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Bridging Social Protection and Occupational Health Services in Madagascar

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Introduction

Human health is determined by physiological factors and by the conditions in which people are born, grow, live, work, play and age and the systems and forces that shape these – in other words, social, environmental, behavioural and political factors (Marmot 2001). At the individual level, the different determinants of health are not experienced in silo and therefore should ideally be tackled and addressed by employing a coordinated and holistic set of policies and institutional frameworks. Social protection and occupational safety and health systems both aim to address some of the social and environmental determinants of health for the working population and beyond, and in particular, occupational health services (OHS) and social protection schemes covering healthcare and employment injury and occupational diseases. They share a common public health objective of promoting good health, preventing (work-related) injuries and diseases, supporting access to health care without hardship, guaranteeing income security throughout sickness and injury and facilitating rehabilitation. In this respect, both policies directly support the achievement of SDG targets 1.3 and 8.8, respectively, and jointly contribute to the achievement of SDG 3 on health and wellbeing for all.

In support of coordinated and holistic approaches, a research project consisting of a scoping review and three country case studies was undertaken as part of the ILO-France Project "Universal Access to Social Protection and Health and Safety at Work" to generate an understanding of existing linkages and coordination mechanisms between national social protection systems and occupational health services, while also highlighting the current gaps in knowledge that need to be filled. This country case study brings together the findings of the research in Madagascar, with the aim of providing an overview of the existing coordination mechanisms between the national social protection system and the national occupational health services system, while also highlighting the current gaps that need to be addressed. By examining current practices and identifying areas for improvement, this case study aims to facilitate the coordination of OHS services and the national social protection system, ultimately ensuring enhanced protection and well-being for all workers in the country.

Background

The Government of Madagascar has made strong commitments towards achieving both universal health coverage (UHC) and universal social protection (USP). These commitments are particularly important given the socio-economic and epidemiological profile of Madagascar. Indeed, poverty rates remain high in Madagascar with great geographical disparities. While 71.5 per cent of the population are living below the poverty line at national level, these rates reach 83.4 per cent in rural areas and 21.8 per cent in urban areas (INSTAT 2020). Despite considerable efforts, the health situation in Madagascar remains sub-optimal, threatening the health system and the well-being of the Malagasy population. For example, rates of malnutrition and neonatal and infant mortality remain persistently high (INSTAT 2022).

In turn, more than 96.1 per cent of employment in Madagascar are in the informal sector, where labour regulations are largely unenforced (ILO n.d.). In turn, a large majority of workers do not benefit from social protection and few of them have access to occupational health services or decent working

conditions. Occupational hazards were identified among the top ten risks responsible for the highest number of deaths in Madagascar in 2017 (IHME 2017), in spite of occupational accidents and diseases being largely under-reported and that current statistics are expected to be underestimated (ILO 2019).

Social protection system

The country adopted its first National Strategy on Universal Health Coverage (SN-CSU) in 2015, followed by the National Social Protection Strategy (SN-PS) for the period 2019–2023. Despite these political commitments, many efforts and resources are needed to achieve these objectives.

Social health protection (SHP) in Madagascar is characterized by a lack of universal entitlements and fragmentation, composed of a range of different mechanisms that achieve low overall coverage. These include:

- The government covers the medical expenses of civil servants, retired civil servants and non-statutory civil servants and their families, as well as military personnel and their families, which is guaranteed by law or decree.
- For vulnerable groups, Decree no. 2003/1040 provides for the use of funds of the "FANOME"[1] to facilitate access to healthcare. The decree does not, however, provide a definition of the target group and coverage remains low.
- The Caisse Nationale de Prévoyance Sociale (CNaPS) covers maternity care for women in the formal economy or the wives of formal workers.
- Exemptions and subsidies are also provided by the government and development partners to assist low-income individuals, covering basic health consultations, vaccinations and the management of certain communicable diseases.
- Voluntary health mutuals, with benefit packages that vary among them, are present in 20 of the country's 22 regions. The government aims to strengthen the role of mutuals by promoting community-based health insurance (LHSS 2023).
- In light of the low coverage of SHP mechanisms, institutions initially responsible for occupational health services, particularly the Inter-Entreprise Medical Services (Service Médical Inter-Entreprise, or SMIE), have come to play an important role in the financial protection and provision of general health care for workers and their families.

