huge and where poorly effective risk management strategies often prevail, there still is a long way to go. Community health insurance, however, appears to be an interesting option for meeting the goal of universal social protection. There is convincing evidence of its positive effect on access to health care. Moreover, community health insurance constitutes a promising channel to give voice to the poor. Today, this particular instrument of social health protection reaches only a small fraction of the African population, but enjoys a growing acceptance and is subject to increasing demands.

Besides the ethical imperative of providing social protection, there is evidence today, albeit limited, indicating that the expansion of social health protection, by improving access to care, may increase people's participation in the labour market, improve their income and contribute to economic growth.

1 Introduction

The International Labour Organisation is currently engaged in a global campaign to increase social protection in the world. Combating poverty by expanding social protection in *health* is the particular mandate of its programme Strategies and Tools against Exclusion and Poverty (ILO/STEP). There are three good reasons why Africa should be the focus of this campaign: it is poor, ill and getting poorer. Of all regions in the world, tropical sub-Saharan Africa ranks lowest in income per capita and life expectancy at birth, and highest in mortality for children under-five. Moreover, it is the only one with a negative growth during 1980-2000 (Sachs *et al.*, 2004).

This literature review concentrates on sub-Saharan Africa and more particularly on its large majority of poor people working in the informal economy. The review intends to increase our knowledge of the role that social health protection plays in reducing poverty and promoting economic development. It aims to examine the evidence that supports the commonly accepted hypothesis that social health protection contributes to poverty reduction and economic growth.

Two aspects …

First, this study explores the poverty implications of ill health: What is the effect of ill health on household income, productivity and economic growth? And what are the consequences for poor households when facing the costs of health care?

Second, protecting households against these poverty implications are scrutinised: What is the effect of the various forms of social protection in health that are currently put into practice for shielding poor people's consumption from the shock of health care costs, on income generation, on productivity and on economic growth?

… and three types of information …

For both of these aspects, three types of information were explored: (1) the arguments guiding current policies, (2) the evidence in sub-Saharan Africa and (3) the opinions of the target population concerned – of poor people themselves.

… organised in four sections

Section 2 is concerned with the poverty implications of ill health. It gives an overview of the current knowledge about the damaging effects of ill health on economic growth, the leading vision about what should change and why, and evidence on the effects of different health problems on the African workforce.

Section 3 describes the main approaches to social protection, the wider context of poverty reduction strategies in which they are imbedded, and the different measures that together constitute a comprehensive social protection system.

Section 4 looks into the effects of social protection measures on household wealth and on the accessibility of health care services. Improvements on these two issues are the two direct outcomes expected from social protection in health. Due to the limited empirical evidence available for Africa, this section focuses on community health insurance.

Section 5 explores the evidence concerning the contribution of social health protection on health status and on economic development. It is followed by a conclusion in which we briefly summarise the evidence of the relationship between ill health and poverty on the one hand, and between social protection and poverty reduction on the other. We further address some of the research priorities that remain to be explored.

2 Poverty implications of ill health

2.1 Trapped in poverty, excluded from health

The correlation between ill health and poverty is widely documented. Causal effects run in both directions. Unhealthy living conditions and malnutrition leave poor people more vulnerable to disease. Poor people often work in more dangerous jobs that put them at risk of illness and disability (see Box 1). When disease strikes, poor people have less access to reliable health services.

Box 1: Poverty, working environment and occupational risks: an illustration

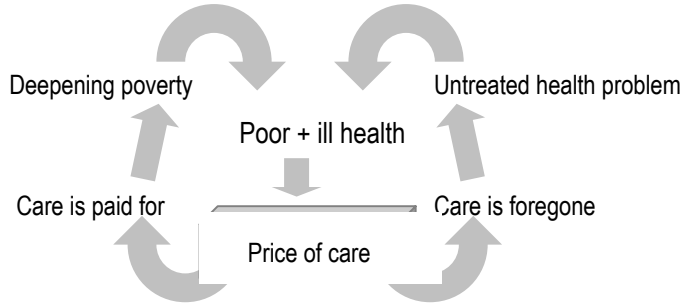
Working in a secure environment boosts productivity (ILO, 1999). In a safe working environment workers not only suffer less accidents but also tend to invest more in their jobs.

In sub-Saharan Africa standards for occupational health and protection are however rarely implemented. Government inspection and law enforcement is weak and sanctions for the employers are rare. In industries such as forestry, wood-product manufacturing, electricity production, mining, metal production and transport, injury rates are greater than 30 injuries per 1000 workers (Loewenson, 2001). Exposure to accidents, polluted air and poor ventilation, noise, toxic chemicals, stress and other hazards is aggravated by high production quotas that are often demanded in manufacturing for export. When poor, African workers are least likely to seek health care even if injured. When injured, they face lasting impairment (WHO and World Bank, 2002; Xaba *et al.*, 2002). Besides compensation for injured workers is uncommon.

Ill health in turn affects learning ability and income levels, whereas seeking health care can reduce household savings or plunge households in permanent poverty (OECD, 2003). The latter, accentuated by the introduction of user fees and the growing proportion of out-of-pocket expenses, has been described as the medical poverty trap (Whitehead *et al.*, 2001). More than just a situation from which it is difficult or impossible to escape, in an already impoverished environment it can lead to poverty and ill health enforcing each other in a spiralling sequence (see Box 2). This cycle of disadvantage is repeated as successive generations become trapped in poverty (ILO, 2003a).

What is true at individual level is also true at the population level. Low-income countries have a high disease burden and deficient health services (Wagstaff, 2002) or, alternatively, countries with the highest burden of disease have low economic growth, are stagnating or regressing (Sachs *et al.*, 2004).

Box 2: The spiralling medical poverty trap at household level



2.2 Which poverty implications of ill health?

Studies on the poverty implications of ill health identify two aspects: the direct cost of seeking care and the indirect cost of productive days lost.

Catastrophic health expenditure: the end of the line of direct cost

Falling ill and paying for health care can cause substantial and unexpected shocks on a household's living standards. This may lead to catastrophic health expenditure. The World Health Organisation defines health expenditure as catastrophic when "a household's financial contributions to the health system exceed 40% of income remaining after subsistence needs have been met" (Xu *et al*., 2003).

The high cost of hospitalisation is viewed as the main cause of catastrophic expenditure.

However, medical expenses for chronic or recurrent illness can also eventually be too costly (Cohen and Sebstad, 2003), and for poor households, even the costs of treatment for common illnesses can be catastrophic (Dahlgren, 2001; Xu *et al*., 2003). The health care services have their part of responsibility in creating catastrophic health expenditure. Many providers charge excessive prices, conduct expensive examinations or prescribe costly treatments that could be avoided. Yet as most people cannot judge what is essential and what is not, they will spend what care providers tell them is needed for the recovery of their family members. The resulting poverty has been called iatrogenic (Meessen *et al*., 2003).

Medical expenses are not the only cost. In many environments, transport to reach health services is even more expensive and when a caretaker is needed, two people need to pay the trip (Hjortsberg and Mwikisa, 2002; Melese *et al.*, 2004; Waelkens, 2003). There is also a seasonal dimension to the financial stress of seeking care. In rural areas, it is during the rainy season that infectious diseases strike most, when nutritional status is worse, cash flows are low, transport cost even higher and the absence of workforce in the fields hits hardest (Criel *et al*., 1999; McCarthy *et al*., 2000; Millinga, 2002; Sauerborn *et al*., 1996; Schneider *et al*., 2001b; Soucat *et al*., 1997; Wood, 2003).

Notwithstanding the many indications that medical expenses are much higher than most African households can afford, the extent to which catastrophic expenditure hits households is hardly documented in the case of African countries (Xu *et al*., 2003). Still we should not forget the many that will choose not to seek health care rather than become impoverished (Gilson, 1997). The poor foregoing care represent a clear case for protection, even in the absence of catastrophic expenditure.

The indirect cost of reduced productivity

From a workforce perspective it is not health expenditure but number of disabled days and the consequences on income that count.

Schultz and Tansel (1997) used data from Living Standard Measurement Surveys done in Côte d'Ivoire and Ghana to study the effects of illness on income and labour participation. They found that about a fifth of all persons report reduced productivity because of illness or injury in a recall period of four weeks. On average, every person looses one day in these four weeks. For each disabled day, wages are 10.5% lower in Côte d'Ivoire and 11.7% in Ghana.

Such large scale studies that evaluate the effects of ill health on productivity or days lost have rarely been carried out in Africa. Information about the economic effects of illness is more often available in studies that concentrate on specific health problems. For example,

in a review of studies on health and productivity, Thomas and Frankenberg (2002) found convincing evidence of the effects of nutritional deficiencies on productivity. Particularly well documented are the negative effect of iron deficiency on productivity and the positive effect of iron supplements on work capacity.

Malaria and HIV/AIDS are two health problems for which poverty implications are well documented. This should not amaze us since malaria is by far the most common disease in sub-Saharan Africa [1] and HIV/AIDS particularly strikes the economically active. Since these two diseases represent the major health problems for productivity in Africa, they can serve as good measuring devices to estimate the effect of disease on productivity. Indeed, it is because of their huge impact on economic growth that fighting these two diseases is part of poverty reduction strategies.

Poverty implications of malaria

The relation between malaria and economic growth has been known for centuries. Several recent reviews give an overview of the evidence and try to quantify the effect of the disease on economic growth (Gallup and Sachs, 2001; McCarthy *et al.*, 2000; Snow *et al*., 1999). Although their estimates differ, it is clear from these reviews that countries with a heavy malaria burden have lower income levels and slower economic growth than countries without malaria. According to Gallup and Sachs (2001), malaria is responsible for a reduction in growth of 1.3% per year in high prevalence countries, and a 10% reduction in malaria would boost economic growth with 0.3%. McCarthy *et al*. (2000) estimate that in sub-Saharan Africa the average annual growth reduction due to malaria is about 0.55%. Evaluated at household level, a recent study done in Vietnam found that a reduction of 10% of malaria cases resulted in a 0.3% increase in household consumption (Laxminarayan, 2004).

