Case study No. 1

The challenge of improving health of the people in Coresia

Social health protection for the people

The various health care schemes come under the purview of the Ministries of Health, Social Development, Planning, Home Affairs, and Finance. It is estimated that at present, about half the population in the country has access to quality health care services through subsidized and contributory schemes. Most informal economy workers are presently not covered by any social protection programmes.

About 18 per cent of the total population is covered under the Public Health Care Plan (PHCP), a health insurance scheme targeted at the poor and near poor population and funded by the Government. Compulsory health insurance programmes, which cater to civil servants, military personnel, and formal private sector employees, have been in existence for many years. The National Law for the Extension of Social Security (No. 293), enacted on 11 August 1995, provides a legal framework to design and implement a system to provide basic social security and welfare to all Coresian workers and their dependants. The Law has been adopted and its implementation started with the design of insurance programmes which facilitate access to essential health care services and facilities to all people.

Existing health care schemes include:

- **"National Health Insurance Programme (NHIP)":** Under this programme, all workers in private sector organizations of ten or more employees can avail insurance in the event of sickness of the employee or their dependants. This also includes documented migrant workers who have a formal work permit in Coresia. The contributions amount to 3 per cent of the wage by employees on a monthly basis and an equal amount by the employer. If the employees have dependants, then they contribute 6 per cent of the wage every month, while the contribution by the employer remains unchanged. The maximum wage

to be considered for contributions is COD20,000 per month. Employers may opt out of the NHIP scheme if they provide higher benefits to employees under privately-run schemes or establish in-house medical services. The NHIP fund is supervised by the Ministry of Labour. In 2011, membership to NHIP reached 4,149,325 workers (about 30 per cent of formal sector workers). The total beneficiaries (including workers and their dependants) stood at 7,247,721 people. This is a very small proportion of the employed and total population. This is due to the non-coverage of small enterprises (fewer than ten employees) and weak enforcement. It is recognized that there is high social evasion by private sector employers who do not provide any health protection to their workers under NHIP or otherwise. In June 2012, the Ministry of Labour Decree No. 373/2012 was enacted, whereby certain high-cost treatments, such as those for HIV-AIDS, heart surgery, chemotherapy, and haemodialysis, have been included in the benefit package of NHIP.

- **"Medical Beneficiary Programme for Civil Servants and Military Personnel (MBP)":** All civil servants (both in service and retired), retired police and military personnel, war veterans, and their dependants are automatically registered under MBP and are entitled to insurance benefits and subsidized medical care under this scheme. The contributions amount to 3 per cent of the salary by public servants on a monthly basis and an equal amount by the Government. Active military and police personnel are entitled to in-house medical care and have access to special military hospitals. The MBP insurance fund is supervised by the Ministry of Finance. In 2011, membership to MBP was 2,421,687.

- **"Public Health Care Plan (PHCP)":** The PHCP is a non-contributory scheme providing essential health care services, medicines, and other necessities to the poor and near poor population free of charge. Beneficiaries are treated or counselled in community health care centres and designated government hospitals. Medicines can be bought at no cost at the community health care centres. The programme provides essential health care but excludes high-cost treatments, including anti-retroviral treatment for HIV, chemotherapy, among others. Under the PHCP, the community health care centres receive capitation payments based on the number of poor and near poor people in the community and historical data on the number of people seeking care at the centres. The per capita cost under PHCP was COD2,500 in 2011. The programme had about 11.5 million beneficiaries in 2011 (18 per cent of the population), of which around 2.3 million were poor (representing 48 per cent of the total poor population). Some provinces that have successfully covered their poor population under the PHCP have extended the scheme to near poor and non-poor informal economy workers as well.

- **"Social Health Insurance for Self-Employed and Informal Sector Workers, and SME employees (SHI)":** The SHI programme for informal economy workers was launched in 2008 following the Ministry of Labour Regulation No. 173/2007 on 'Providing Social Security and Health Care to workers in the informal sector as well as workers in small and medium-sized enterprises (SMEs)'. The programme is targeted at self-employed workers, informal economy workers, and SME employees. It is assumed that their average monthly earnings is at the level of the minimum wage of COD6,000 per month. Under this programme, the protected workers and their dependants can avail health care benefits and services. For health care, the employee contribution is 3 per cent of the reference income (minimum wage) for workers without dependants and 6 per cent for workers with dependants. Employers pay contributions of 3 per cent of the reference income. In the case of self-employed workers, the worker pays both worker and employer contributions. After a sharp increase in coverage, the total number of the insured seems to have stabilized

at around 1 million people. Membership to SHI varies widely from one month to the next because affiliation is voluntary and members can easily opt in or opt out of the programme. Surveys show that the programme is not very popular among its target group.

Growing challenges

Although the Government of Coresia has made an effort to include the entire population in health insurance schemes, a sizeable portion still does not have access to any scheme. Currently, over 50 per cent of the poor population is not covered by health insurance.

Implementation of SHI for informal economy workers has not been very successful. The main reasons are:

- Many workers who earn less than the minimum wage cannot afford to pay regular contributions.
- Microenterprises are often not registered with the Ministry of Commerce and it is difficult for the SHI scheme to identify all the prospective beneficiaries.
- Among the insured members of SHI, only 35 per cent of self-employed workers manage to pay contributions on a regular basis.