This high level of fragmentation results in low coverage, with 4.3 per cent of households protected by SHP mechanisms that have legal bases if SMIEs are excluded (ILO 2022).

The CNaPS administers contributory social protection schemes, covering family benefits, pensions, disability and survivors' benefits, occupational injury and disease compensation and maternity benefits for women in formal employment or the spouses of formal workers. Affiliation to the CNaPS is mandatory for employees in the formal private sector, but self-employed, agricultural and temporary workers, who constitute a significant share of Madagascar's labour force, are not covered. While CNaPS coverage theoretically reaches 10 per cent of the workforce, approximately just 840,393 workers were effectively covered in 2021 (ILO 2023).

Non-contributory cash and in-kind benefits include "human development cash transfers"[2] and cash for work programmes, as well as emergency cash assistance implemented in the southern part of the country. These programmes are largely donor funded and achieve low coverage, particularly when compared with poverty rates in the country (MPPSPF 2019).

Occupational health services

The Ministry of Labour, Employment, Public Service and Social Legislation (MTEPSLS) is the main authority overseeing occupational health services. Within this ministry, the Directorate of Social Security for Workers (Direction de la Sécurité Sociale des Travailleurs, or DSST) manages compensation, social benefits, prevention and occupational medicine.

Within the Ministry of Public Health, the Occupational Health and Intercompany Organizations Department[3] is responsible for developing occupational health guidelines, focusing on non-communicable diseases and health protection for vulnerable populations.

[1] Acronym for "Fandraisan' Anjara NO Mba Entiko", or "Financing for Non-stop Drug Supply"
[2] Les Transferts Monétaires de Développement Humain
[3] Service de la Santé au Travail et des Organisations Interentreprises

Occupational health services are regulated primarily by Decree no. 2003-1162, later amended by Decree no. 2011-631 and by the Labour Code (Law no. 2003-044). These outline four models of occupational health services (SMT)[4] in Madagascar[5]:

- SMIE are non-profit associations organized by several private companies, designed to provide health services to employees within a 30-kilometer radius in areas where there are more than 1,500 workers. SMIE funding comes from contributions, amounting to 6 per cent of gross salary (that is, 5 per cent from the employer and 1 per cent from the employee), with a minimum based on the statutory wage. There are currently 28 SMIEs in the country.
- Companies employing more than 500 workers based outside the geographical scope of existing SMIE organize services internally through Autonomous Medical Services for Enterprises[6], of which 50 were registered in 2017.
- State Medical Services provide occupational health service for public establishments.
- Public Health Training Centres offer services to smaller companies unable to establish or join SMIEs, through agreements with employers of fewer than 500 workers.

According to the above-mentioned decrees, employers are mandated to organize occupational health services through affiliation with one of the occupational health provider models outlined above. Affiliation of self-employed individuals and independent professionals is voluntary, meaning that only 5.55 per cent of the population in Madagascar is effectively covered by occupational health services (ILO 2022).

Similarly, the legal and regulatory frameworks also provide for a role of the CNaPS, as well as the Ministry of Public Health, in the delivery of certain OHS functions, with the latter focusing on workers in the informal economy.

Linkages between occupational health services and social protection

Dual role of the Service Médical du Travail (SMT)

The SMT fulfils a dual role, both providing occupational health services and delivering and providing financial protection for general health care services that go beyond occupational health. Indeed, Decree 2003-1162 and Decree 2011-631 outline the range of services that must be covered by the SMTs, which include in relation to OHS:

- Routine medical check-ups
- Provision of food for sick workers in isolated areas while awaiting evacuation
- Occupational safety and health education
- First aid training
- Workplace inspections to assess working conditions
- Prevention and awareness programmes on sexually transmitted diseases and human immunodeficiency virus (HIV)

The Decrees also require SMTs to deliver and cover preventive care and health education, medical care for illness and medical evacuation to the nearest medical facility for both workers and their families. In this system, there is broadly[7] no provider-purchaser split, with the SMTs both providing financial protection for healthcare services and delivering them. In practice, a review of services covered and delivered by SMIEs highlighted that these go even beyond what is outlined in the regulation for workers and their family members and include:

- **General medicine:** General consultations, pharmacy access and basic care
- **Specialized medicine:** Cardiology, gynaecology, neurology and other specialities
- **Diagnostic services:** Radiology, ultrasound and laboratory analyses
- **Occupational medicine:** Routine check-ups, workplace visits and awareness programmes on topics such as nutrition and hygiene.