The effect of malaria on economic growth has different dimensions: there is the effect of many workdays lost on production, the effect on labour mobility and migration, the loss of foreign investment and of opportunities to develop infrastructure projects (McCarthy *et al*., 2000). The most telling example of the effect of malaria on the workforce is that of the building of the Panama Canal that would not have been achieved without malaria control programmes (Gallup and Sachs, 2001). In sub-Saharan Africa, malaria holds back investments in mining, tourism and agriculture.

Studying the link between illness and economic growth is particularly important where new crops and innovative agricultural practices are introduced with the aim to increase the income of farmers. New cultivation techniques may increase incidence of diseases and ultimately result in a negative effect on the wealth of the farmers. It was for this reason that a series of investigations on the link between malaria and farming activities was carried out recently in the northern savannah of Côte d'Ivoire (Audibert *et al*., 2003a; De Plaen *et al.*, 2003; Henry *et al*., 2003). They did not identify a greater malaria incidence due to changes in types of crops but confirmed that indeed malaria reduces the productivity, income and consequently wealth of farmers. In this study area, inhabitants have on average two fever attacks per year. One study particularly focused on cotton farming and the role of illness in the efficiency of producers (Audibert *et al.*, 2003b). Efficiency in farming methods is important given the competitive nature of the international cotton market. Malaria once

[1] Malaria accounts for as much as 30-50% of inpatient admissions, and up to 50% of outpatient visits in high prevalence areas (Roll Back Malaria Internet site <http://www.rbm.who.int/>)

more made a difference: it appeared that farms affected by high-density malaria infection had lower yields than others.

In another study in rural Côte d'Ivoire, Girardin *et al.*, (2004) investigated the effect of malaria on the performance of farmers in the specific agro-ecologic environment of intensive vegetable farming. Intensive vegetable farming typically presents the risk of water-related infectious diseases that may have a perverse impact on household income. In this particular setting, farmers suffered on average 14-15 days of ill health during a study period of ten months, of which eight to nine days due to malaria. Yet vegetable farming is labour-intensive and the yields suffer from even short durations of absenteeism. It was found that farmers who missed more than two days had 53% lower revenues than farmers who missed less than two days. Workers trained in intensive vegetable farming cannot easily be replaced by untrained family members. This means that swift access to treatment is important for farmers who decide to improve their income by turning to intensive vegetable farming. Indeed, it was the healthier farmers who continued with intensive vegetable production, while those who suffered higher numbers of days lost to illness finally gave up (Girardin *et al*., 2004).

The economic impact of malaria on large industries, in this case the mining sector, is the subject of a review of historical documents carried out by Utzinger *et al.* (2002). Their study describes the economic effects of integrated malaria control sustained during a period of 20 years in four copper mining sites in Zambia (former Northern Rhodesia). The impact of the malaria programme on the health of the copper mining communities, on the productivity of the mines as well as on the national economy was huge. Over the 20 years of the programme, an estimated 14 122 deaths, 517 284 malaria attacks and 942 347 workdays lost were averted. The researchers estimated that reduced absenteeism contributed to a decrease of US$ 5 678 745 (in 1995 US$) in indirect costs. The healthier working conditions also attracted migrant labourers from a wide geographical range. Copper production increased dramatically once the malaria control programme was introduced. Northern Rhodesia became the leading copper producer in Africa.

Poverty implications of HIV/AIDS

HIV/AIDS represents a great threat to economic development in sub-Saharan Africa. For Africa as a whole, decline in life expectancy caused by AIDS would be responsible for a reduction in economic growth of about 1.7% per year (Jamison *et al*., 2001). In countries with a high HIV prevalence, such as Botswana, the decrease in economic welfare due to AIDS counts for 8% per year. Bell *et al*. (2003) argue that the long-term economic costs of AIDS are likely to be much higher. AIDS not only destroys existing human capital, but the death of young adults also weakens the transmission of knowledge and skills to the younger generations. The transmission of capacities from one generation to the next will continue to weaken because children of AIDS victims who have little education and knowledge will in their turn be less able to invest in the education of their own children. In countries with high HIV prevalence this failure to accumulate knowledge may lead to a progressive collapse of human capital and productivity.

At household level, income loss due to long illness and death, high health care expenses and funeral costs, frequent interruptions of daily work, also to attend funerals of family members and neighbours, all influence livelihood in communities where the prevalence of HIV/AIDS is high (Cohen and Sebstad, 2003). The costs of health care hit households hard. In a rural population in Tanzania, for example, 29% of households that had lost a member to AIDS had to sell property to pay for health care. Only half of people who died

of AIDS had benefited of hospital care (Ngalula *et al*., 2002). In rural areas, food security may become problematic where labour is lost due to illness and caring for the sick (ILO, 2003b).

Where HIV prevalence is high, companies suffer declining profits as a result of HIV/AIDS (International Organisation of Employers and UNAIDS, 2002). Productivity declines because of absenteeism and death. Production costs rise because of high turn over and training costs of new personnel, higher life insurance premiums and pension contributions because of early retirement or death, higher medical expenditure or health insurance premiums, and funeral costs. These HIV/AIDS related costs may increase labour costs by 6% or more (Rosen and Simon, 2003). The HIV/AIDS related costs of a transport company in Zimbabwe amounted to 20% of profits (International Organisation of Employers and UNAIDS, 2002). In a commercial farm in Kenya, HIV/AIDS related medical expenditure was 400% higher than the projected expenditure without AIDS. These increased costs ultimately affect the benefits that companies can provide to their workers. Many large South African employers cut costs by reducing the levels of benefits for health care, sick leave, retirement and death. Other companies in Southern Africa cut back on investments, others still relocate to countries that impose fewer social protection measures on the employer (Rosen and Simon, 2003). To these measurable costs should be added the losses in human knowledge, and the difficulty to find replacement for skilled workers. The loss of personnel with specialised skills and organisational experience will cause disruption in businesses and administration (ILO, 2003b).

Poverty implications of other tropical diseases

Many tropical diseases affect the workforce and productivity. Trachoma, for example, a chronic conjunctivitis, is the world's first cause of preventable blindness. Because of progressively worsening eye lesions caused by chronic and repeated infections, adult patients typically need surgery, by trained ophthalmic nurses, to prevent blindness. But many patients decide not to have surgery. For patients interviewed in The Gambia, the costs, both in terms of money and time lost, were the two main deterrents (Bowman *et al*., 2002). The cost of treatment was US$6, to which travelling to the health facility for patient and a care-taker should be added. The days of work lost for diagnosis and treatment, and also the fear of a long recovery time, were especially a barrier for those "too busy" in agricultural and domestic work.

Another example is that of the non-blinding strain of onchocerciasis. Infected people may suffer intense itching that is not only debilitating in itself but commonly leads to insomnia and fatigue. The adverse economic impact of onchocercal skin disease was studied in a coffee plantation of Ethiopia (Kim *et al*., 1997). About 23% of the workers of the plantation were severely affected and 40.5% were moderately affected by this skin disease. Severely affected permanent workers work about two days less per month than their non-affected colleagues. They are also less productive on the days that they work, which further affects their income because they are paid according to output through a system of quotas and bonuses. Depending on the severity of the symptoms, wages of affected workers are 10 to 15% lower than wages of workers without symptoms. According to the World Health Organisation[2], people with onchocercal skin disease spend each year 15% of their annual

[2] <http://www.who.int/tdr/research/progress/fil_afr/economic.htm>

income more than others on health-related expenditures and spend more time seeking health care.

Tropical diseases may render entire regions unattractive for agriculture and settlement. River blindness (Rémy, 1983) and sleeping sickness (Gilles and Rémy, 1983) have caused in the past massive exodus of entire areas of fertile land when the proportion of disabled people became too high for the economical survival of the community. It is estimated that sixty million people are at risk of sleeping sickness (Cattand *et al*., 2001). The disease strikes economically active adults most and is fatal without treatment (Shaw and Cattand, 2001). Sleeping sickness has devastating effects on households and on whole communities when it develops into an epidemic. The disease may considerably reduce labour force, disrupt agricultural activities and create food insecurity, and totally destroy local economies.

For most tropical diseases, studies are underway to establish their effect on ability to work and economic productivity as well as the economic benefits of different interventions for surveillance, prevention and treatment[3].

Poverty implications of disability

Disabled persons are disproportionately represented among the very poor. They are often victim of social exclusion. Children with impairment are often excluded from education and adults have less access to employment (Yeo and Moore, 2003). In resource-poor countries, the health services rarely respond to the specific health needs of disabled people and where they exist, households cannot pay the cost or will prioritise other expenses (WHO and World Bank, 2002). In Ethiopia, for example, where the prevalence of blindness is estimated at 1.1-1.5%, eye care services hardly exist. The cost of transport to the few existing centres and expenses for accommodation and food were the main reasons reported for not seeking care (Melese *et al*., 2004). From a public health point of view, if disability is addressed, it is mainly from a preventive perspective, to avoid further impairments, rather than from a right-based perspective and inclusion of those already affected (Yeo and Moore, 2003). However, it is mainly economic considerations that have motivated governments to introduce inclusive approaches for disabled persons. A rare study that focuses on disabled persons highlights the high cost of their exclusion and the economic burden on the household when they are not given the opportunity to contribute to society. In this study in rural India, the cost of disability calculated as direct, indirect and opportunity costs has been estimated to amount to 5.5% of total village income (Yeo and Moore, 2003).

2.3 Poor people's thoughts on poverty and health

Poor people are very much aware that poverty and ill health occur together. Health and ill health emerged as the central concerns of poor people interviewed across the globe in the World Bank study *Voices of the Poor*. The socio-economic determinants of ill health were strongly outlined: poor places kill (Narayan *et al*., 2000a). So were the consequences of ill health: illness was the most frequently cited cause of destitution (Narayan *et al*., 2000b). Poor people interviewed in Kenya, Tanzania and Uganda ranked ill health as the first cause

[3] <http://www.who.int/tdr>

of financial stress, even before death: "*I would sell my land to treat my sick son, but I would not sell my land to bury my dead son*" (Sebageni 2002). Natural disasters such as floods and drought were ranked well behind illness and death. People in the above three countries observed that death and illness were increasing because of HIV/AIDS and other life threatening illnesses such as drug-resistant malaria (Cohen and Sebstad, 2003).

