

World Social Security Forum

31st ISSA General Assembly

Doha, 10 – 15 November 2013

Mutual benefit societies: A tool for developing social protection worldwide, particularly in the health sector

Steering Committee of Mutual Benefit Societies
International Social Security Association
Geneva



Mutual benefit societies: A tool for developing social protection worldwide, particularly in the health sector

Steering Committee of Mutual Benefit Societies
International Social Security Association
Geneva

1. Introduction

This report was written by the Technical Commission on Mutual Benefit Societies of the International Social Security Association (ISSA). Its purpose is to examine how and under what conditions the mutual benefit model may be used to extend health coverage.

Eighty per cent of the world's population lacks coverage under any social protection system. The current crisis and resulting budget cuts in Europe show that social protection systems covering the remaining 20 per cent may face challenges, even in countries where they were taken for granted.

International organizations have organized to protect populations against social risks. In March 2012, the International Social Security Association signed an agreement with the International Labour Organization (ILO) to strengthen their cooperation in support of extending and promoting social security.¹

In addition, the Bachelet Report,² published in the fall of 2011 by the ILO under the auspices of the United Nations, and ILO Recommendation No. 202³ on national social protection floors marked a **significant political shift**, underscoring a critical point: **Social protection is not a luxury**. It is not just a cost to society or an adjustment variable that may be reduced in time of crisis. Rather, investments that ensure minimum access to essential services (such as food and water) and minimum income security are development factors and buffers against crisis.

Extending social protection is a two-part issue. It involves both **increasing the percentage of individuals who are covered in countries where that figure is low** and **maintaining it at a high level in those countries where it is under challenge**. The mutual benefit approach offers an ideal response to this dual challenge because it works in conjunction with existing social coverage:

¹ http://www.ilo.org/global/about-the-ilo/newsroom/news/WCMS_176113/lang--fr/index.htm.

² *Social Protection Floor for a Fair and Inclusive Globalization*, Report of the Social Protection Floor Advisory Group chaired by Michelle Bachelet, established by the ILO with the cooperation of the WHO, Geneva, International Labour Organization, 2011, ISBN 978-92-2-225337-1 (print version), ISBN 978-92-2-225338-8 (Web pdf) www.ilo.org/wcmsp5/groups/public/.../publ/.../wcms_176520.pdf.

³ Recommendation No. 202 on national social protection floors: http://www.ilo.org/wcmsp5/groups/public/---ed_norm/---relconf/documents/meetingdocument/wcms_183327.pdf.

1. The first section analyses the context of the report. **The need to establish national floors for social health protection for all** was not obvious 10 years ago. However, beginning in the 2000s, international organizations have gradually addressed this issue, leading to publication of ILO Recommendation No. 202.
2. The second part of the report identifies the problems associated with extending social protection and the solutions that health mutual benefit societies may provide.
3. How do mutual benefit societies contribute to extending social health protection?
 - a. **In countries where social health protection does not exist**, the population self-insures by risk-sharing. Mutual benefit societies, which are a form of self-insurance, often constituted the foundation of public social protection systems. Starting in the 18th century, they played that role in Europe via mutual aid societies and continue to do so today in developing countries, such as Burkina Faso and Mali. **In the first step toward establishing a social protection system**, the State covers “formal” populations (including civil servants and employees of large organizations), but universal coverage cannot be available immediately. The State must find ways to cover the self-employed (including informal workers, professionals and farmers) and organize the collection of contributions or tax payments. In this intermediate step, which can take several decades, mutual benefit societies offer coverage to the informal sector, which may constitute 70 per cent of the population (as in Benin, for example).
 - b. **Last, countries where a social protection system already exists** face the issue of maintaining services when confronted with new problems, such as population ageing, growing rates of chronic disease, and financial and economic crisis. Mutual benefit societies address these problems by adapting to new needs, improving the level of coverage and taking on the new costs that the State transfers to them. They help to improve health coverage by increasing treatment reimbursement levels, offering care at competitive prices (through health clinics operated by mutual benefit societies), providing innovative services (including patient information platforms) and creating social relationships (through forums and electing representatives).