[4] Service Médical du Travail
[5] This case study primarily focuses on the work of the SMIE and is based on a review of the coverage and service delivery of five SMIEs, namely: Organisation Sanitaire Tananarivienne Interentreprises (OSTIE); Association Médicale Interentreprises de Tananarive (AMIT); Centre Médical FUNHECE SMIE; FUNABE SMIE; Espace Sanitaire Interentreprises d'Antananarivo (ESIA).
[6] Services Médicaux Autonomes d'Entreprise
[7] As outlined below, when the resources of a SMIE do not allow the provision of all services covered, they may establish agreements or 'conventions' with other health facilities to deliver such services, the costs of which are covered by the SMIE.

In relation to maternity and work injury or occupational disease, the CNaPS covers a complementary range of benefits. For maternity, the CNaPS provides maternity income benefits and covers part of the healthcare costs. In cases of occupational disease or injury, the CNaPS reimburses SMTs for the care they have provided, covers pharmaceuticals and hospitalization once the occupational nature of the injury or disease is confirmed, supports rehabilitation and reemployment for work-related injuries and provides income security for affected workers.

Implications

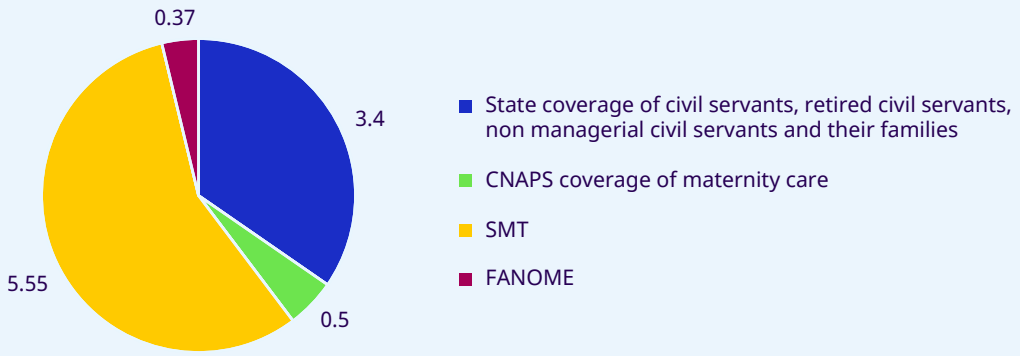
The model adopted in Madagascar and the dual role played by SMIEs in OHS and SHP have several implications.

Coverage

Firstly, the model adopted by Madagascar and the dual role exercised by SMIEs have implications for the coverage of both OHS and SHP. From the perspective of OHS, the model adopted in Madagascar for the delivery of OHS through the SMIEs supports access to OHS for workers, pooling as it does risks through the SMIE. This considerably reduces the burden on each affiliated company, as compared to models based on employer liabilities, thereby promoting compliance with regulations and in turn facilitating access to such services for workers, particularly for workers in small and medium enterprises.

From a SHP perspective, the delivery and coverage of services that go beyond occupational health contribute to the expansion of coverage of existing mechanisms. Indeed, effective SHP coverage currently reaches about 4.3 per cent of the population: however, this rises to 9.8 per cent if SMIEs' coverage is taken into account, effectively doubling the share of persons protected by a mechanism, as illustrated in figure 1 (ILO 2022). Indeed, it is the limited coverage of SHP mechanisms itself that is said to have been one of the driving factors behind the expansion of SMTs' services into general medicine, with employers placing pressure to access a broader range of services to compensate for limited coverage of other SHP mechanisms.

▶ Figure 1: Effective protection by social health protection mechanisms or occupational health services by population group, as a % of the total population in 2018



Source: ILO 2022b.

On the other hand, from the SHP perspective, the level of risk pooling within the SMIE is relatively fragmented, with wide variations in the coverage of each SMIE as illustrated in table 1 below. This level of pooling is closer to that seen in mechanisms such as mutuals, where pooling is fragmented and which can affect the financial sustainability of SMIEs.

▶ **Table 1: Number of enterprises and workers affiliated to SMIEs (Service Medical Inter-Entreprise) and persons covered by them, 2023**

	Number of affiliated enterprises	Number of covered workers	Estimate[8] of the population covered
OSTIE	4 228	161 591	678 682
AMIT	648	30 667	129 000
FUNHECE SMIE	349	13 201	17 868

Source: Data collected directly from the SMIE under the project.