Poor people describe the financial risks of illness both in terms of the cost of medical care and the income losses associated with reduced labour and productivity. They describe the downward spiral into poverty that begins with loss of income and expenses for health care, selling of assets and getting into debt, withdrawing children from school, reducing food consumption which leads to malnutrition and greater proneness to illness (WHO and World Bank, 2002). They discuss the days of work lost or the risk of losing a business (Sebageni, 2002). Women have to close their shop to take care of their ill children or relatives. In rural areas, hospitalisation or long-term illness of a main breadwinner can make households miss an entire harvest when the illness coincides with the planting season (Millinga, 2002).

2.4. Investing in health to reduce poverty

In 2001 the Commission on Macroeconomics and Health (CMH) advocated that to reduce poverty in the world, we should concentrate on the relation between health and income rather than count on better economic welfare to improve the health of people in low-income countries (Sachs, 2001). By highlighting health as a determinant of economic success, Sachs and colleagues adopted a position first taken four decades earlier by Mushkin (Mushkin, 1962). They no longer accepted the mainstream assumption that economic growth alone would improve poor people's health. On the contrary, they argue that investing in the health of poor population groups of low-income countries is a first step to make economic growth possible. Indeed, when looking at health and economic growth in various countries and at different times in history, interventions that improve health seem to account for a substantial part of accelerated economic growth wherever it happened (OECD, 2003; Hamoudi and Sachs, 1999). CMH's plea for health investments is tempting for sub-Saharan Africa, where the burden of disease in itself is a major barrier to economic development.

The CMH describes the following effects of improved health on economic growth (Sachs, 2001):

- *Improved human capital*: Healthy children learn better and miss fewer school days;
- *Higher labour productivity*: Healthy adults miss fewer days of work and, when at work, are more productive on the job and earn higher wages;
- *Demographic transition*: Better health and education contribute to lower fertility and mortality rates. Over time, fertility falls faster than mortality. This evolution in the demographic balance between active workers to dependants is a factor of wealth at household level and of resilience in times of crisis;
- *Higher rates of savings*: Healthy people can put more savings aside that not only reduce their vulnerability but provide funds for investment;
- *Higher rates of national and foreign investment*: Beyond the individual productivity, a healthier workforce makes companies more profitable and investment more attractive. Controlling diseases that are particularly detrimental to

attracting investment, such as AIDS and malaria, may encourage foreign investment and lift a major barrier to developing tourism.

Life expectancy is attributed an additional effect on these factors (Sachs, 2001). Increased life expectancy directly translates into more productive life years for the household and at the same time creates the conditions for longer-term strategies that will lift the household out of poverty: investing in better education and health for each child, increased household savings and property accumulation that can be invested in assets that have longer-term development benefits.

The CMH estimates what avoiding untimely deaths could mean in terms of economic growth for low-income countries. For instance, they start from the observation that a few health conditions (such as HIV/AIDS and tuberculosis, malaria, pregnancy related conditions and micronutrient deficiencies) are responsible for a high proportion of deaths. Assuming the appropriateness of a selective health care approach, an additional annual investment of $66 billion in health interventions to tackle these health problems could save at least 8 million lives each year and translate into a growth of at least $360 billion per year. Other factors being equal, each 10% improved life expectancy is associated with an increase of economic growth of at least 0.3% per year. This means a huge opportunity for economic growth in sub-Saharan Africa where access to basic health care could avoid many deaths caused by these health conditions. The costs of improving health in low-income countries would be largely outweighed by the outcomes, which is why investing in health is seen as a predominant element of the strategies for poverty reduction (Sachs, 2001).

It should be noted that the CMH approach has its opponents. In his letter ‘Worse than a crime; a mistake’, former WHO adviser Cohen enounced that the report discarded the principles and achievements of comprehensive primary health care, by dealing almost exclusively with macroeconomic aspects of health (Cohen, 2003). Waitzkin went one step further seeing the report as un update of early 20th century Rockefeller Foundation practice: enhancing the economic prospects of the better off in both rich and poor countries by reducing poverty in poor countries (Waitzkin, 2003). Nonetheless, the assumptions and arguments of the CMH report greatly influenced current policies and strategies for poverty reduction. Whether they will also translate in improved financing for social protection and health is still unclear.

3 Social protection in health: an overview

3.1 Social protection as part of strategies for poverty reduction

Social protection was one of the most significant achievements of the 20th century: it enabled the cohesion, security and development of societies while ensuring the well being of their citizens (Bonilla García and Gruat, 2003). On the other hand, social protection policies have always been disputed for their supposed negative impact on economic performance. Especially in the blooming decades of globalisation, growth and not redistribution became the predominant policy. It was not until the mid 1990s that economic and social development were finally recognised by all actors as mutually reinforcing. The 1995 Copenhagen Declaration on Social Development marked a turning point by putting poverty eradication in the spotlight (United Nations, 1995). With worldwide inequality growing exponentially between and within countries (ILO, 2003a; Wade, 2001; Wade, 2004), poverty re-emerged as a universal concern. In particular the Southeast Asian crisis highlighted that economic growth alone is not sufficient for development, let alone for sustained poverty reduction. A study in Ghana illustrates this observation for Africa: while growth was observed for the country as a whole, the situation of the chronically poor in the northern savannah did not change (McKay and Lawson, 2003). Following the focused attention on poverty reduction, a growing quest for social protection surfaced. International actors increasingly recognize the need for expansion of social protection, which more than half of the world's population still lacks. It is argued that for the goals of poverty reduction and sustainable development to become reality, social protection for all must be a key objective (Bonilla García and Gruat, 2003). Social protection measures should be an integral part of poverty reduction strategies to protect the livelihoods of the poor against crisis (Holzmann and Jørgensen, 2001) and to assist the most vulnerable.

Three predominant frameworks for poverty reduction …

Poverty Reduction Strategies

Launched in 1999 by the Bretton Woods institutions, the Poverty Reduction Strategy (PRS) was a change of course in answer to the failure of adjustment policies driven by growth-oriented macroeconomic principles. For years the World Bank's Structural Adjustment Programmes (SAP) had focused on reforms such as privatization, devaluation, trade liberalization and budget balancing based on cuts in government spending. Particularly in low-income countries, structural adjustment and socio-economic changes had produced large vulnerable groups (ILO, 2001). With high incidence of extreme poverty and lack of sustained growth clearly at odds with desired outcomes (ILO 2004), World Bank president Wolfensohn in 1998 launched the Comprehensive Development Framework (Wolfensohn, 1998). Based on a broad development concept composed of structural, human, governance, environmental, economic and financial elements, it was a major contribution to the PRS one year later.

The strategy's framework explicitly, but not exclusively, aims at poverty reduction. It is part of concessional financing through both the World Bank's International Development Association and the International Monetary Fund's Poverty Reduction and Growth Facility and is linked to the Heavily Indebted Poor Countries debt relief initiative. In using country-

prepared Poverty Reduction Strategy Papers (PRSPs), it also addresses the long-standing demand of developing countries to place the main responsibility for policy design and implementation in the hands of the governments of the poorest countries (ILO, 2003a). Poor countries' governments are to prepare their PRSP through a process that involves participation of the civil society, bilateral, multilateral and non-governmental development partners, and aims to promote involvement of all stakeholders in their implementation. Pivotal in a country's PRSP process is the proposal and approval of a road map to reduce poverty and to promote economic growth (World Bank, 2001a). In the first years of implementation this strategy still suffered an uneasy and unresolved tension between comprehensive development and stabilization-focused macroeconomic policy (ILO, 2004). Initially insufficient attention was given to social protection (ILO, 2002d), whereas health was dealt with in a limited or sketchy way (Walford, 2002; Dodd and Hinshelwood, 2002).

Poverty Reduction Strategies are an endeavour in progress. By mid 2004, 42 countries had produced full PRSPs. By now both low-income countries and their external partners see PRS as the country-level operational framework for development and poverty reduction, in particular for progressing towards the Millennium Development Goals (World Bank and International Monetary Fund, 2004).

Pro-poor health strategies

Pro-poor health approaches start from the two assertions that (1) health is central to overall human development and poverty reduction and (2) that the poor are disproportionately excluded from health services (Wagstaff, 2002).

The framework for pro-poor health interventions described by the Organisation for Economic Co-operation and Development (OECD, 2003) is built on four pillars in and out of the health sector:

1. A health system that provides quality preventive and curative services;

2. A health financing and social protection strategy that promotes access to health services for the poor, that protects against the impoverishment induced by the costs of health care and that is inclusive for the poorest members of society;

3. A health policy that encompasses the wide range of factors outside the health sector that affect health outcomes: delivery of public services such as access to water, sanitation, waste management and improvement of environmental conditions, but also socio-economic interventions that address social exclusion, access to education, food security, and pro-poor economic, trade and fiscal policies;

4. A coherent international collaboration with regard to the major diseases that affect many low-income countries and Global Public Goods for health such as research on diseases that affect the poor.

The Millennium Development Goals

At the United Nations Millennium Summit in 2000, the world's political leaders made a strong commitment to reduce poverty (United Nations General Assembly, 2000). Following the Summit, United Nations agencies collectively identified a set of eight Millennium Development Goals (MDG) to be reached by the year 2015, as well as 18 targets and 48 indicators to measure progress in their implementation (United Nations General Assembly 2001). At first sight, the formulation of exclusive goals could lead to a

vertical and non-systemic approach. However, as the UN Secretary-General stated, *"while the Goals may not by themselves constitute a comprehensive development vision, they are a measurable set of human development benchmarks that can provide clear indications of whether the world is managing to build the more 'inclusive and equitable' globalization called for"* (United Nations General Assembly, 2003).

Three out of eight MDGs are directly related to health. They set global targets and provide quantitative indicators for common health problems, namely in child mortality, maternal mortality, HIV/AIDS, malaria and tuberculosis, that particularly affect the poor and for which cost-effective interventions are available. Although social protection was not explicitly mentioned in the goals, targets and indicators, there is actually clear agreement that appropriate provision of social protection is necessary to achieve the MDGs (World Bank, 2003).