Mutual benefit societies thus provide solutions to the challenges of social protection systems, whatever their level of development. They are particularly appropriate in this context as their basic **values** also reflect those of the founding principles of universal social protection. Mutual benefit societies operate on the basis of the solidarity principle. Their long-term goal is to establish protection for all, without exclusions based on individuals’ risk or income. In that regard, mutual benefit societies always act in accordance with public policy and its principles of universality and solidarity. Mutual benefit societies are thus not restricted to the “charitable sector” or vulnerable members of the population. Rather, they function based on principles of solidarity and mutual responsibility.

However, the “**homogenization**” of the mutual benefit model threatens mutual societies’ **existence**. They must continue to demonstrate the model’s relevance so that they can claim the right to its recognition.

2. Definitions

What does “social protection” mean? What is a “mutual benefit society”? Terms that refer to social protection, mutual benefit and micro-insurance are often used loosely, but require careful definition.

2.1. What does social protection mean?

This report takes a broad definition of the term social protection (or “social security”), as defined by the International Labour Organization:⁴ “All measures, financial or in-kind,” that help to ensure that citizens have “income security” and “access to health care.”⁵

Mireille Elbaum, a scholar specializing in the field of social protection, presents a more detailed version of the ILO definition. “Social protection includes all **institutional mechanisms – public and private** – that take the form of a collective insurance system and/or that implement the principle of **social solidarity** to cover the costs, for individuals or households, associated with **identified social risks** (such as health, ageing, unemployment and poverty).”⁶

Its role is thus to ensure that individuals facing risks may obtain benefits, **without requiring beneficiaries to make an equivalent, simultaneous payment.**

Since World War II, one of the State’s key roles has been to ensure that citizens receive this protection. As ISSA has emphasized,⁷ the State insures citizens’ security, through legislation or incentives, against risks associated with ageing, disability, unemployment and dependent children.

While the State may guarantee social security, for example via broad and mandatory participation in the system, **other systems, both public and private, still contribute to ensuring social protection.** This is particularly true for mutual benefit societies, which share the mandatory system’s values of solidarity, universality and non-discrimination.

2.2. What is a mutual benefit society?

The European Parliament report, *The role of mutual associations in the 21st century*,⁸ offers the following definition: “Mutual associations are **voluntary groups of persons** whose purpose is primarily to **meet the needs of their members rather than achieve a return on investment.** They operate according to the principles of **solidarity** among members, who participate in the governance of the business. Together with cooperatives, foundations and associations, mutual enterprises are one of the main components of the **social economy.**”

Today’s mutual benefit societies, which operate in the area of health and insurance, are heirs to the “mutual aid societies” that first appeared in Europe in the Middle Ages. They were established by individuals who united to protect themselves against risk. These societies differ fundamentally from commercial insurance companies in that they are not profit-based and are founded on principles of solidarity and democracy. In addition, members share risks,

⁴ *World on Social Security report*. 2010-2011. “Providing coverage in times of crisis and beyond”, ILO, 2011, p.14.

⁵ Also see “ILO Income Security Recommendation 1944” (No. 67) and the “Medical Care Recommendation, 1944” (No. 69).

⁶ Caicedo, Koubi and Yanat-Irfane. 2011. In Mireille Elbaum. *Economie politique de la protection sociale* (Presses Universitaires de France), p. 5.

⁷ <http://www.issa.int/fre/Topics/About-social-security>.

⁸ *The role of mutual associations in the 21st century*, Directorate-General for Internal Policies, Commission on Employment and Social Affairs, European, IP/A/EMPL/ST/2010-004, PE 464.434, July 2011, page 9 of the French and English versions.

This report may be downloaded from the European Parliament’s Website: www.europarl.europa.eu/document/activities/cont/201108/20110829ATT25422/20110829ATT.

while commercial insurance companies accept a portion of the customer's risk in exchange for payment of a premium.

Mutual societies operate in very diverse sectors, from death coverage to health insurance, miscellaneous risk insurance, and social funds. This report addresses primarily the role of health mutual benefit societies.

Focus on mutual benefit societies in Europe:

In November 2012, the European Commission issued a publication titled, *Study on the current situation and prospects of mutuals in Europe*.⁹ It is the most comprehensive study to date on the mutual benefit sector in the European Union's 27 countries.

- According to this report, mutual benefit societies provide health and social services to approximately **230 million European citizens**. They operate in the areas of insurance, health care, social services and lending.