Yet, there are several gaps in coverage that remain, as well as challenges to the expansion of SMIE coverage.

- Firstly, geographic limitations restrict the reach of SMIEs. Owing to the rules on their establishment, SMIEs are mostly found in urban areas, with eight of Madagascar's 22 regions lacking an active SMIE and almost a quarter of the population residing outside the radius of SMIE coverage (INSTAT 2020). Agricultural workers, who face high occupational risks, are therefore often effectively excluded. Although some SMIEs have expressed interest in expanding their coverage beyond the 30-kilometer radius defined in regulations, they are in fact constrained by current regulations (ILO 2019). Accordingly, while regulations allow voluntary affiliation of self-employed workers, SMIEs are not obligated to offer coverage to this category of workers and indeed, of the five SMIEs studied, only one allowed these affiliations, with others fearing financial strain arising from them. For self-employed workers, the high contribution rates (based as they are on the minimum salary) may pose a financial barrier. Though state subsidies could help low-income workers and households' access to SMIEs, no such support currently exists in Madagascar.
- Secondly, there are also questions as to how the coverage of SMIEs aligns or articulates with that of other SHP mechanisms. Indeed, it was reported that competition is starting to arise between SMIEs and community-based health insurance (CBHI) mechanisms in locations in which both mechanisms operate, which the Ministry of Public Health is promoting in order to advance UHC. As they often offer lower contribution rates, CBHI systems attract self-employed workers who might otherwise join SMIEs, potentially reducing access to OHS for this group.

A third consideration revolves around the comprehensiveness of the **benefit package** delivered and covered by the SMIE, as well as the articulation between the services covered by the SMIE and those covered by the CNaPS. In relation to the first point, it is important to highlight that while some services delivered by the SMIE are mandated by decree (for example, Decree 2003-1162 and Decree 2011-631), any care provided beyond what is specified in these Decrees is not legally guaranteed. This absence of guaranteed benefits is at odds with international standards. In turn, SMIEs currently provide first-level medical care without hospital or rehabilitation services. For maternity, SMIEs cover pre- and postnatal care but not obstetric care or hospitalization. In the case of maternity and health care services for workers affected by WIOD, there is a certain level of complementarity with the benefits covered by the CNaPS for workers affiliated to it. However, the distribution of benefits and services between the two entities is very complex, with gaps in coverage for certain services and benefits, which might negatively affect continuity of care. The intricacy and complexity of the divisions may also create confusion for affiliates and their families over which services are covered and by whom. Yet even for those affiliated with CNaPS, effective access to covered maternity health care services is extremely low, with only an estimated 2.9 per cent of births among CNaPS affiliates effectively covered (ILO 2022), which may be a result of lack of awareness or confusion owing to the divisions in coverage. This highlights the need to better rationalize and align benefit packages and coordinate between CNaPS and SMIE benefits to ensure complementary and coherent access to care and income security.

Range of OHS functions

The dual role played by SMIEs also in part affects the range of OHS functions that should be under

[8] Based on an average household size of 4.2 persons (INSTAT 2020)

their purview. The provision of curative care and public health services to workers and their families represents the majority of SMIE activities, with one estimate suggesting that between 60 and 90 per cent of the expenditure and working time of SMIEs is dedicated to the provision of non-work-related health services (ILO 2019). While this effectively responds to the needs of their members (particularly given the low level of coverage of other SHP mechanisms) it is observed that it leaves little scope for SMIEs to engage in their preventive role. For example, an ILO assessment of SMIEs found that some were unable to adequately advise employers on health, safety and hygiene, which was partly due to limited workplace visits and insufficient assessment capacities. SMIEs also fulfil only a partial role in health, hygiene and ergonomics training, focusing largely on first aid, the delivery of curative services for workers and their families and public health training rather than on occupational health (ILO 2019).

