November 1, 2011

# Summary

# Rodulio Perdomo: *Social Protection in Honduras*

The SPER (Social Protection Expenditure Review) methodology, developed by the ILO, constitutes an important analytical tool that permits the analysis of the benefits and result indicators of social protection systems. It provides a framework that identifies not only existing social protection mechanisms but also allows for the identification of gaps in view of the different social risks faced by the citizens of a country. In the case of Honduras, there has been a tendency to view social protection in a narrow manner - as a tool to cover the needs of highly vulnerable social groups. As a result, there have been efforts to develop a social protection policy focused on addressing the needs of 16 groups of people identified as the primary beneficiaries of social protection:

1. Children between 0-5 years of age not covered by health services and in risk of malnutrition, sickness and death
2. Children between 6-11 years of age (3-5, 6-11) out of formal schooling, in risk of failing to obtain the necessary knowledge and abilities so as to finish primary school and enter the labour market
3. Child and youth workers (exploitation)
4. Children victims of sexual violence
5. Abandoned and street children
6. Children and youth in conflict with the law
7. Women, children and youth suffering from violence and abuse
8. Pregnant teenagers and young parents
9. Women in reproductive age (15-49 years)
10. Youth with low levels of education and work
11. HIV-positive persons and those affected by or vulnerable to the virus
12. Children and youth with drug addiction
13. Elderly people over the age of 60
14. Disabled persons
15. Indigenous and afro-descendent populations

16. People residing in disaster areas

This narrow conceptualisation of social protection forms the basis for focusing this analysis in a more comprehensive manner on 1) social security 2) health, and 3) social assistance. This review pays attention to effective coverage as well as groups marginalised or insufficiently catered for by the existing social protection institutions. This review analyses the three aspects of social protection in the Honduran context and allows for the gaining of insight into future social protection efforts and scenarios in the country.

The quantitative data on the functions in each of the three policy areas mentioned above have been drawn from the specific Budgets of the year 2011. With regards to social security for formal sector workers, it becomes evident that coverage is differentiated because the system is very fragmented and there are important differences in the social security benefits provided by each individual institution. In the case of health care, the quality of the coverage of services varies depending on the population: rural population is attended to y auxiliary nurses and access a limited selection of basic medicine, whereas the urban population accesses the services of general and specialised medical doctors (through regional and national hospitals). As regards social assistance to the extremely poor, different schemes have reached almost a half of the extremely poor through a range of subsidy and cash transfer programmes. Yet, in most cases it is relevant to pay attention to the fact that social assistance schemes are often interrupted every four years, along with the changes in the administration. A holistic vision of the three policy areas will allow us to better understand achievements and immediate and medium term challenges in social protection.

## 1. Social security

The Economically Active Population of Honduras is estimated at 3.3 million, of which only 763 000 are active contributors or direct beneficiaries of the country's social security institutions. This proportion, which equals 23 percent of the EAP, is a reflection of the gaps found in social security and indicative of the magnitude of the challenges the country faces in the coming years in this respect. Indeed, *Plan de Nación – Visión de Pais 2010-2038* sets a goal to expand social security coverage to reach 90 percent of the salaried EAP in the future. Yet, despite the clear political intention to reach this goal, it will be demanding to advance to incorporating the own-account workers of the country, who experience the greatest deficits in the field of social protection.

In addition, the available data permits us to make the cautionary observation that the prospects of extending social security coverage depend crucially on IHSS, as the remaining 4 social security institutions of the country cater exclusively for specific groups: namely, teachers, university professors, military personnel and public sector workers. The existing imbalances between operational budgets and the number of contributors lead us to the conclusion that the different social security institutions are very distinct and, consequently, provide very different levels of coverage and protection.

**Table 1. Social Security Institutions' Coverage and Budget in Honduras, 2011**

| | **Budget 2011 (lempiras)** | **No. of contributors** |
|---|---|---|
| Instituto Hondureño de Seguridad Social | 3 662 081 022 | 611 177* |
| Instituto Nacional de Previsión del Magisterio | 5 853 149 200 | 70 942 |
| Instituto de Previsión Social de los Empleados de la Universidad Nacional Autónoma de Honduras | 712 645 444 | 6 298 |
| Instituto de Previsión Militar | 2 319 763 701 | 27 639 |
| Instituto Nacional de Jubilación de los Empleados y Funcionarios del Poder Ejecutivo | 4 926 500 000 | 47 895 |
| Total | 17 474 139 367 | 763 952 |

**IHSS contributors numbered 611 177 in the Sickness and Maternity scheme and 502 016 in the Occupational Safety and Health scheme*

These differences derive from the fact that there is a wide range of benefits, especially pensions, which translates into heterogeneity in the quality of benefits accessed by elderly people. Very few access an adequate pension after retiring, and most pensioners receive merely a sum equivalent to 100-150 dollars, enough to cover only 60 percent of the cost of a basic food basket. This implies that the coverage by the existing institutions of contingencies faced in old age is insufficient and does not correspond to the real needs of the population. It is interesting to contrast the total social security budget of 17 billion lempiras with the expenditure levels found in other areas of social protection described in the following sections.