In general¹⁰, mutual benefit societies reflect the following principles:¹¹

They are composed of persons (natural or legal):

- Mutual benefit societies are composed of a group of persons (natural or legal) called "members" or "subscribers." They are not collections of funds (as in the case of corporations) and are not publicly traded, as a mutual benefit society has no shares or shareholders.¹²

They are based on principles of solidarity ...

- **They are not profit-based:** they do not seek to earn a surplus, but to serve the interests of their members.
- **They do not discriminate** or **set their rates** based gender or health status.¹³ Risk is pooled on the basis of joint solidarity and financing combines "good" and "bad" risks.
- There is no cost to join or withdraw. In general, both are voluntary.

... and democracy

- They are representative: each member has the **right to vote** and directors are elected.
- They **create accountability** among members by allowing them to participate in the governance of their mutual benefit society.
- The society's members are both "**insureds and insurers**."

⁹ *Study on the current situation and prospects of mutuals*. Final report, Report requested by the European Commission, November 2012. Page 9. http://ec.europa.eu/enterprise/policies/sme/files/mutuals/prospects_mutuals_fin_en.pdf.

¹⁰ Because mutual benefit societies reflect national changes specific to each country, their characteristics may vary significantly by country. The 2011 European Parliament report and the 2012 European Commission study highlight this diversity.

¹¹ The mutual associations and their international body, *Association internationale de la Mutualité (AIM)*, which represents mutual health organizations internationally (48 members in 27 countries), affirm these principles. The European Parliament's also analyses them (p. 19 of the French version).

¹² The EC report provides details on the 40 mutualist schemes identified in Europe: while some of them may have investors, those investors have no rights with regard to the governance of the society. Only members and/or their elected representatives have that authority.

¹³ P. 6 Elbaum. 2011.

The European Commission (EC) report,¹⁴ Study on the current situation and prospects of mutuals in Europe, confirms these criteria. The study identified 40 mutual schemes in the 27 European Union countries.¹⁵ Despite this diversity of legal forms, **the European Commission concluded that 95 per cent of the mutual societies identified meet five criteria.** Mutual societies are:

1. **private companies;**
2. **associations of people;**
3. **democratically run;**
4. **based on solidarity; and,**
5. **not profit-based.**

Thus, mutualist principles, which originated in 19th century workers' movements and value solidarity and universal access to health care, are very similar to the principles on which public social security systems are based.

The two historic models that influenced today's social security systems

Beveridge's universal social security principles (Great Britain, 1942):

- population base: universal
- organization of coverage: single, national public system; uniform benefits
- tax-funded

Bismarck's mandatory social insurance principles (the State is responsible for institutionalizing social protection, which was previously handled by multiple "mutual aid funds," 1883:

- population base: the employed (solidarity based on work)
- organization of coverage: compulsory insurance schemes
- funded through social security contributions

These models have evolved over time and most countries have adopted mixed systems.

2.3 Are mutual benefit societies and micro-insurance identical?

A mutual benefit society is governed in accordance with the above criteria. Its scope of activity is broader than that of micro-insurance. Mutual societies operate in the insurance sector, but also in the areas of health care facilities management (Great Britain), social services (including in-home care and accessible housing for the disabled) and, even, tourism (for example, Argentina). If a mutual benefit society operates in the insurance sector, is small and covers the poor, particularly in developing countries, it is considered a micro-insurance entity. However, a large mutual benefit society is not considered to be a micro-insurance institution.¹⁶

¹⁴ http://ec.europa.eu/enterprise/policies/sme/files/mutuals/prospects_mutuals_fin_en.pdf.

¹⁵ Mutual schemes are found in most European Union countries. However, they do not exist in Eastern European countries and those countries lack the legal tools to create them.

¹⁶ For example, *Harmonie Mutuelle*, which was created in December 2012 following the merger of five French mutual associations, covered 4.5 million people (as of February 2013). <https://www.harmonie-mutuelle.fr/web/harmonie-mutuelle>.

Micro-insurance may be provided by a mutual benefit society, but may also be a commercial undertaking. It reflects “the adaptation of insurance services to **populations that are not served by traditional insurance**. In other words, micro-insurance targets low-income populations in the formal and informal sectors in rural, urban and peri-urban settings.¹⁷

Micro-insurance is thus a financial instrument for insuring populations that are usually deprived of insurance. It **may be established by many stakeholders, including mutual benefit societies**. Other actors, such as Non-governmental organizations (NGOs), may create micro-insurance systems that receive outside support and commercial insurance companies may organize micro-insurance, while ensuring that they earn profits.