Quality of services

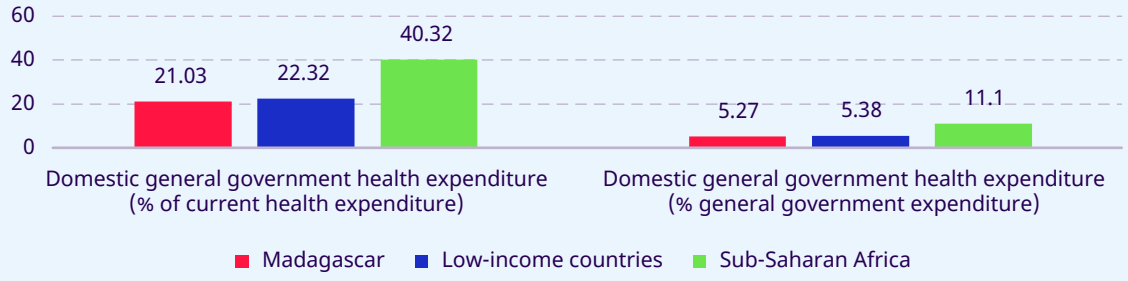
The model and dual role also have some implications for the quality of services provided and covered. One positive aspect to the dual role played by SMIEs in occupational and general health is that this can bridge the commonly observed divide between these two areas. For example, SMIEs reported that this integration facilitated the exchange of information between general and occupational physicians, which is often a challenge (Persechino et al. 2017), thereby enabling a more comprehensive monitoring of workers' health status.

On the other hand, there is wide variation between SMIEs in relation to available infrastructures and resources. While Decree 2003-1162 provides for the Minister of Labour to support the financing of SMIEs, there is no state funding provided for this in practice. As a result, while some SMIEs emanated from pre-existing medical centres with advanced facilities (for example, X-rays and ambulances), in other cases initial setup costs are dependent on resources available amongst member companies, which can result in disparities in terms of the resources and infrastructures available among SMIEs. Thus, when the resources of an SMIE are not sufficient to provide all the services covered, they may establish agreements, or 'conventions', with other public or private health facilities to provide curative care to affiliated workers and their families, the costs of which are borne by the SMIE.

Financing

Another element to highlight is that the dual role played by SMIEs brings resources to bear in the SHP system. This is particularly important given that the resources available and allocated to health in Madagascar are limited and below both regional averages and averages amongst countries in the same income group, as is illustrated in figure 2 below.

Figure 2: Domestic general government health expenditure in Madagascar, low-income countries and sub-Saharan Africa



Source: WHO, n.d.

Mandate of the Caisse Nationale de Prévoyance Sociale (CNaPs) for occupational health services

A second linkage identified in the research relates to the responsibilities of the CNaPS in the delivery of certain OHS functions for specific categories of the population. The legal framework in Madagascar assigns CNaPS a preventive role in terms of monitoring occupational accidents and diseases, enforcing employer compliance with health and safety standards and promoting preventive practices. CNaPS's role in accident prevention and occupational health includes awareness-raising, training and advisory activities, typically requested by employers for audits. In practice, the ILO study notes that many stakeholders are unaware of CNaPS's prevention programmes, with a lack of clarity and occasional duplication in roles between the CNaPS, DSST and SMTs, especially concerning the provision of technical advice to companies, prevention and inspections (ILO 2019).

Conclusion

The engagement of SMIEs in the coverage and delivery of general healthcare services addresses important gaps in the coverage of SHP mechanisms, representing a response to the needs of their members; and indeed, coverage by an SMIE is an aspiration for many uncovered workers, with an ILO study of workers in small and medium enterprises in the urban informal economy highlighting that 70 per cent of respondents expressed a desire to be covered by the CNaPS and/or a SMIE (ILO n.d.). Achieving UHC will require reflection on the manner in which the SHP mechanisms articulate with one another to guarantee coherent and universal coverage. While the role played by SMIEs is recognized in the National Strategy for Universal Health Coverage of 2015, specific guidelines on their integration with other mechanisms are lacking. This could be facilitated through better coordination in relation to the geographical location or target populations covered and/or through the harmonisation or complementarity of benefit packages.

Furthermore, the responsibilities of the CNaPS in relation to the prevention of occupational risks can complement coverage of SMIEs. Similarly, there are also opportunities to strengthen coordination among health, social protection and occupational health actors. For example, greater coordination could be envisaged between the SMIEs, employers and the CNaPS in relation to the reporting of work injuries and occupational illnesses so as to facilitate access to benefits. As mentioned above, the under-reporting of accidents at work or occupational illnesses is thought to be high, mainly owing to a lack of willingness on the part of employers and workers, but also the restrictiveness of the list of occupational illnesses (ILO 2019). The Ministry of Public Health could also, through its engagements in the promotion of worker health, raise awareness about social protection and support the expansion of its coverage with a view to promoting access to a comprehensive range of benefits.

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