… and two predominant approaches to social protection …

Within this context, two major approaches to social protection are that of the World Bank and that of the International Labour Organisation.

Social risk management

In the 2000/2001 World Development Report, the World Bank advocated for social protection based on a technical interpretation of social risk management (World Bank, 2001b). Individuals, households, communities and societies are vulnerable to a range of natural and manmade risks. Poor people are more exposed to risk than people with more assets but have less access to effective risk management strategies. Their own protection mechanisms to prevent, mitigate or cope with risk are insufficient to protect their livelihood when shocks occur. Offering the poor better instruments for risk management will help them to protect their livelihood and at the same time provide a safer environment to help them out of poverty, to engage in economic activities that may be riskier but are likely to yield higher returns (Holzmann and Jørgensen, 2000). Social protection is thus seen as an investment rather than a cost.

In its definition of social protection, the World Bank mentions a series of possible interventions that help individuals, households and communities to manage risk and reduce vulnerability of the poor. The Bank recommends a modular approach to select safety net tools adapted to country-specific risk patterns, involving partnerships among poor communities, the private sector and the state (World Bank, 2001c). In this technical approach the combination of risk management arrangements (informal, market-based, or publicly provided) and strategies (prevention, mitigation, or coping) depends on the type of risk and the available tools. The resulting interventions may range from macroeconomic policies, good governance enhancement, labour market regulations, public work programmes and formal social security systems, over access to basic education and health care, to targeted support to the very poor (Holzmann and Jørgensen, 2001).

Expanding social security

For the International Labour Organization (ILO), the leading UN agency dealing with social protection, social protection is in the first place a human right. Indeed, social protection is listed in the Universal Declaration of Human Rights (art. 23, 25) and in the International Covenant on Social and Economic Rights of the United Nations (art. 9). Social protection is defined by the ILO as the set of public measures that a society provides

for its members to protect them against economic and social distress that would be caused by the absence or a substantial reduction of income from work as a result of various contingencies (sickness, maternity, employment injury, unemployment, invalidity, old age, death of the breadwinner), the provision of health care and the provision of benefits for families with children (ILO, 1998; ILO, 2000). By this definition, social protection is broader than social security since it incorporates non-statutory or private measures for providing social security, but still encompasses social security measures such as social assistance and social insurance (Bonilla García and Gruat, 2003). The ILO places social protection in the context of a Decent Work for All strategy that advocates productive work opportunities for women and men in conditions of freedom, equity, security and human dignity. The framework has the following four strategic objectives (ILO, 1999):

1. Promote fundamental principles and rights at work;
2. Create opportunities for decent employment and income;
3. Enhance the coverage and effectiveness of social protection; and
4. Strengthen tripartism and social dialogue.

Social protection being a basic right, universal social security coverage is for the ILO a priority objective.

… are gradually merging

These different strategies and approaches have in common that they clearly emphasise the importance of good health to promote growth and reduce poverty. They differ however in the weight they give to social protection in health. Health and access to health care is surprisingly little expanded upon in many documents and studies that deal with poverty, risks and risk management (e.g. Barrientos and Shepherd, 2003; Bigsten *et al*., 2003; Dercon, 2002; Devereux, 2002; McKay and Lawson, 2003; Mukherjee and Benson, 2003). Social health protection is more prominent in the ILO strategies for low-income countries. This can be explained by the fact that low-income countries only have limited resources to invest in social security and have to make choices in what will be covered first. Traditionally, social security systems focussed first on old age pensions and other long-term income security benefits (Reynaud, 2003). In low-income countries, where nor the government nor the poor themselves have the resources to provide for comprehensive protection benefits, preference restricted by availability of resources goes to the provision of short-term benefits.

Poverty reduction strategies as well as pro-poor health strategies strongly recommend social protection systems. The strategies also give considerable weight to community-driven development and to meaningful participation by the poor communities themselves in designing and managing the interventions, which increases the likelihood that their needs will be taken into account. Taking into consideration that many poor people live in localities where government is weak, they also promote a process of decentralisation to obtain better services for the poor. Finally, all three approaches join that of the Commission of Macroeconomics and Health in stressing the need for scaling up financial resources for health and the need for international financial assistance to meet the health-related Millennium Development Goals.

Social risk management, promoted by the World Bank as a technical approach, is widened by the ILO as a societal issue involving political choices based on the interaction of all stakeholders. As such, social protection has the ability to contribute to social cohesion and stability. At the same time social protection is increasingly looked at though the glasses of the MDG framework.

Different types of poverty, different needs of social protection

Different types of poverty imply different strategies for poverty reduction and protection systems.

A distinction is made between chronic and transient poverty. Transient poverty concerns those households that have insufficient capacity to insure themselves against fluctuations in their living conditions and against shocks that may lead to temporary or chronic poverty. Poverty may be induced by factors such as volatility in prices, bad harvest, illness and death. Chronic poverty concerns households trapped in low-productivity activities, that do not have the physical and human assets to improve their own situation, or that have a high proportion of dependent members (Barrientos and Shepherd, 2003; McKay and Lawson, 2003).

The majority of people belong to the transitory poor, which is illustrated for Ethiopia by a study based on panel data (Bigsten *et al*., 2003). Of the total studied population, the proportion of households moving in or out of poverty was 63% in rural and 46% in urban areas, while 7% of rural and 13% of urban households were considered chronic poor (remained poor throughout the study period from 1994 to 1997).

The social protection strategies needed to avoid descending into chronic poverty – for the non-poor as well as for the transient poor – are different from those needed to improve the situation of the chronically poor (Hulme and Shepherd, 2003; World Bank, 2001c). The transient poor need risk management strategies that help them to rapidly recover after shock. The chronically poor households should benefit from income transfer schemes and targeted social assistance programmes.

Another type of poor people that need targeted social assistance are those that cannot effectively provide for themselves: the elderly, orphans, people with disability or with long-term illness and widows in societies where the household properties belong to the family of the deceased husband (Devereux, 2002; Wood, 2003).

Social protection in health *in the context of poverty reduction*

Improving health status through increased use of effective health services and protection of household income could be considered as two key goals of social protection in *health*. Just as social protection *as a whole* needs different approaches according to the different types of poverty, so does social protection in *health*.

Health insurance is a way to protect households against impoverishment as a consequence of catastrophic health expenditure (Kawabata *et al*., 2002). Health insurance may avoid people moving into poverty, but will do little to move the chronically poor out of the poverty trap (Wood, 2003). The poorest need a comprehensive social protection policy, including programmes that ensure free access to health care. Health problems that affect

whole communities, such as sudden epidemics, need direct government or international intervention. In countries with a high prevalence of HIV/AIDS, there is reason to consider the pandemic as a covariant risk (World Bank, 2001c). HIV/AIDS affects whole communities, seriously affects their opportunities for economic growth, their social cohesiveness and resilience.

The following subsections describe first the prevailing informal strategies on which poor people draw in the absence of formal social protection mechanisms, and subsequently the formal mechanisms that are currently put in place in sub-Saharan Africa.

3.2 Informal African strategies in the absence of formal social health protection

In Africa as elsewhere, in the absence of formal social protection households use a range of strategies to cope with health shocks. These are of two types: strategies in health seeking behaviour and financial management strategies.

Strategies in health seeking

The health seeking patterns in settings where access to health care is problematic are well known. To avoid costs and time loss, ill persons first try out local and cheap solutions: home remedies, modern or traditional drugs that are available on the market or in the nearby store. When these do not help, they seek care with the most convenient and accessible provider of traditional or modern health care. If these are too expensive or a visit would cause too big a loss of time, seeking care is postponed. Delaying care prolongs illness, may result in emergency treatment, hospitalisation and much more expensive care, or death (Asenso-Okyere *et al*., 1998; Atkinson *et al*., 1999; Dahlgren, 2001; Fabricant *et al*., 1999; Msiska *et al*., 1997; Nyamongo, 2002; Sauerborn *et al*., 1994; Schellenberg *et al*., 2003; Watkins, 1997).

Financial strategies

Financial strategies go from reducing consumption to relying on self-insurance mechanisms and informal risk-sharing mechanisms (Dercon, 2002). Self-insurance includes adapting income sources and labour, calling in debts, borrowing or seeking contribution from friends and relatives, withdrawal of savings or selling farming products or livestock. In most African countries there is a great variety of informal group-based mechanisms, such as ‘burial societies’ and ‘friends in need groups’, savings and credit associations or other member-based associations that give, in return for due contributions, a right to access of the group resources for a determined purpose (Cohen and Sebstad, 2003). Informal group-based mechanisms may be designed to manage risks *ex ante* or to cope with shocks *ex post*. Most, however, can only make available small amounts of cash that are rarely sufficient to cover the whole cost of health care (Cohen and Sebstad, 2003; Fall, 2002). The benefits are not sufficient to help a household return to its level of financial stability before the crisis (Sebageni, 2002). In a rare study in Africa based on panel data, Skoufias and Quisumbing (2004) found that villagers in Mali and Ethiopia manage to protect the food consumption of their household when illness strikes, but risk sharing strategies are insufficient to protect other needs. Poor people everywhere report that their informal support mechanisms and networks are increasingly less adapted to a changing

world and do not provide any longer a sufficient level of protection (Cohen *et al*., 2003; Fall, 2002; World Bank, 2001a; WHO and World Bank, 2002).

To mobilize the large sums of money required for hospitalisation, Kenyans sometime organise fund raising events, or *harambees*, but also this practice is less effective than it was before. Whereas previously *harambees* were a successful mechanism to transfer funds from the rich to the poor, more and more, they are organised among people of similar wealth groups, and poor people needing hospitalisation do not manage to collect among their peers the amount needed (Cohen *et al*., 2003).