As a Desjardins study notes,¹⁸ “In Africa, micro-insurance is available in various forms: cooperatives, community-based mutual health societies, non-governmental organizations, microfinance institutions (MFI), regulated commercial insurance companies and informal mechanisms, such as tontines, burial associations and other mutual aid groups.”

Its purpose is to assist low-income populations better manage life’s risks. Mutual benefit societies that insure the poor, who lack access to traditional insurance, thus offer micro-insurance in a mutualist form; that is, a not-for-profit private partnership consistent with democratic governance, not-for-profit and solidarity principles.

Focus: Low penetration rate in Africa

Insurance cover remains a concern in Africa. Despite many initiatives launched since the 1990s, the penetration rate of micro-insurance remains low. In its study of 32 countries, *The landscape of microinsurance in Africa*,¹⁹ the International Labour Office estimated that only 2.6 per cent of the target population was covered (14.7 million people) in 2008, primarily by life insurance.

3. Social protection floors must be implemented for all

Since the publication of the Bachelet Report and Recommendation No. 202 on social protection floors, the perception of social protection has changed considerably. A consensus is emerging that it is a right of all people and a critical component of national development strategies. The third chapter of the report describes the international initiatives that have produced this international consensus.

3.1. Eighty per cent of the world’s population lacks coverage

While institutionalized, generous social security systems do exist in some countries, most of the world lacks any protection.

¹⁷ Definition developed by the Portail de la Micro-finance, www.lamicrofinance.org/section/faq.

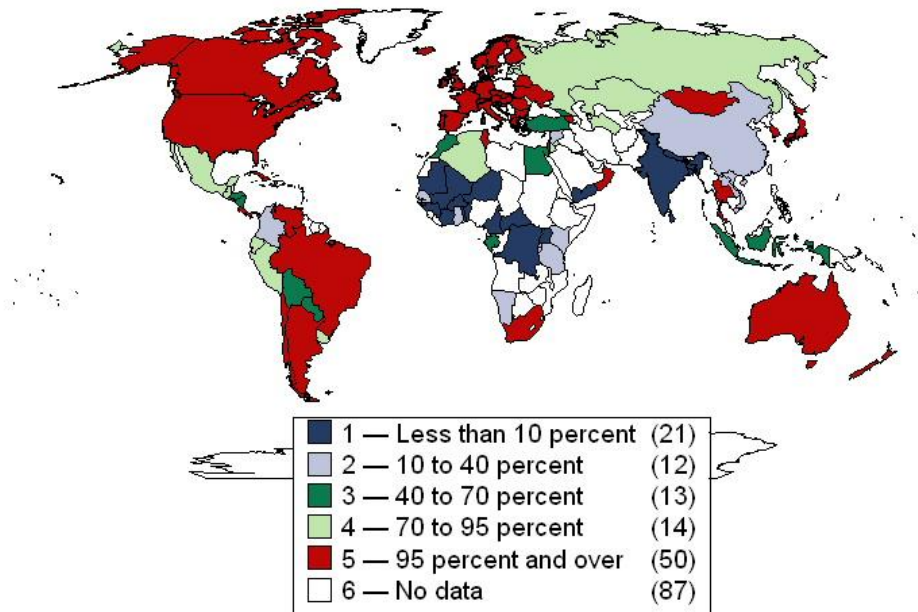
¹⁸ *Etude sur la microassurance dans la zone CIMA, Etat des lieux et recommandations*. Dossier 4410-36-34 (0053), June 2011. Published by *Développement international Desjardins (DID)*, page 1 www.did.qc.ca.

¹⁹ Michal Matul; Michael J. McCord; Caroline Phily and Job Harms. *The Landscape of Microinsurance in Africa*, in ILO Briefing Note 1, 2009.

Social protection is still limited to a minority of people

According to International Labour Office statistics, only 20 per cent of the population of the 184 countries analysed benefit from social security in the areas of income security and health.²⁰ In sub-Saharan Africa and South Asia, that figure is between 5 and 10 per cent of the working population. The numbers speak for themselves – the vast majority of the world’s population lacks any social security and the situation is very unequal from one country to the next.