The Public Health Care Plan, which aims to provide free health care to poor and near poor people, has been extended to the non-poor informal economy workers in some provinces. While this is seen as a positive step, some inconsistency is created as the target group is not the same across the country. The Government is considering replicating this initiative in all provinces, but the discussions are still in initial stages. If this happens, the SHI scheme will probably be replaced entirely by PHCP.

During joint discussions, the UN-GOC SPF team in Coresia recommended that the Government may consider the gradual extension of PHCP to non-poor informal economy workers all over the country. It has been observed that high-income informal economy workers are already availing private insurance schemes and being treated in privately owned hospitals. As a result, the high-income group will likely not use the PHCP if extended to the informal economy population.

The Public Health Care Plan, which aims at providing free essential health services to poor and near poor people, does not have a comprehensive database recording information on beneficiaries and utilization of health care services. This affects the sustainability of the programme. The Ministry of Health is presently working on establishing a common database for the PHCP.

The PHCP benefit package lacks clarity in definition. Beneficiaries often are not aware of the facilities they can avail. An interview with Kim Luie, who lives close to a community health care centre, revealed the following: *"My family and I were refused treatment on two occasions last year. When we went to the centre because my daughter had viral influenza, a doctor told us that they cannot treat her. Another time, we were asked to pay money. We left because we did not have any money to pay the doctor."*

Further interviews with beneficiaries revealed that people in remote areas do not have sufficient money to travel long distances to community health care centres. The Government has been considering the introduction of additional benefits, such as reimbursement of transportation costs to hospitals or health care centres. Concerns have been voiced about the quality of medical services

and treatments at remote hospitals and centres. Check-in of patients takes time and they are asked to fill lengthy forms. The system needs some improvement.

In the private formal sector, most employees claim not to have access to NHIP or to private insurance schemes. NHIP is a compulsory scheme and employers can only opt out of it if they provide better health care plans to their employees. It is important that the penalty for evasion by employers is made strict and enforceable and supervisory mechanisms to monitor registration and contributions are put in place. Certain high-cost treatments, such as heart surgery and chemotherapy, are excluded from most schemes, even private ones. NHIP recently included these treatments in their benefit package.

The legal framework

Table 1. Legal framework of social health protection programmes

Programme	Legal framework
National Health Insurance Programme (NHIP)	• Law No. 157/1984 on 'Ensuring worker health and safety' • Ministry of Labour Regulation No. 29/1986 on 'Health and safety of workers' • Ministry of Labour Decree No. 373/2012 on 'High cost treatments'
Medical Beneficiary Programme for Civil Servants and Military Personnel (MBP)	• Law No. 110/1973 on 'Welfare of civil servants, military, and veterans' • Ministry of Finance Regulation No. 12/1977 on 'Contributions to health insurance for civil servants' • Ministry of Finance Regulation No. 36/1979 on 'Health care for police and military personnel'
Public Health Care Plan (PHCP)	• National Law No. 293/1995 for the 'Extension of social security' and its amendments • Law No. 619/2008 on 'Guaranteeing public health services'
Social Health Insurance for Self-Employed and Informal Sector Workers, and SME Employees (SHI)	• Law No. 157/1984 on 'Ensuring worker health and safety' • National Law No. 293/1995 for the 'Extension of social security' and its amendments • Ministry of Labour Regulation No. 173/2007 on 'Providing Social Security and Health Care to workers in the informal sector as well as workers in small and medium-sized enterprises (SMEs)'

Questions:

Module 8 – Please complete the assessment matrix provided to you on the basis of the case. You are encouraged to discuss the case within your group and refer to the *World Café* reports while completing the matrix. Please keep in mind that you should address the issue of health care only.

Module 10 – Please translate the recommendations of your group into three scenarios.

Module 11 – Please calculate the cost of implementation of each scenario. Your group is required to propose one scenario to the Government for implementation. Please keep in mind that the cost

of implementing the scenario you propose should not exceed the budget allotted to your group in the *Jeopardy* and *Who wants to be a protectionaire?* games. Strengthen your proposition by linking the cost of implementation to economic indicators such as GDP.

Module 14 – Please develop an advocacy campaign to lobby for one or several policy options and gain support for the endorsement and implementation of your recommendations.

Assumptions for costing (for facilitators to provide to their groups)

Table 2: Share of formal and informal employment

Share of formal employment	**37.7%**
Share of informal employment	**62.3%**

We assume that the share of informal sector population in the total population is 62.3 per cent and that this percentage remains constant for all years until 2020.

The PHCP scheme covers 18 per cent of the total population. In further detail, PHCP covers 48 per cent of the poor population. These percentages may be assumed to remain constant for all years until 2020.

The annual per capita cost of PHCP benefits is COD2,500 in 2011. It increases in proportion to the average wage increase every year until 2020.

The administrative cost of targeted social health protection schemes is assumed to be 15 per cent of the cost of benefits. The administrative cost of universal programmes is lower at 5 per cent of the cost of benefits.