## 2. Health care

The Honduran Secretariat of Health manages a network of 28 hospitals: 6 national-level, 6 regional, and 16 local ones. Mobile health services comprise 32 maternity and children's hospitals, 380 health centres with medical and dental services (CESAMO), 1018 rural health centres (CESAR), 4 peripheral emergency clinics (CLIPER) and 14 family clinics specialised in intra-household violence, 9 community centres with specialised childbirth care and 8 houses for mothers. The country has 298 municipalities, of which 70 percent have predominantly rural inhabitants, who primarily depend on CESAR health centres with auxiliary nurses in charge of the provision of care. The peripheral clinics are urban health centres that regulate and control the demand for the services of national-level hospitals[1]. Table 2 demonstrates that there is a persistent problem of under-coverage, as regards both primary health care and hospital services. The budget of the Secretariat of Health is slightly inferior to a half of that of social security.

**Table 2. Public Health Budget and Estimated Coverage in Honduras, 2011**

| **Health provider** | **Coverage (no. of persons)** |
|---|---|
| Secretariat of Health | 9 743 261 800 |
| **Level of attention*** | **Coverage (% of population)** |
| Primary care | 61.2 |
| Secondary care | 38.8 |

* *Estimated coverage for the period 2006-2008, one or more consultations.*

The resources channelled to health care correspond to approximately 70 percent of the total Honduran health expenditure. The deterioration of the quality of health services, especially the unavailability of medicine and surgical supplies, translates into a high share of private health spending, apparent in the period 2005-2010.

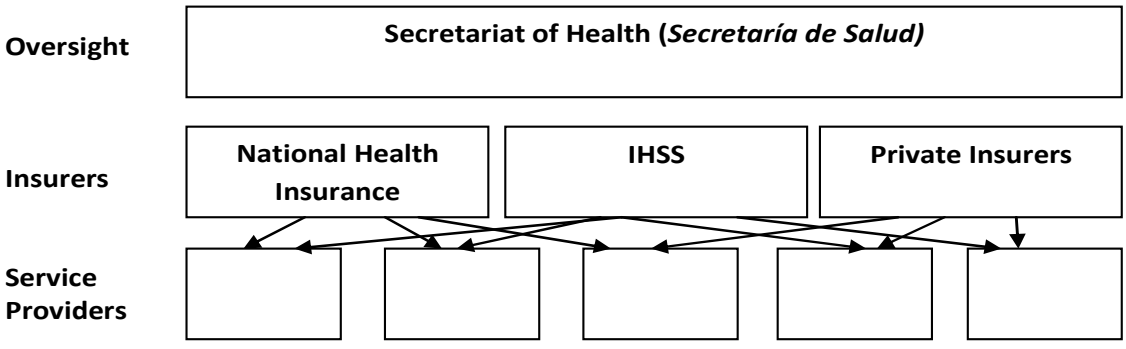
[1] The residents are not registered to a specific health clinic, but can freely choose which hospital to turn to for services. For this reason, it is common that residents from different parts of the country prefer to seek care at the national-level hospitals where there are specialised medical professionals and the adequate technology not available in other health establishments.

**Table 3. Total Health Spending in Honduras, 2005 and 2010**

| Type | 2005 | 2010 |
|---|---|---|
| **Health spending (millions of lempiras)** | 10 538 | 20 874 |
| **Health spending as % of GDP** | 6.7 | 7.1 |
| **Public health spending as % of total** | 67.9 | 70 |
| **Private health spending as % of total** | 32.1 | 30 |
| **Average yearly spending per inhabitant (lempiras)** | 1491 | 2594 |
| **Average yearly spending per inhabitant (dollars)** | 78 | 136 |

The upward trend in health spending, by both the public health authorities and the households, is explained by the fact that health spending is highly inelastic because of the inevitable nature of health risks and the corresponding financial costs. Yet, it is also certain that radical transformations are needed in the existing health service model, so as improve its effectiveness and guarantee access to the same basic services in all levels of the health centre hierarchy.[2] The response of the government to this challenge has been concentrated on efforts at increasing coverage. This may be understood with the help of the following diagram that portrays the goals of its health reform endeavours. The diagram reveals the government intends to turn the Secretariat of Health into an oversight and financing organism and reduce its role in the direct provision of services.