When self-insurance and informal risk-sharing mechanisms are exhausted, the only alternatives left are to sell assets, default on loans, take children out of school, or turn to moneylenders who charge exorbitant interest rates, sometimes as much as 30 percent per month (Ahmed *et al*., 2003). Rural households that rely on land produce for survival may sell reserves designated for next year's production. In the long run, many poor people may be trapped in a vicious cycle of shocks and increasing indebtedness and irreversible slippage into poverty.

In their study of health insurance in Kenya, Tanzania and Uganda, Cohen and Sebstad (2003) and Cohen *et al.* (2003) classified household's different strategies to respond to shock from what they perceived as the less stressful to the most stressful (see Table 1).

Table 1: Classification of household insurance and coping strategies to deal with shock

Responses to a risk event	Secondary shock impacts
Low stress – Modify consumption – Improve family budgeting – Call in small debts – Draw on informal group-based insurance – Draw on formal insurance	Reallocate household resources Reduce unnecessary expenditures Temporary change in lifestyle
Medium stress – Use savings – Borrow from formal or informal sources – Diversify income sources – Mobilise labour – Migrate to work – Get help from friends – Shift business to residence	Depleted financial reserves Indebtedness – claim on future income flow Long work hours Interference with family life Increased social obligations Loss of customers, reduction in scale of business
High stress – Sell household assets – Sell productive assets – Let employees go – Run down business stock – Default on loans – Drastically reduce consumption – Divest of family ties – Take children out of school to work	Loss of productive capacity Loss of income Depleted assets Loss of access to financial markets Untreated health problems Social isolation

(Modified after Cohen *et al*., 2003)

The social constraints of informal risk sharing and coping mechanisms

Descriptions of informal risk sharing and coping mechanisms highlight a third aspect, next to catastrophic health expenditure and income losses that contributes to the descent into chronic poverty: the social environment. The strategic choices to deal with shocks occur in a given social environment that may make it nearly impossible for poor people to escape the poverty trap.

High transaction costs of mechanisms for mutual aid

Since the sums that can be found in informal risk sharing mechanisms are usually small, people are compelled to invest in multiple reciprocal relations, which increases the transaction costs of protecting their household against risks (Cohen *et al*., 2003). Maintaining a network of reciprocal relationships demands an investment in cash and time. Because of this reciprocal basis of informal risk-sharing arrangements, the poorest in society have the least access to mutual protection (Skoufias and Quisumbing, 2004).

Clientelism

Not only reciprocal, but also hierarchical relations are part of the social contexts in which informal risk management strategies are designed (Wood, 2003). When all other options are exhausted, the poor may decide to enter a patron-client relationship in exchange for social protection. The poor promise loyalty and acceptance of the established social order and may be obliged to engage in exploitative relations by committing themselves, family members or even future generations into unpaid or bounded labour, client loyalty, loss of autonomy and rights. Risk management and seeking protection in the present may thus obstruct poor households' opportunity to ever escape poverty by their own means because they are trapped in a patron-client relationship.

Inefficient choices in mutual assistance

The decision taken by mutual associations to release funds or the decision to assist a neighbour in need is not always the most rational in terms of protecting health. The decision may indeed be motivated by moral considerations leading to assistance refusal for illnesses one should not have contracted in the first place – like for instance sexually transmitted diseases (Waelkens and Criel, 2002).

Severity of illness may also play a role: *"Sickness normally comes when you have no single coin in your house; you can treat malaria by using less than Tsh 1,000* (less than one dollar) *but if you do not have that amount of money, it will cost you at least Tsh 15,000 since reporting late to hospital complicates the illness. . . . The unfortunate part of the story is that neighbours and friends will only assist you when you are seriously sick"* (Millinga, 2002). On occasion people may simply not be willing to assist others to bear the cost of treatment, whereas they would readily share in the funeral costs of the same person (Arhinful, 2003).

Lessons for social protection

The shortcomings of informal risk sharing and coping mechanisms hold some lessons for the organisation of formal systems for social protection in health.

Institutional options should (1) give access to the total sum needed to cover the cost of health care, (2) be organised in such way that they give timely access, (3) with a minimum of transaction costs, (4) they should contain social control: guarantee privacy about the financial situation of the household, about the type of illness and avoid the refusal to cover certain illnesses, and (5) improve health seeking behaviour: increase opportunities to seek health care when needed and with the adequate provider.

When locally organised, formal social protection systems should consider the realities of the social domain (Wood, 2003). Social protection strategies should not only limit people's financial vulnerability, but also circumvent the social conditions that keep people into long-term poverty. They should thwart structural inequities and confront exploitative power relations. Micro-credit programmes did breach the unequal power relations between haves and have-nots by providing the poor with access to money without the exploitative conditions of informal money lending (Gertler *et al*., 2002). Their success should not only be attributed to better financial conditions, but also to social emancipation that these institutions made possible.

These social dynamics of poverty hold a warning for pro-poor strategies that promote community-driven development and decentralisation (Plateau and Gaspart, 2003). Because of the limited ability to reach poor people with top-down approaches, poverty reduction strategies and institutions dealing with poverty reduction promote decentralisation and the organisation of interventions at local level with active community involvement. Social protection programmes may not be effective to reach the poor, but may be appropriated by the local elites if nothing is done to change the structural inequalities (Plateau and Gaspart, 2003; UNDP, 2001). Clientelism is also common among local politicians and civil servants. Decentralisation of local government without promoting changes in the socio-economic environment may be as counterproductive as relying on community leaders and local elite (Ellis *et al*., 2003). Promotion of institutions for social protection at peripheral level should go with political changes and the introduction of instruments that promote genuine democratic control on decision-making by the poor themselves.

3.3 The changing formal African social health protection mechanisms

Initially, African governments opted for provision of free access to publicly financed health services, but few countries have the resources to finance health care through general revenues. The current tax basis is too small and there is limited administrative capacity for adequate tax collection in the large informal sector (Preker *et al*., 2002). User fees introduced to complement government financing deprived many of access to health services. In this context, health insurance is considered an effective alternative to improve access to health care and protect households against the impoverishing consequences of illness. Various systems of social health protection based on insurance currently exist in African countries, namely statutory social security for employees of the formal sector characterised by contributions by employee and employer, private insurance whose clients are mostly employees of private sector companies, and community health insurance (or micro-insurance) whose primary target population are workers of the informal economy (Baeza *et al*., 2002).

Expanding the coverage of health insurance

Formal sector employment as a basis for risk pooling did not expand in Africa as was expected in the 1960s and 1970s. In sub-Saharan Africa, statutory social security covers not more than 5 to 10% of the working population and is even shrinking (Reynaud, 2002). Moreover, we should not ignore that also in the formal sector there is room for improvement. Coverage of health care expenditure is, in practice, often partial at best. In Niger, for example, the government should pay 80% of the hospital costs of civil servants, but this is rarely done. Civil servants then start their own mutual health organisation to improve the coverage of their health expenses (Midou, 2001).

The main challenge, however, remains to find alternative strategies for the large majority that work in the informal economy by designing systems that are adapted to their needs, working and living conditions.

What is meant by the informal economy?

The term informal economy covers many different livelihood activities. A first category is that of self employment in unregistered enterprises: family businesses comprised of independent home-based own-account workers and family workers, entrepreneurs of small unregistered businesses and the self-employed subsistence farmers that form the majority of rural workers. A second category is that of paid employment without secure contracts, worker benefits or social protection: paid workers in informal enterprises, casual or day labourers without fixed employer, temporary and part-time workers and subcontracted home workers (ILO, 2002b and c; Xaba *et al*., 2002; Lund and Nicholson, 2003). Figures are not precise, because each country defines the informal economy differently and many of the invisible jobs such as unpaid workers in family businesses, street vendors and sex workers rarely appear in country statistics (Xaba *et al*., 2002). Based on available data, the ILO found that 72% of non-agricultural employment in sub-Saharan Africa is informal (ILO, 2002c). The large majority of those are self-employed. Women are more often engaged in informal income generating activities than men, especially in home-based work and street vending.

Globalisation contributes to the expansion of the informal economy. Competition between international exporters makes employers cut costs. To avoid the costs of social protection, employers resort to outsourcing to informal enterprises or home-based workers or to engage temporary workers who have no social protection. National labour legislation often focuses on permanent, full-time labour in the formal economy and excludes temporary and seasonal workers. Contracting out to independent home workers is frequent in the garment and textile industry and hiring temporary or seasonal labour is characteristic of the agricultural sector. Contract labour is often organised by a ‘third party’ labour contractor: producers needing manpower hire daily or temporary workers via a contractor who is responsible for employment conditions. Workers employed in this manner more often than not have no written contracts (Lund and Nicholso,n 2003). Such arrangements can aggravate the trapped power relations in which informal economy workers live. HIV/AIDS has a similar cost-cutting effect: in countries with high HIV prevalence, formal sector enterprises reduce the level of health care benefits and other costs related to HIV/AIDS by hiring casual workers or by contracting out to informal businesses (Rosen and Simon, 2003).

Tough competition discourages workers of the informal economy to seek sufficient social protection. A low income is better than no income at all and the fear of loosing work keeps workers from demanding it as part of their remuneration (Lund and Nicholson, 2003).

Not only are workers in the informal economy not covered by social legislation, have no job security or workers benefits, they are also more frequently exposed to dangerous and unhealthy working conditions, while being insufficiently informed to avoid consequences (ILO, 2002a). Surveys have found higher rates of occupational illness among informal than among formal sector workers (Loewenson, 2001). Specific health risks of workers of the informal economy are, however, poorly documented (ILO, 2002a). Lund and Nicholson (2003) describe the situation of seasonal workers in the horticulture industry in South Africa. They observed exposure to pesticides and fumigation during packing that cause allergy, eye soreness and dermatitis, and could be responsible for the relatively high incidence of malformation among new-born. Long working hours may cause disability due to work-related accidents. The shantytowns where seasonal workers live have poor housing conditions, sanitation and access to safe water. They particularly noticed injuries and death from accidents due to transport of poor quality. Given their low income, any expenditure for life cycle events may become a risk, yet their income is too low to pay the contribution asked by insurance companies.

