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**Understanding causes of inequity in social health protection coverage in sub-Saharan Africa: an analysis using three different knowledge paradigms**

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Background

Health systems researchers have become increasingly concerned with explaining the causes of policy success and failure, reflected by the growing focus on policy evaluation. One particularly important area of evaluation is exploring reasons why socio-economically disadvantaged groups are often relatively less likely to benefit from publicly funded social health protection policies, despite having greater need. If universal health coverage (UHC) is to be achieved, underlying mechanisms to explain how and why this exclusion occurs need to be better understood and addressed.

Yet causality is an ultimately unresolved issue in social science. One central dilemma is whether social structures or individuals have primacy in shaping human behaviour (“agency versus structure”). Health systems researchers must implicitly or explicitly choose between three main knowledge paradigms in order to address this question: positivist, critical realist and social constructionist. This paper reviews the differential use of knowledge paradigms in studies of causes of inequity in social health protection coverage and discusses the implications for policy.

Methods

A systematic literature review (using PubMed and ISI Web of Science) of studies of causes of inequity in coverage of social health protection policies (e.g. user fee exemptions, health insurance, vouchers) in sub-Saharan Africa was conducted. Methodologies used by the studies to identify causes of inequity and the study results were analysed through the lens of each of the three knowledge paradigms.

Results

Using different knowledge paradigms generates different attributions of causality. The review produced three sets of explanations for inequity of social health protection coverage relating to (a) individual behaviours and incentives (e.g. payment of health workers), (b) historically and contextually rooted generative mechanisms (e.g. social closure or mobilisation of institutional bias) and (c) contested, conflicting and contradictory nature of concepts that inform policy debates and interventions (e.g. “corruption”, "trust” and “solidarity”). Each type of paradigm also produces different policy implications. Yet all three paradigms exhibit clear limitations and no one paradigm alone provides a comprehensive explanation for the complex social phenomena at the heart of exclusion from UHC.

Conclusions

There is overlap across the three paradigms, meaning they need not be mutually exclusive; each has strengths that should be used to evaluate and develop policy. Policymakers should (a) be able to distinguish between and understand these different paradigms which lead to different causal explanations of policy success or failure and (b) foster collaboration across researchers holding different kinds of knowledge and perspectives.