***Health Service Model – National Health Plan 2010-2014***




[2] Many less poor rural residents access national hospitals, while many lack the means to do so. There are project responses to this issue, e.g. 1) mobile surgery units that visit remote areas, 2) Local Emergency Funds that pay for poor patients' transport costs. There are fewer longer-term programmes to address these needs.

This diagram is found in the *Plan Nacional de Salud 2010-2014,* or National Health Plan. The proposed pluralistic model implies a process of separation of functions, in which the role of the Secretariat is focused on the oversight and regulation of the health system. Additionally, insurance would be provided by a National Health Insurance subsidised by the State and directed at the poor population that cannot contribute to a social security institute. In addition, IHSS would be transformed into an institution focussed solely on insuring. Lastly, the presence of private insurers is recognised.

## 3. Social Protection

The task of estimating the net public spending on social transfers to poor households and individuals is not, under the current conditions, a simple one. No methodology exists that would permit differentiating between gross and net social assistance spending by income status of the beneficiary families. As many as 22 different transfer schemes may be identified, and of these, we exclude 3 schemes[3] that are controversial because of their nature or because of the difficulty of estimating their beneficiary population or budget. In the following table, 19 types of transfers are presented (PRAF comprises several schemes not listed here but counted among the 19). These include the long-running PRAF family transfer programme as well as other less well known schemes, which nevertheless have an impact on the well-being of the poorest households.

**Table 4. Public Expenditure on Social Assistance Programmes in Honduras, 2010**

| Social assistance scheme | Beneficiaries** | Expenditure (lempiras) |
|---|---|---|
| PRAF cash transfers* | 683 477 | 635 044 500 |
| Bono 10 000 cash transfer | 160 000 | 1 120 000 000 |
| School transport subsidy | 150 000 | 60 000 000 |
| Public transport subsidy | n.a. | 162 000 000 |
| ENEE electricity subsidy | 600 000 | 360 000 000 |
| SANAA water subsidy | 500 000 | 75 000 000 |

[3] The following have been omitted: 1) gas subsidy – preferential tax rate for LPG gas used by poor households, 2) HONDUTEL telephone cross-subsidy – cheap local calls in exchange for more expensive international calls, 3) subsidy for basic consumption products.

| | | |
|---|---|---|
| School feeding | 1 345 000 | 627 000 000 |
| Small farmer support | 150 000 | 70 000 000 |
| **Total (households)** | 3 588 477 | 3 109 044 500 |

**284.7 million lempiras were transferred from PRAF to Bono 10 000. Therefore, PRAF net transfers amounted to 351 million lempiras in 2010.*
***Calculating the number of beneficiaries is complex. If a household member receives a benefit, all household members are considered beneficiaries of the scheme.*

It is worth noting that the total sum of a little over 3 billion lempiras that is spent on social assistance ranks third in the order of magnitude among the three categories of social protection analysed in this review. The reason for the upward trend in the volume of social assistance spending is that the total now includes spending related to the decentralised institutions SANAA (water subsidy) and ENEE (electricity subsidy), and others, which previously were not treated as part of social protection but are now incorporated. The same applies to the Secretariat of Education, which in cooperation with the World Food Programme and other partners finances the school feeding scheme present in almost all primary school in the country. Also, the introduction of Bono 10 000 in 2010 and the unprecedented level of the benefits provided to households by the programme has an impact: benefit levels go from 600 lempiras per year to 10 000 lempiras a year from 2010 onwards.

## 4. General Observations

The three basic areas of social protection: 1) social security 2) health, and 3) social assistance were allocated a total of 30 billion lempiras in Honduras in 2010. This equals 10.4 percent of the 2010 GDP of the nation. In the context of the national poverty incidence of 60 percent, this level appears inferior to the investment that would be required in order to extend the coverage of social protection.

**Table 5. Estimate of Social Protection Coverage and Expenditure in Honduras, 2010**

| | **Expenditure (lempiras)** | **Coverage (No. of persons)** |
|---|---|---|
| **Social Security** | 17 474 139 367 | 763 952 |
| **Health*** | 9 743 261 800 | 4 921 492 |
| **Social Assistance** | 3 109 044 500 | n.a. |
| **Total** | 30 362 445 667 | |

| | |
|---|---|
| **GDP 2010** | 290 990 000 001 |
| **Social protection as % of GDP** | 10.4 |

**Coverage of primary health care*

For a minimum level of social protection to be guaranteed in Honduras, more resources are required. Also, there must be commitment to build the capacity to effectively target the households and individuals that could eventually join an insurance scheme, while providing social assistance for the remaining persons with special needs[4] who are in need of state subsidies, not only limited to social insurance arrangements.

[4] Poor households with at least one member suffering from a severe illness, such as cerebral palsy, HIV/AIDS, multiple sclerosis, Chagas, leprosy, etc. represent target groups that have needs distinct from those of the classic assisted household that needs help for a limited period of time.