Extension of social health insurance to workers of the informal economy

A first option to protect workers of the informal economy against health risks is to integrate them into the statutory social protection system. Extending social security to workers of the informal economy seems most feasible for those workers who directly work for formal sector enterprises, such as daily workers, temporary workers or home workers (Fall, 2002). In South Africa, for example, steps were taken to incorporate informal workers in the labour legislation (Lund and Nicholson, 2003). Basic protection measures such as maximum working hours, sickness benefits, annual leave and written contracts apply now also to seasonal and temporary workers in the agricultural sector. A difficulty remains to enforce these regulations, especially where labour brokers, more difficult to trace than the actual producers, are the ones arranging contracts and employment conditions. To avoid regression of the social security coverage, contributions of formal sector workers that are organised on a voluntary base, as is the case in South Africa, could be made compulsory. As it is now, many workers opt out of company-sponsored medical-aid schemes because they find the contributions that are deducted from their pay too high (Rosen and Simon, 2003). In Senegal, it was tried to expand the statutory social protection system to workers of the informal economy by allowing them to enrol for coverage of family benefits and work-related accidents (Fall, 2002).

Expansion of statutory social protection could also be promoted by encouraging informal businesses to officially register. Making national regulatory frameworks and bureaucratic procedures more transparent would be a first step (Xaba *et al*., 2002).

A new stakeholder in the promotion of social protection of workers of the informal economy is the Western buyer of the end products. Western buyers voice their disagreement about unregulated and unprotected working conditions. Western companies at the end of the production chain start to promote better working conditions through ‘codes of conduct’ pressure (Lund and Nicholson, 2003). In this sense globalisation that in the first place encouraged the expansion of the informal economy could influence power relations and improve social protection of the informal workers.

It is estimated that about 5-10% of the population could be reached through these measures for extension and reform of statutory social insurance (Xaba *et al*., 2002). It should however be kept in mind that voluntary measures cannot replace labour legislation (Loewenson, 2001).

Community health insurance

Community health insurance is a second option to improve access to health care and reduce vulnerability of households that get their income in the informal economy, especially for independent small businesses in urban areas and subsistence farmers in rural areas that have no links with formal sector employers. Five principles characterise community health insurance (Fonteneau, 2003) (see Box 3) – even if individual schemes, in practice, apply these principles to a more or lesser degree.

Box 3: Definition of community health insurance

1. Social protection through sharing of health risks:

   health care needs of members are paid for from a common fund set up with members' regular contributions

2. A community-based dynamic:

   organized by or for persons who share common characteristics within a given community (a village, an association, etc.)

3. Participatory decision-making and a management system controlled by the members

4. Voluntary participation:

   contrary to formal sector workers, for whom employers have the legal obligation to organise health care protection, the decision to subscribe is taken on a voluntary basis

5. Not-for-profit character of the schemes

Because it is based on voluntary enrolment, community health insurance needs to be made attractive and should be adapted to the needs of workers of the informal economy. The poor self-employed anywhere – also in Western countries (Meer and Rosen, 2004) – are tempted to avoid the cost of a premium, even more so when it does not respond to their expectations. But many are willing to contribute, provided that the social protection system meets their priorities (Xaba *et al*., 2002). Most important requirements for success are adequate responses to their financial constraints, a benefit package that meets their expectations and a transparent and trustworthy management. Community health insurance therefore needs to be flexible. There is not one form, but a variety of models that suite different groups of people in different conditions (Waelkens and Criel, 2004).

Targeted social assistance

Health insurance is only an option for the 'better off poor' that are able to pay the insurance premiums. Health insurance helps them to avoid to descent into chronic poverty. The very poor households need other approaches (Hulme and Shepherd, 2003). The worse off should benefit from targeted social assistance programmes: programmes that provide free access to health care and that address the social aspects of poverty and exclusion.

Exemptions and waivers do not work well

Many countries introduced legal provisions for waiver for the poorest when user fees became the rule. In practice, however, exemption and waiver strategies are rarely implemented in sub-Saharan Africa – and when they are, there are not very effective (Bitrán and Giedion, 2003; Dahlgren, 2001; Gilson, 1997; Kivumbi and Kintu, 2002; Stierle *et al*., 1999). Health personnel are reluctant to waiver fees. They fear that this would endanger the financial viability of their health facility since the financial loss is not compensated by government subsidies. A second problem is that of identifying who may benefit. Selection is usually left to the health personnel who do not have the necessary expertise to do so and who are usually not provided with transparent identification criteria (Collins *et al*., 1996; Russell and Gilson, 1995). Moreover, they are often under pressure to accept people who are not eligible (Gilson *et al*., 1995; Willis and Leighton, 1995). Where the authority to allocate exemption certificates lies with a specific social welfare department, as is the case in Zimbabwe, administrative procedures are complicated for the applicant and reimbursement of the health facility not guaranteed (Watkins, 1997).

An alternative: social support programmes

Some countries are conducting experiments with safety nets to cover the costs of health care for the very poor that do not rely on waivers but pay the health care expenses from specifically earmarked funds (OECD, 2003). The most detailed description of such a fund is one run in Cambodia, where it is called Health Equity Fund (Hardeman *et al*., 2004). A local non-governmental organisation manages the fund, identifies the beneficiaries and pays the costs of hospitalisation, transport, food and other necessities. Its personnel have experience in social work. They handle adequate identification guidelines and, as an independent organisation, do not face the constraints of conflicting interests that the hospital faces.

In Africa, only a few locally organised social support programmes have been documented (see Box 4), although there probably exist many small-scale programmes run on a rather informal basis. Such programmes of social assistance inevitably require government and/or external funds. They provide a channel for donors who wish to invest in poverty reduction (Hardeman *et al.*, 2004). But they also explicitly attempt to provide more than financial support. They promote social inclusion and contribute to the dignity of the poorest. When run by a specific social institution, they also offer social and psychological support.

Box 4: African local social support programmes

In **Mauritania**, the Ministry of Health and Social Affaires, together with the *Deutsche Gesellschaft für Technische Zusammenarbeit* (GTZ), has introduced an experiment to pay for health care expenses for the destitute in 17 sites in the South-Eastern part of the country (ould Aïda, 2003). This particular model seeks to make use of the prevailing attitudes of the Muslim population towards sick and poor citizens. The Koran recommends moral and material support for the sick, as well as redistribution of wealth from the rich to the poor. In the sites, local committees are formed with involvement of the local government, religious leaders and community organisations. The fund is made up from a specific government budget and locally collected contributions. The criteria for selection have been defined through a consensus process. The committee has the roles of collecting resources locally, managing the resources and identifying beneficiaries. Accepted persons receive a certificate that gives access to health care subsidised by the fund.

In **Mali**, the organisation *Médecins sans Frontières* introduced a Fund for Medical Assistance in the district hospitals of Sélingué and Bougouni in 2001 and 2003 respectively (Thomé, 2004). The funds are made available by the local government and private donations (25%), the hospitals (25%) and *Médecins sans Frontières* itself (50%), and are managed by the social services of the hospitals. Both projects are still small-scale (current beneficiaries amount to 2% of hospitalised patients whereas 21% of the population lives in extreme poverty); yet other hospitals, local and central government have expressed their interest in the model.

In **Nairobi**, Kenya, *Médecins sans Frontières* set up a specific fund to cover the social needs of the people affected with HIV/AIDS that were admitted in its programme (Waelkens, 2002). This was in the context of a comprehensive care programme for people with AIDS that covered medical, nursing, psychological and social care. The social assistants of the programme identified five domains that had an impact on the health of the patients, for which destitute patients received financial assistance. These were (1) health care expenses, (2) transport to the health facility, (3) food assistance, (4) payment of house rent and (5) school fees for the children. Payment of house rent was particularly important to ensure that patients treated for tuberculosis did not interrupt their treatment – before they run off to escape their landlord. Payment of school fees had a beneficial effect on parents' health by doing away with a major cause of stress.

Towards universal social protection in health

Beyond measures that ensure better access to care for individuals, the larger framework for social protection includes collective measures that contribute to the health protection of the poor. In an even wider context, social protection encompasses all interventions that attend to both health status improvement and poverty reduction. The ultimate aim is to integrate the different options into a national coherent system for social protection in health. There is no universal blueprint for extension of social protection: each country needs to identify the most appropriate combination of social protection options and start from what already exists and is most adapted to its population (Baeza *et al*., 2002). The way to achieve this is likely to be a combination of improved performance of statutory social health insurance and its extension to those types of workers of the informal economy that work in connexion with the formal sector, community health insurance for the majority of the population of the informal economy, and targeted cash transfers to pay for health care for the core poor.

Some countries are currently designing systems of social protection that combine different options for health insurance (Dussault, 2004). Kenya's National Hospital Insurance Fund that at present covers 10 million people is being developed into a National Social Health Insurance Fund that should cover all 30 million citizens. Ghana officially launched its National Insurance Health Scheme in March 2004. It is designed as a district based system that combines the National Workers' Social Security Scheme that covers 850,000 people in the formal sector, private commercial insurance and mutual health insurance schemes. The government plans to subsidise care for such groups as the elderly and the indigent. Côte

d'Ivoire is designing a national social protection system that combines voluntary and compulsory health insurance. Senegal combines expansion of the social security system and promotion of micro-insurance (Fall, 2002). Mali is experimenting innovative ways to increase the reach and effectiveness of mutual health organisations (Ouattara, 2004).

4 The effectiveness of social protection in health: the potential of community health insurance

To evaluate the effectiveness of social protection in health we should measure whether it contributes to the improvement of people's health and whether it protects households from catastrophic health expenditure (Baeza *et al*., 2002). Both these questions remain basically unanswered for sub-Saharan Africa.

Yet we have partial answers in the domain of community health insurance, hence the strong focus on this particular instrument in the present section. Documentation on community health insurance all over Africa shows coherence on several points. First, there increasing indications that community health insurance improves financial access to health services, which may in its turn substantially contribute to better health. Second, people show growing acceptance of community health insurance, so demand is increasing. Third, community health insurance may be the best strategy available today to improve access to health care for the poor (Preker *et al*., 2002), thus opening a road to sustainable poverty reduction. These three aspects are discussed in the following subsections.