Figure 1. Health coverage: proportion of the population covered by law (in percentage)²¹



Link: <http://www.socialsecurityextension.org/gimi/gess/RessFileDownload.do?ressourceId=15109>

Source: national legislation, various dates. See ILO, GESS (ILO, 2009d).

Individuals working in the informal sector are almost always excluded²²

Most countries have established social security coverage for formal sector employees (for example, civil servants). However, most workers in the developing world work independently (as artisans) and are grouped, haphazardly, under the term “informal workers.” They are not protected by the State.

The informal sector is composed of a variety of populations. It may include artisans who earn enough to purchase private insurance, but generally refers to populations involved in “independent activities or very small units of production.” In general, these are populations with modest income, little education or training and no access to organized markets and technology. Their working conditions are generally poor.²³

²⁰ Reynaud, E. 2002. *The extension of social security coverage: The approach of the International Labour Office*, Social Security Policy and Development Branch- ESS. Paper No. 3, Geneva: International Labour Office.

²¹ ILO: *World Social Security Report 2010-2011*. “Providing coverage in times of crisis and beyond”, Figure 3.7, p. 41 (Geneva, first published in 2010).

²² See also: Marius Paul Oklivier and Adriaan Wolvaardt. *The extension of social protection to non-formal sector workers, with specific reference to social insurance coverage: some recent developing country experience*. (ISSA, 2010).

²³ <http://www.ilo.org/public/french/standards/relm/gb/docs/gb277/pdf/esp-1-2.pdf>.

According to the International Labour Office,²⁴ this sector is expanding in all regions. However, it remains difficult to assess precisely because, by definition, it involves workers at the margins of the State-organized system. In 2000, the informal sector produced 54.7 per cent of sub-Saharan Africa's Gross domestic product (GDP) 37.7 per cent of North Africa's GDP and 30.6 per cent of Latin America's. In Niger, this percentage was as high as 76.6 per cent and, in Benin, 71.6 per cent.

According to a study by the ILO regional office for Latin America and the Caribbean of 16 countries in the region:²⁵

- 33 per cent of the workers belong to the informal sector; and,
- 12 per cent worked informally within a company in the formal sector.

These estimates provide an indication of the proportion of the population that is excluded from any social security system.

3.2. 2000-2010 initiatives to improve coverage worldwide

Devastated by the two wars in the first half of the 20th century, the European countries drew on Bismarck's and Beveridge's principles to establish social protection systems. The International Labour Organization advocates actively for such protection and in 1952, published an historic document, Convention 102 on Social Security (minimum standards).

Since the 2000s, in the face of continued lack of social protection in the emerging and developing countries, the major international organizations became aware of the need to protect populations around the world.

3.2.1. The Millennium Development Goals (MDGs)²⁶

In 2000, 193 United Nations (UN) member States signed an agreement to achieve eight objectives by 2015. They address major humanitarian issues, including reducing extreme poverty and infant mortality, battling several epidemics (including HIV/AIDS), providing access to education, ensuring gender equality and implementing sustainable development.

Initiatives involving different UN agencies, together with citizens, civil society organizations and municipalities, have been launched to fight poverty, hunger and disease. Specific efforts focus on strengthening the progress achieved in the area of women's and children's health.²⁷

- Objective 1: eradicate extreme poverty and hunger
- Objective 2: achieve universality primary education
- Objective 3: promote gender equality and empower women
- Objective 4: reduce child mortality
- Objective 5: improve maternal health
- Objective 6: combat HIV/AIDS, malaria and other diseases
- Objective 7: ensure environmental sustainability
- Objective 8: build a global partnership for development

²⁴ *The informal plague goes global*. 2005. *Labour Bulletin No. 44*. See table pp. 3-4. Statistics by region.

²⁵ *Panorama Laboral 2011. América Latina y el Caribe*, January 2012, ILO. http://www.ilo.org/global/publications/books/WCMS_171539/lang--es/index.htm.

²⁶ <http://www.un.org/fr/millenniumgoals/>.

²⁷ <http://www.everywomaneverychild.org/>.

The current status of Millennium Development Goals is very mixed and most of the goals will not be achieved. However, they serve as a framework for action for all international organizations, whose activities are described below.

