United Nations Research Institute for Social Development

Social and Solidarity Economy as Main Actor of the Extension of Social Protection in Health in Africa?

Bénédicte Fonteneau
HIVA–KU Leuven

Draft paper prepared for the UNRISD Conference
Potential and Limits of Social and Solidarity Economy
6–8 May 2013, Geneva, Switzerland

The United Nations Research Institute for Social Development (UNRISD) is an autonomous research institute within the UN system that undertakes multidisciplinary research and policy analysis on the social dimensions of contemporary development issues. Through our work we aim to ensure that social equity, inclusion and justice are central to development thinking, policy and practice.

UNRISD, Palais des Nations
1211 Geneva 10, Switzerland

Tel: +41 (0)22 9173020
Fax: +41 (0)22 9170650
info@unrisd.org
www.unrisd.org

Abstract

From the 90s, many mutual health organizations have been set up to provide social protection mechanisms to populations uncovered by their national social protection systems. In various African countries, these organizations are expected to play a major role in the upcoming policies related to social protection. Mutual health organizations are expected to cover de facto about 80% of the population. The inclusion of such organizations in public policies can be interpreted as recognition in terms of capacity of the Social and Solidarity Economy in providing service, governance and representation of the interests of the members. But the low number of mutual health organizations and their weak capacity to scale-up raise questions about the feasibility of such policies. In this paper, we propose an analysis of this paradoxical situation from both the perspective of public policies and the perspective of the social and solidarity economy.

Introduction

In most African countries, social security systems originated in the 50-60s. The design of these systems was based on the assumption that developmental processes in Africa would certainly follow the Western model. This explains why existing social security systems in Africa are somehow a copy/paste of the Western social security systems, mostly strongly linked to the labour market. As we know, development processes in Africa have taken another turn and the majority of the population is (still) working in the informal sector or in the rural sector without any kind of formal social protection in health. Existing State-run social security systems are offering limited benefits for a small part of the population, namely the civil servants and workers employed by formal enterprises. In addition, administrations in charge of social security issues are in many African countries, rather inefficient and sometimes ineffective in their duty (ISSA, 2008).

From the late 80s, many community- or NGO-based initiatives have been taken to somehow offer health insurance packages to people not covered by their national state-run social security systems and neither able to buy insurance package from private for profit companies. Many of these initiatives led to the creation social and solidarity organizations, namely, mutual health organizations.

This situation has been left as such for years, with African governments and the international community paying no attention to social security and social protection issues. But since 2000, social protection has been (re)appearing on public policy agendas under the influence of major international organizations (ILO and the World Bank in particular) (see. e.g. Social Security : a new consensus", 2001; de Haan, 2000; Barrientos & Hulme, 2009). Over the years, various tools have been developed by these international organizations to operationalize the extension of social protection, especially in developing countries: specific analytical framework in the second-generation of PRSP, the Social Protection Floor initiative launched by the ILO in 2009 in collaboration with other UN agencies, adoption in June 2012 of a new ILO recommendation (202) of social protection that marks the recognition of social security as an economic and social right and a social necessity for the development and progress.

In many developing countries, social protection systems have entered in deep reform process. In the health sector, these processes are closely linked with the ones about financing health systems and the "path to universal health coverage" since a more equitable, effective and efficient health systems financing is considered as a part of the solution to a better social protection in health (WHO, 2010).

In several francophone African countries (i.e. Mali, Burkina Faso, Benin, Senegal) social protection strategies being developed or under discussion classify the overall population classified according to their activity (formal - public or private economy, rural/urban informal economy - incl. agriculture -) and/or individual characteristics (vulnerable groups: women, people with disability, children under 5, absence of revenue). To each group correspond specific (private, public or community-based) mechanisms (insurance, assistance) and financing sources (government revenue, contribution of the population, international aid). Social and Solidarity Economy

organizations are expected to play a major role in this new social protection model systems since mutual health organizations should, according to the model elaborated in these countries cover about 80% population, namely all those working in the informal economy or in the rural sector.