The positive findings of improved access and growing acceptance of community health insurance schemes must however be contrasted with their current low coverage and limited financial capacity to cover expensive health care episodes.

4.1 Improved access for the insured

There is increasing evidence that members of community health insurance schemes have better access to health care than non-members do. High utilisation rates may sometimes suggest misuse of cards by non-members, due to insufficient control procedures and the absence of a feeling of ownership (Agyepong-Amarteyfio *et al*., 2002; Atim and Sock, 2000; Musau, 2004). However, in the large majority of schemes, higher utilisation by members compared to non-members can be interpreted as an indicator of better access to necessary health care (Atim, 1998; Atim, 1999; Criel and Kegels, 1997; Massiot, 1998; Musau, 1999; etc.). Members not only seek care more frequently, but also earlier at the onset of illness thus avoiding delay in seeking care, and preventing more severe illness and more expensive care (Arhin, 2001; McCord, 2000; Massiot, 1998; Schneider *et al*., 2001a; etc.). This is confirmed in interviews and focus group discussions with members and non-members throughout Africa (Chee *et al*., 2002; Criel and Waelkens, 2003; Jutting, 2004). Health personnel corroborate these findings (Chee *et al*., 2002; Wiegandt *et al*., 2002). People also report the positive effects of health insurance on avoiding seasonal exclusion.

A notable aspect of improved access is that the insured have a greater chance to receive and take a complete treatment course, whereas direct payment often leads to procurement of partial treatments (Asenso-Okyere *et al*., 1998; Cohen *et al*., 2003; Schneider *et al*., 2001b).

4.2 Growing acceptance and increasing demand

Generally, interviewed people are favourable to the concept of health insurance. Households welcome the lower transaction costs of subscribing to one scheme compared to the range of relationships needed with informal risk management strategies (Cohen *et al*., 2003). There is also an expressed demand for *ex ante* protection mechanisms to manage risk. Access to micro-insurance reduces people's *ex post* stress, resulting in a lower depletion of savings and borrowing and selling of assets to deal with shocks. In Uganda, subscribers expressed how the knowledge that they would financially cope when struck by sudden illness gave them a feeling of security (Sebageni, 2002). Also managers of small enterprises and schools observed that their workers or students have better access to health care and that the administrative burden is dramatically reduced (McCord and Osinde, 2003). In Guinea-Conakry, people convincingly expressed their interest in the design of mutual health organisations and listed the possible advantages for their household (Criel and Waelkens, 2003).

People who do not have access to social protection ask for it. Among communities interviewed in Kenya, Tanzania and Uganda, the demand for micro-insurance is high (Cohen and Sebstad, 2003). In Senegal, where mutual insurance schemes exist since quite some time, people living in areas where they are not yet introduced also express a demand for insurance, provided the management of the scheme is trustworthy and the benefit package responds to their priorities. Most had an income and were willing to contribute (Fall, 2002).

If the exponential growth of the number of new initiatives is an indicator, the enthusiasm of the population is evidence that should not be discarded. In Ghana, for example, the number of schemes increased from 4 in 1998 to 47 in 2000 and 157 in 2004 (Atim *et al*., 2001; Bennett 2004). There is a sharply increasing membership all over West Africa in terms of number of new schemes and number of new members (Fonteneau, 2003). This is confirmed by the most recent count carried out by the Coordination Network (*La Concertation*)[4] in 11 countries (Benin, Burkina Faso, Cameroon, Côte d'Ivoire, Guinea, Mali, Mauritania, Niger, Senegal, Chad and Togo). Community health insurance schemes in West Africa show a growth from 76 active schemes in 1997 to 199 in 2000 and 366 in 2003 (Ndiaye, 2004). Next to these, another 220 schemes in the early stages of development were counted.

4.3 A promising channel …

Pro-poor policies recognise the limits of a top-down approach to reach the poor, and therefore promote decentralisation and community-driven development. But, as seen before, both decentralisation and community-driven development may be as ineffective as centrally driven programmes in reaching the poor. The poor tend to accept as normal the fact that the local elites appropriate the lion's share of community budgets and capture the benefits of decentralisation. They need to be organised to reverse patterns and to manage social protection in a more equitable way (Platteau and Gaspart, 2003). By providing an alternative to the clientelist relationships between rich and poor, formally organised social protection may create the conditions needed to circumvent the long-term poverty trap

[4] <http://www.concertation.org>

inherent to informal risk management mechanisms (Hulme and Shepherd, 2003). Community health insurance offers an opportunity for the change needed.

… to give voice to the poor, …

Both the Declaration of Alma-Ata (WHO/UNICEF, 1978) and the Bamako Initiative (UNICEF, 1988) aimed at making primary health care universally accessible through community financing and greater community participation in decision-making, planning and management of health services. However, effective community involvement in decision-making about health care is rarely achieved (Jewkes and Murcott, 1998; Gilson *et al*., 2000; Jaffré and Olivier de Sardan, 2003). Yet, organising the community in health insurance schemes may enhance the process of civil society participation.

First, the part of people's financial contribution in the evolution towards an effective participatory process should not be underestimated. Platteau and Gaspart (2003) illustrate the relationship between financial contribution and participation in decision-making with the relationship between governments and taxpayers in higher-income countries. In countries where the large majority of citizens pay taxes, accountability of the government, control by and negotiation with the taxpayers is inherent to the system. In contrast, in many African countries where the majority does not pay taxes, this relationship of control, accountability and negotiation with the citizens hardly exists. Whereas community health insurance schemes do not necessarily establish participation in decision-making from the start, members express their desire to have a voice in decisions about health service provision (Chee *et al*., 2002; Musau, 1999). Since people invest their own money in the schemes, they seem to feel more entitled to have their say. Organisations that function with people's financial contribution open a gate for democracy.

Second, the democratic structure in itself of many community health insurance schemes enhances both the emancipation and the bargaining strength of the poor (UNDP, 2001). People's involvement in the design of the scheme is an opportunity to adapt the benefit package to their felt needs and the payment modalities to their financial and social situation. Moreover it is expected that the involvement of communities will contribute to greater responsiveness of the health services and improved patient satisfaction. This positive evolution was observed in community health insurance schemes in Rwanda: in the districts where community health insurance was introduced, quality of care improved for members as well as non-members (Schneider *et al*., 2001b). An added expected outcome of democratic decision-making is that it will increase enrolment in health insurance schemes and thus increase use of health services (OECD, 2003).

Third, health insurance schemes as organised groups representing people may also be effective vehicles for making people's health needs known at national level (UNDP, 2001). Evidence from Rwanda sustains this assertion. The general assemblies of mutual health organisations progressively became important interest groups that contributed to putting health on the political agenda (Schneider *et al*., 2001a and b).

… to extend social protection, …

One of the most frequent criticisms of community health insurance is that it excludes the poorest (Gilson *et al*., 2000). Lack of money is indeed a major reason why many do not enrol or do not pay their contributions regularly (Atim, 1998; Atim and Sock, 2000; Bennett *et al*., 1998; Fall, 2002; Jutting, 2004).

However, this inherent limitation should not lead to the conclusion that community health insurance does not reach the poor. First, population groups targeted by micro-insurance often live on less than US$2, even less than US$1 a day. Even if the poorest among them remain excluded, many poor households can and are willing to join (Arhin-Tenkorang, 2001; Preker *et al*., 2002). In Tanzania and Uganda, the average member falls above and just below the poverty line (Cohen and Sebstad, 2003). In Rwanda, 53% of surveyed members belonged to the poor, compared to 21% to middle income and 26% to higher economic groups (Schneider *et al*., 2001b). Second, from a risk management point of view, avoiding the descent into extreme poverty is as important as reaching the very poorest. Since the high costs of hospitalisation, chronic diseases and illness of different household members can be devastating for the less poor also (Cohen and Sebstad, 2003), they definitely need protection from catastrophic health spending (Arhin-Tenkorang, 2001; Kawabata *et al*., 2002).

Once community health insurance schemes are established and well managed, they can in their turn be entry points to reach the poorest with targeted subsidies (Schneider *et al*., 2001a; World Bank, 2001). In a first phase, organising these subsidies can be piloted by non-governmental organisations and financed by donor funds (Arhin-Tenkorang, 2001). This was done in the community health insurance schemes of Kabutare in Rwanda, where church institutions paid the annual enrolment fees for 3 000 destitute people and for 40 members of AIDS associations (Schneider *et al*., 2001b). In addition to providing access to health care to the poorest, subsidising their premiums within a health insurance scheme promotes integration into the mainstream benefits and social inclusion.

Particularly in Africa, HIV/AIDS is a threat to the continued existence of community health insurance because the cost of care for people with AIDS is high. It is also a cause of exclusion when affected households can no longer afford to pay the premium (Cohen and Sebstad, 2003). However, insurance schemes can be effectively used as a channel to subsidise AIDS-related treatments and to organise prevention and care activities.

In the long run, community health insurance can be an entry point to larger pooling arrangements and ultimately be integrated into a national system of social protection in health (Reynaud, 2002). But this process will take time (Meessen *et al*., 2002a). First, existing schemes should attract a larger proportion of their target population. Once that is achieved, schemes should federate into larger pools. Mechanisms should be developed to promote solidarity and cross-subsidising between richer and poorer schemes. All these changes deserve international promotion but should not be pushed through too quickly. Health insurance is not only about introducing a financial system, but also involves social changes that should be given the time they need.

… to expand health services, …

Community health insurance may also become a channel to expand health services to its members. Several schemes in Kenya, Tanzania and Uganda purposefully introduced preventive activities and promotion of healthy life styles with the aim to decrease the need

for curative care. Some do active promotion of antenatal care, others dissemination of health information or distribution of impregnated bed nets against malaria at subsidised prices (McCord and Osinde, 2003). In Rwanda, as a side effect of easier access to curative care, members use preventive services more often than non-members (Schneider *et al*., 2001a). Also in the early European experiences, health insurance programmes were effective channels for disseminating information about health and healthy lifestyles (Winegarden and Murray, 2004).