The Bachelet Report (addressed in points 1.3 and 1.4) thus defines the “social protection floor (2012)” initiative as among efforts to achieve the MDG. **The floor complements the MDG perspective and provides a coherent social policy tool for achieving the goals.**

3.2.2. International Labour Office – International Labour Organization

In 2001, the International Labour Office launched an international debate to demonstrate that social protection is a relevant issue in the new millennium. Starting in 2003, it undertook a campaign to extend social protection coverage and address alarming findings, including that:

- only one of every five people in the world has minimum social protection;
- only 15 per cent of the unemployed worldwide receive certain unemployment benefits; and,
- a worker dies from a work-related accident or illness every 15 seconds.

In 2007-2008, the campaign issued a social justice recommendation that the UN adopted in 2009 as one of nine priorities in the context of the current crisis.

The ILO’s studies²⁸ showed that **extending social protection is associated positively with a significant increase in entrepreneurial activity**. It estimates that **3.5 per cent of the GDP of many African countries would cover the entire elderly and child population** (pensions and child support, respectively).

The ILO, which is actively involved in the social protection floor initiative, played an influential role at the 100th International Labour Conference in June 2011 and signed Recommendation 202 in 2012.

The ILO’s June 2012 report, *The ILO at work: 2010-2011*,²⁹ states, “Social protection contributes to fair growth, social stability and enhanced productivity, providing a springboard to sustainable development. Decent wages, working time and occupational safety and health are essential components of a decent job. Migrant workers and their families and people living with HIV/AIDS are particularly vulnerable and need protection, including from discrimination at the workplace.”

The ILO highlights social coverage of women, “who face higher exclusion from social security than men, due to discrimination throughout the life cycle and the burden they usually shoulder in family and care responsibilities.”

Examples of the ILO’s support include:

- In Argentina, the ILO supported a national programme of cash transfers to families in the informal economy for health and education.
- Ten member States, including **Burundi, Cambodia, Mozambique and Timor-Leste**, adopted policies to broaden social security coverage with ILO assistance.
- New social security schemes were implemented in **Nepal and Togo**.

²⁸ ILO: *World Social Security Report 2010-2011, Providing coverage in times of crisis and beyond* (Geneva, first published in 2010).

²⁹ *The ILO at work* may be downloaded in English, French and Spanish: http://www.ilo.org/pardev/development-cooperation/WCMS_180602/lang--en/index.htm.

3.2.3. The Organisation for Economic Co-operation and Development

In 2009, the Development Co-operation Directorate of the Organisation for Economic Co-operation and Development (OECD)³⁰ stated that “social protection directly reduces poverty and helps make growth more pro-poor ... It helps build human capital, manage risks and promote investment ... **Social protection programmes can be affordable, including for the poorest countries, and represent good value for money.**”

The OECD thus affirms that social protection programmes are **affordable and support growth.**

3.2.4. The African Union

The Livingstone Process, which was initiated by the African Union (AU) in 2006, established social protection as a key African initiative to protect poor and vulnerable members of the population. In 2008, following the Livingstone conferences, the AU adopted a social policy framework for the continent. It recommends strengthening social protection mechanisms and improving access to education and health care.³¹

“Social protection” leads governments to adopt and pursue a medium- and long-term vision. The AU defends the conviction that social protection “should be a serious obligation of the State.” **It is presented as a response to a fundamental human right, not occasional assistance or a request for help.**

3.2.5. The World Health Organization

In its Resolution 58.33, the World Health Organization (WHO) **states that universal coverage is a political objective** (2005).

In addition, WHO provides major analyses of ways to improve access to health care by reforming the financing system. It notes that to obtain care, most households must pay for treatment directly out-of-pocket. However, **direct payment is the least equitable system of financing**, because it automatically excludes disadvantaged populations. More than 100 million people thus fall into poverty every year as a result of catastrophic health expenses.³²

In its 2010 World Health Report, *Health systems financing: the path to universal coverage*,³³ the WHO notes that the only way to significantly reduce the use of direct payment systems is for governments to encourage risk pooling and prepayment to distribute the risk across the entire population and thus avoid catastrophic health expenses. It also suggests that governments prepare for the transition to universal coverage for all citizens by pooling risks based on social insurance, tax-funded mechanisms, or a combination of the two.