In this paper, we will propose to critically look at such social protection policies mainly based on social and solidarity economy initiatives. We will start from an empirical description of the development of mutual health organisations in Africa and of their relations with the State. Based on this situation, we will try to analyse the challenges associated with such policies from both the perspective of public policies and the perspective of the social and solidarity economy. This paper will focus on several Francophone West Africa countries (Mali, Senegal, Burkina Faso, and Benin) where the development of mutual health organizations has been more significant than in other regions. We will more in particular make reference to the cases of Senegal and Burkina Faso (based on our own research and studies; see bibliography) where the development of mutual health organizations and the proposed reforms related to social protection in health also present important common characteristics.

1. Development of Mutual Health Organizations in Africa

1.1. Mutual health organisations as Social and Solidarity Economy organizations

The existence and implementation of MHOs in Africa did not occur by chance. African MHOs first appeared in the late 1980s and early 1990s, coinciding with two developments (Fonteneau & Galland, 2006): 1) beginnings of democratization processes and 2) the implementation of the Bamako Initiative. In many African countries, the late 1980s represented the beginning of democratization and the emergence of a civil society. As a result, many initiatives were undertaken by the population to respond to urgent needs and political issues. These initiatives were encouraged by development cooperation agencies that wanted to support the democratization process. In this context, the associational affiliation of MHOs, as non-profit, autonomous, mutual-interest organizations was an easy and flexible way to launch a collective initiative. During the 1990s, the Bamako Initiative (launched in 1987 by the World Health Organization and UNICEF) was also progressively implemented. Designed to secure access to quality primary healthcare, the Bamako Initiative rested on three principles. First, primary healthcare services must attain a sufficient level of self-financing, which requires patients to contribute through user fees. The second was the principle of better access to medicines, particularly generic pharmaceuticals. The third principle was community participation to enhance the quality of care. The principle lies on the idea that if representatives from the local community sat on the boards of the healthcare centres, this would make the providers more transparent and responsive. More broadly, this last principle recognized that a range of actors should be involved in the healthcare system, including community-based organizations.

Standard features of mutual health organisations reflect the "classical" criteria of social and solidarity economy organizations (Defourny & Develtere, 1999, Fonteneau & Galland, 2006, Fonteneau et al., 2010):

- Improve access to healthcare through risk-sharing and resource-pooling
- Not-for-profit
- Members are owners and beneficiaries at the same time
- Autonomy
- Participatory decision-making
- Voluntary membership

Like other insurance systems, mutual heath organizations are based on a mechanism of risk-sharing and resource-pooling. But as social and solidarity economy organizations, these organizations are non-profit and do not select their members based on their individual risk profiles. Access to healthcare through solidarity is thus the main objective of these organizations. The members of mutual health organizations are the owners, the decision-makers and the policyholders. This feature requires strong participation and control mechanisms to make collective decision-making effective. Annual general meetings decide on issues such as budgets, accounts, what to do with surpluses, and operational matters as well as overall strategy. Membership is voluntary. This principle clearly distinguishes MHOs from compulsory insurance schemes such as most national and often state-run social security systems. As in any non-profit organization, a person may choose to become a member but is never forced to join. In most MHOs, members share some common characteristics, such as being members of the same organizations, inhabitants of the same village or workers in the same trade, often because they are built from or on an existing organization. Bearing in mind that membership is voluntary, a MHO has to find a way of ensuring that it can gather a "sufficient" number of members to run the risk-sharing mechanisms in an efficient and attractive way: the larger the group, the greater are the benefits for the members.

But MHOs cannot be reduced to their insurance function. As participatory mutual interest organizations, MHOs fulfil functions beyond insurance, like health education. They also act in a sector (healthcare) where the interests of users have only recently been represented. By organizing potential users of health services, they become an interlocutor that represents members' interests vis-à-vis e.g. healthcare providers. In the same way, we observe MHOs representing (individually or collectively) the population in policy discussions an lobby on different issues: health financing, quality of care, etc.

1.2. Development of mutual health organisations in West Africa: where do we stand?

In this section we will briefly give an overview of the main features that characterised the development of MHOs in West Africa (Jakab & Krishnan, 2004; Churchill, 2006; Fonteneau & Galland, 2006; Matul, Mc Cord et al., 2010; Lievens & Witter, 2011).