… and eventually to reduce poverty in a sustainable way

Community health insurance's combined potential of giving voice to the poor, extending social protection and expanding health services represents a unique opportunity. Together, these positive effects are both a condition and a result of a democratic process that may contribute to the empowerment needed for sustainable poverty reduction, even if the development of community health insurance in the African context still needs a long way to go.

5 The impact of social health protection: access to health as lever for economic performance

Access is as pivotal for public health professionals as productivity is for economists. Economists provided ample evidence that better health contributes to higher productivity. From a public health point of view, common sense suggests that social protection in health can have a positive impact on economic performance by increasing access to health care. But is there any evidence that supports this assumption?

5.1 International evidence

Winegarden and Murray (2004) explored the effects health insurance exerted on health in five European countries (Belgium, Denmark, France, Germany and Sweden) at the end of the 19th and the beginning of the 20th century. Growing health insurance coverage was associated with a dramatic decline in mortality. Health insurance contributed to this trend by improving access to medical care for more people and through the better dissemination of health information.

Dow *et al*. (2001) examined the effects of financial accessibility of health care on health status, labour force participation and wages, based on experimental data from the United States and Indonesia. In a health insurance experiment conducted in the United States during the late 1970s and early 1980s, study subjects were enrolled in health insurance plans with different levels of deductibles and co-payments. For the poorest population groups, the absence of co-payment was associated with more use of medical services, resulting in better health outcomes and greater labour force participation. The results of a similar experiment in Indonesia showed that health services use declined where care was most expensive, and so did labour force participation. This negative impact on labour was highest among men and women with the lowest education levels.

The evidence from both experiments suggests that for those who are most vulnerable, better financial access to health care indeed has benefits for participation in the labour market, income and economic growth.

Few other studies investigated the links between health insurance, general health status and economic prosperity. Lack of panel data for poverty analysis is still a problem in Africa (Hulme and Sheperd, 2003; Laterveer *et al.*, 2003; McKay and Lawson, 2003). Health data are rarely suited for exploring economic impact (Gallup and Sachs 2001; McCarthy *et al.*, 2000; Snow *et al*., 1999). A recent article in *The Economist* (2004) discusses the imprecise costing of AIDS in sub-Saharan Africa: *"The most dreadful cost of AIDS is in lives cost. A second cost, shared by those not infected, is economic. However, estimating the damage done by the disease, especially in southern Africa's mostly feeble economies, is an inexact exercise even by the standards of economics, because AIDS has struck hardest in areas where data are least accurate: subsistence farming, casual labour markets, rural barter and so forth"*. As far as community health insurance in Africa is concerned, most information comes from descriptive studies that are not designed to determine causal pathways (Thomas and Frankenberg, 2002). Some give information on improved access to care and financial protection of the household, but little is known about the impact of

community health insurance on health or the workforce (Baeza *et al*., 2002; Jutting, 2004; Preker *et al*., 2002).

Moreover, studying the impact of social protection faces serious methodological difficulties.

First, selecting the appropriate health indicators is not easy at all. Measuring specific objective health indicators in large-scale household surveys is expensive (Dow *et al*., 2001). Most surveys therefore rely on self-reported health status. This may lead to biased conclusions, as higher-income or more educated people tend to report more illness than their lower-income counterparts (Russell, 1996). On the other hand, the multi-dimensional complexity of health hampers the applicability of more objective measurements of health status. Mortality for example is the most frequently used and relevant indicator in public health, its measurement is relatively straightforward and it gives information about healthy life years lost. But is not an appropriate indicator to measure neither labour force participation nor productivity. It is precisely because health status is so difficult to measure that Dow *et al*. (2001) choose to use labour outcomes as an indicator for the relationship between health care cost and health outcomes, which provided us the opportunity to use their evidence on the link between access to health care and productivity.

Second, social protection is part of poverty reduction strategies and of health strategies that both consist of many other components that may influence economic and health outcomes. Hence, the range of possible confounding factors is extensive and isolating the contribution of social protection measures is difficult. In their previously mentioned study, Winegarden and Murray (2004) aimed to establish the contribution of health insurance to decreased mortality. They were cautious enough to examine a large sample over a large period of time. They selected a period in which mortality was decreasing dramatically and countries where health insurance was expanding rapidly. Still, they concluded that improved health was due to a combination of measures and that health insurance was *"an additional contributory factor that has hitherto been overlooked, in addition to living conditions, the workplace, urbanization, education (especially of women), advances in medical science, infant-feeding practices and hygiene, politicians, planners and reformers"*. Dow and Schmeer (2003) choose to evaluate the effect of health insurance on infant and child mortality in Costa Rica. This country deviated from third world standards by adopting national health insurance and providing excellent statistical data. Infant and child mortality rates dropped rapidly, but this could not be explained by health insurance alone. Other changes in maternal, household, and community characteristics contributed as much to the drop in mortality.

5.2 Evidence for specific health problems

While information about the impact of social protection on general health is scarce, there is more evidence for specific health problems. Several studies describe the effect of health interventions for specific diseases on the workforce and productivity.

Malaria interventions

As mentioned in chapter 2 of this review, Utzinger *et al*. (2002) investigated the economic effects of the malaria control programme in Zambian copper mines. They described how the comprehensive malaria control programme implemented by the mining management

dramatically reduced morbidity and mortality, and increased the overall productivity of the mining companies.

Although this programme shows the positive effects of disease control on productivity and economic growth, it does not give us direct information on the effects of social protection and of improved access to health care. There were no traces in the well-kept company records of any financial assistance to pay for the cost of care. Nor did the workers receive payment for the days they were absent due to malaria attacks. Environmental management to reduce mosquito infestation was the main intervention strategy. However, access to health care services had its place: because of great attention to rapid malaria diagnosis and treatment, death due to malaria was very rare. Access to health care was indeed improved because of its availability on the site and because the income of mining workers was substantially higher than that of farmers.

Environmental management is still one of the pillars of malaria control, but not often carried out on a large scale. Current programmes give more importance to prompt access to treatment and individual protection with insecticide treated mosquito nets. However, both treatment and protective nets are too expensive for many households. In parts of Africa with high malaria prevalence, poor households spend up to 25% or more of their annual income on malaria prevention and treatment (WHO, 2002). Buying bed nets, even at subsidised prices, would for many households be at the expense of basic needs (Guyatt *et al*., 2002). To avoid costs, many first treat themselves with drugs sold on the market, but these are often of questionable quality or sold in inadequate doses. Such inadequate treatment contributes to the increase in drug resistance, which is one of the most pressing issues facing Africa (WHO, 2002). Health insurance that encourages timely access to correct treatment is therefore not only essential for a quick recovery but also to avoid building resistance against currently used drugs.

AIDS interventions

Debswana, a diamond-mining company in Botswana, had started an AIDS education and awareness programme in 1988. Yet between 1996 and 1999, it was noticed that HIV/AIDS-related morbidity and mortality was increasing among its employees. The starting point for investigating the scope of the problem and for defining a company strategy to deal with HIV/AIDS was that without such strategy, the company could not survive. The employees and the unions were involved from the start in the study itself and in determining what should be done to provide for the infected employees and their dependents. Although expensive, the company management concluded that providing antiretroviral therapy would be beneficial because it would result in a decrease in absenteeism, hospitalisation costs and sick leave, a reduction in the cost of replacement and training of new recruits, a reduction in death and disability remittances, and ultimately in greater productivity. Next to these quantifiable benefits, the company believed that the workforce performance would benefit from the psychological impact of providing antiretroviral therapy because it would give new hope, boost morale, motivation and cohesion among company workers. One year after the programme had started, 190 patients had registered for treatment. HIV prevalence rate dropped from 28.8% in 1999 to 22.6% in 2001 (Barnett *et al*., 2002).

Also the International Organisation of Employers (2002) recognises that it is imperative for businesses to respond to HIV/AIDS because not doing so may result in exponentially increasing costs. Promoting access to antiretroviral therapy can help prolong the lives of employees and hence provide long-term benefits to the company.

5.3 Poor people's opinion: health care as a road out of poverty

Poor people everywhere, when interviewed, stress the importance of access to health care services for their survival and livelihood (WHO and World Bank, 2002). Poor people heavily rely on their labour productivity, and shortening an episode of illness means avoiding a drop in earnings. Participants of focus group discussions held in Guinea, for example, repeatedly described the benefits of health insurance in terms of swift access to treatment, swift recovery and thus faster return to work (Waelkens and Criel, 2002).

6 Conclusions

We wish to present three main conclusions at the end of this review.

The first conclusion, by no means surprising, is that the poverty implications of ill health are clear. There is plenty of evidence in sub-Saharan Africa, especially coming from studies conducted on malaria and HIV/AIDS that illustrates the causal effects between ill health and poverty. People themselves are perfectly aware of this vicious relationship. The poverty implications are situated in the field of health expenditure taking catastrophic dimensions, but also in the field of reduced productivity and loss of income.

The second conclusion is that there is a strong case for expanding social protection in sub-Saharan Africa, and this for the following reasons. First, there is an *ethical* reason. Social protection simply is a human right – just as is the case for access to basic health care. Second, there is a *social* reason. There is a strong and largely unmet demand for effective, affordable and non-discriminating systems of social protection. They are expected to reduce people's anxiety in case of health shocks, safeguard their dignity and self-esteem, and eventually improve their overall well being. And third, there is a *technical* reason. There is today in sub-Saharan Africa little documented evidence on the specific impact of social health protection on health status, poverty reduction and economic growth (it was pointed out in this review how difficult it is in methodological terms to actually prove such impact). But common sense invariably dictates us to invest in social protection, and evidence from OECD countries indicates that a comprehensive package of health and poverty reduction interventions, including social protection, succeeds in reducing poverty levels.

The third conclusion we wish to put forward is the need to accept that African social protection systems, if they are to effectively cover more people than is the case today, will need to take a multiform appearance. Different models must be developed concomitantly and should be properly articulated in one way or the other. This is a complex managerial task implying sound insights into the strengths and weaknesses of each model, but also knowledge of the optimal balance to be achieved between them in different contexts. Here lies an immense, but hardly explored, area for future research.

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