The WHO thus encourages governments to combine the following mechanisms:

- pooled prepaid resources (social insurance and/or tax-funded);
- contributions based on household income; and,

³⁰ http://www.oecd.org/topic/0,3699,fr_2649_37419_1_1_1_1_37419,00.html.

³¹ Social Protection and Achieving the Millennium Development Goals in Africa, workshop organized by the Economic Commission for Africa (CEA), 14-16 July 2010, Kenya.

³² Xu K et al. “Protecting households from catastrophic health spending,” *Health affairs*. 2007. 26:972-983.

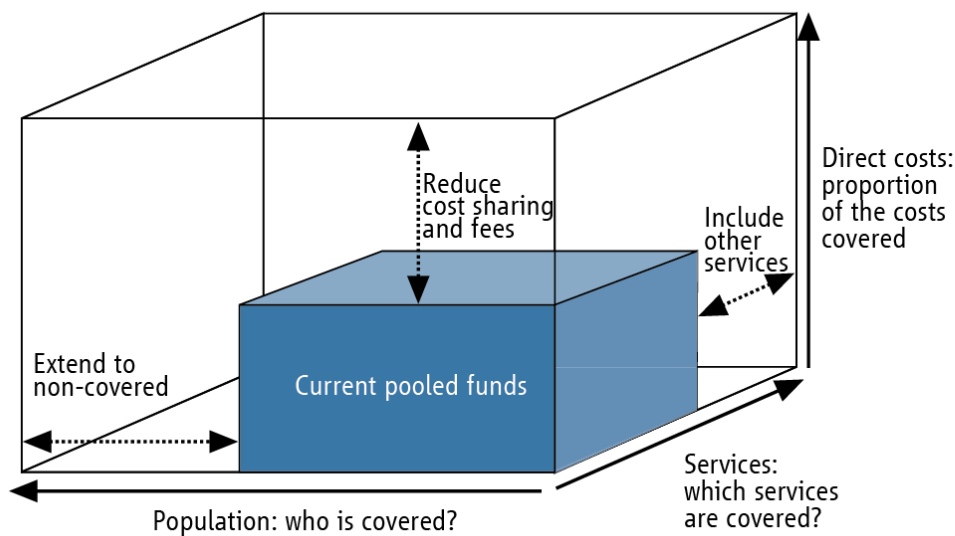
³³ *Health systems financing: The path to universal coverage, The World Health Report*, WHO, 2010, page 44.

- use of funds by those who need them (including for high-quality care).

Together with the ILO,³⁴ the WHO jointly summarized the three dimensions along which health coverage can make a difference. “Moving towards universal health coverage is a gradual process. It involves making progress on several fronts for everyone: the available range of **services** (medicines, medical products, health workers, infrastructure and information); the **proportion** of costs of services covered; and the **proportion of the population covered**.”

The three-dimensional diagram³⁵ below shows how universal health coverage can be achieved by improving coverage in the three areas noted above:

Figure 2. Towards universal coverage



Source: World Health Report, WHO, 2010.

Explanation of the figure

1. Including new services

New services may be included to respond efficiently to the populations' needs. For example, the State could begin by defining a “package of essential health care services” that would expand gradually, based on resources and priorities.

2. Increasing the share of costs covered (thus reducing the share paid directly by households)

This dimension would increase the share of health expenses covered.

3. Extending coverage to populations not covered

This extension is often achieved by incorporating segmented occupational and regional sectors gradually and can take years. For example, universal medical coverage (CMU) in France was only adopted in 2004.

³⁴ *Towards universal health coverage: concepts, lessons and public policy challenges*, background document, WHO/World Bank Ministerial-level meeting on Universal Health Coverage, 18-19 February 2013, WHO headquarters, Geneva, Switzerland.

³⁵ Idem. *Health systems financing: The path to universal coverage. The World Health Report*, WHO, 2010.

The path towards universal coverage involves a combination of gradual improvements along three dimensions. **With a given amount** invested in health care, **a State may choose to emphasize one dimension over another.**

However, the share of costs covered does not increase in linear fashion. It may vary based on the government's priorities and the economic context. Since the 1980s, most countries that have faced crises have limited their expenditures, thus reducing the share of costs covered by the State via household deductibles and co-payments. These measures, which increase the amount that households must pay, significantly increase the poorest households' decisions to forgo medical care.

The measures that the Greek, Spanish and Portuguese governments are implementing today are examples of budget cuts that affect citizens' social protection.