As for many other social and solidarity economy initiatives in Africa, there is a serious lack of comparative and reliable data on mutual health organizations. Yet, there have been some attempts to carry out multi-country inventories (La Concertation, 2004 and 2007). The 2004 inventory of 'La Concertation' identified 622 schemes in 11 countries. From these 622 organisations, 366 were functional (delivering insurance service), 142 being set up, 77 projected to be set up and 33 in difficulties. The last inventory carried out by La Concertation in 2007 in 15 countries described 188 functional MHOs. The difference between the 2004 Inventory does not imply that the 2007 inventory was incomplete as some schemes may have stopped operating, or have remained too small to partake in further rounds of the inventory. But if some methodological factors (e.g. geographical scope, typology of MHOs taken into consideration in the surveys) can explain this difference, it reveals above all the lack of lack of monitoring at both the project-level (when MHOs are supported by international or national development organisations) and at the national level (by the State or other national programme).

In order to give a better idea of some current dynamics, we present hereunder some recent primary data extracted from surveys or monitoring reports of support organisations. With the exception of Burkina Faso, the mentioned initiatives do not reflect the entire existing dynamics at the national level. These data illustrate the relative sober outcomes of MHOs in West-Africa despite the number of existing entities and the continuous creation of new MHOs initiated by diverse local or international initiatives.

	Network or Support organisation	**Number of MHOs**	**Number of beneficiaries (insured person)**	**Sources**
Benin	Réseau Alliance Santé (Borgou District)	27 MHOs	26 000	French NGO CIDR, 2009
	Réseau des mutuelles de Bembérèké (Borgou District)	8 MHOs	6880	Belgan NGO WSM, 2009
Senegal	Oyofal Paj (Region of Kaolack)	11 MHOs	22 000	Solidarité Socialiste Monitoring Report 2012
Burkina Faso	National Survey	165 MHOs	100 479	NGO Solidarité Socialiste, 2011
Mali	(National) Union Technique de la Mutualité	81 MHOs	NA	UTM Monitoring Report 2013

Table 1. Overview of recent data on MHOs (source: own compilation ; Sources mentioned in the table are detailed in the bibliography).

Apart from a few exceptions, the size of MHOs remains relatively small, namely between 300 en 1000 beneficiaries (beneficiaries being defined as a person covered by the insurance (namely a registered person whose the financial contribution has been paid). From an insurance point of view, this limited size restricts the resource pooling and in consequences the services packages that can be provided. The majority of MHOs only cover smaller risk (primary health care). Packages including larger risk like in-patient care remain the exception.

In theory, mutual health organisations are open to all types of members, whatever their socio-economic profile. In the practice, and moreover due to the community-

based character, members often share the same characteristics, namely households with limited and/or irregular revenue from their activity in the agriculture or the informal economy. MHOs are for those populations the only way to get a health insurance. Especially in the beginning, the membership of an MHO is often homogenous, which can have negative effects in terms of risk diversification. Such a situation also has a limited ability to achieve vertical solidarity through cross-subsidization between richer and poorer people.

Most MHOS are still run by elected members, sometimes supported by “managers” whose salaries are funded by temporary programs of development agencies). Despite some signs toward a more professional management, this kind of management has broadly demonstrates his weaknesses. In terms of governance, a recent survey carried out in Burkina Faso (Zett & Bationo, 2011) showed that MHO general assemblies (gathering all members) are mostly held according to MHO constitution but that board meetings are much more difficult to organise on a regular basis.

The reasons behind these findings are of different orders. MHOs are obviously very dependent on the health sector and in particular the provision of care. However, the quality of care is generally low in health facilities in West Africa. In that sense, it may not be attractive to become member of a MHO (and buy insurance product) that facilitate the access to health facilities providing bad quality of care. Especially in rural areas, MHOs often do not have other options than contracting with public health facilities. In urban areas, health facilities providing better level of quality of care exist but they are often not affordable for MHOs.

The low contributory capacity of populations is often used to explain the small mutual and low contribution collection argument. Whereas the amounts of the contributions are relatively low (between 1800 and 3600 FCFA / year / person, so between 10,800 and 21,600 FCFA (per year for a household of six persons), it is difficult to argue that the ability to pay is itself the cause of the weak development of mutual health organisations in all parts of the population. This incapacity/unwillingness to pay should be put in perspective with the level of insurance package offered by most mutual health organisations (mainly limited to small risks), the poor quality of care some and some management and trust related issues.

The development of mutual health organizations in West Africa has been supported (or initiated) by many national and international stakeholders (national support