3.2.6. The Providing for Health Initiative

The Providing for Health Initiative (P4H) was created in June 2007 at the G8 Summit in Heiligendamm, Germany. It involves major bilateral and multilateral partners, including the ILO, World Bank, African Development Bank, the French Ministry of Foreign and European Affairs (MAEE), the French development finance institution (AFD) and the French international health and social protection agency (GIP SPSI³⁶), and Germany, Spain and Switzerland. The initiative addresses social health care.

Its objective is to promote social health protection in developing countries and support countries that seek help to define and implement mechanisms covering the risks of illness.

Since its founding, P4H has developed partnerships in Africa (including Senegal) and Asia (Sri Lanka) to help governments implement mechanisms covering the risks of illness appropriate to each context.

3.3. The United Nations social protection floor initiative (2011): A major step forward

The United Nations' social protection floor concept, as advocated by the ILO and the WHO and supported by the Bachelet Report, has generated a consensus among 19 U.N. agencies,³⁷ led by the WHO. The concept combines the initiatives referred to above (from the OECD, WHO, African Union and others).

The social protection floor has two key components:

- access to essential services (including water, sanitation and food); and,
- transfer programs for the poor, whether in-kind or cash-based, to provide a steady source of income and guarantee a minimum livelihood (health care and essential services).

According to the Bachelet Report, **the floor is both necessary and feasible.** It analyses real-life case studies, including Brazil, which has shown that each time the government allocates one per cent of GDP to family allowances, growth rises by two points. Increasing the buying power of the poorest has an immediate impact because it produces immediate spending.

³⁶ GIP SPSI : *groupement intérêt public sur la Santé et la Protection sociale*. <http://www.gipspsi.org/>.

³⁷ ILO, WHO (leaders), FAO, IMF, HCHR, UNAIDS, DESA, UNDP, Unesco, UNPF, UN-Habitat, UNHCR, UNODC, United Nations regional commissions, UNRWA, UN WFP, WMO and WB.

The current crisis also highlights the crucial role of social protection. Countries with coverage (wealthy and moderate-income nations) have been more resilient in the face of the crisis, in large part because their households have not fallen into poverty thanks to the social and health protection provided. **Social protection and related expenditures** have not slowed development; on the contrary, they are a **bulwark against poverty and can even spur development.**

From a political perspective, **these declarations constitute important progress.** The social protection floor concept is moving forward and is now included in the statements of stakeholders who have been hesitant to do so. The final statement of the 2011 G20 in Cannes, for example, included the notion of social protection “floors.” This is progress, although the use of the plural reveals on-going reservations. It signals the rejection of a universal floor, but marks the acceptance of minimum floors that are specific to each national situation.

“Extending social protection is a ‘win-win’ investment that pays off both in the short term, given its effects as a macroeconomic stabilizer, but also in the long term, due to the impacts on human development and productivity.”

Michelle Bachelet, Executive Director of UN Women and President of the Consultative Group on the Social Protection Floor in 2010.

3.4. Achieving real international consensus: Recommendation 202 on national social protection floors (June 2012)

The publication of the Bachelet Report placed the issue of social protection floors on the agenda of the International Labour Conference. On 14 June 2012, at its 101st session, the Conference adopted **Recommendation 202 on national social protection floors**³⁸ by a tripartite vote of 452 in favour, none opposed and one abstention.

This vote confirms the desire to establish basic social security guarantees, defined at the national level. The objective is to ensure minimum income security and access to essential health care and other social services for all.

The European Union’s Social Protection Committee included social protection floors in its **2012 work plan**,³⁹ which represents important recognition for the EU’s external action, particularly with regard to programming for external assistance and the next European Union communication on social protection in connection with development cooperation. The European Union is the leading development assistance donor worldwide.

4. Overcoming obstacles to a social protection floor ensuring access to health care: The response of mutual benefit societies

The social protection floor initiative marks a historic turning point in the history of social protection. For the first time, a consensus exists on the need to cover all populations

³⁸ Recommendation 202 on national social protection floors: http://www.ilo.org/wcmsp5/groups/public/---ed_norm/---relconf/documents/meetingdocument/wcms_183327.pdf.

³⁹ <http://ec.europa.eu/social/BlobServlet?docId=7397&langId=eu>.

worldwide, regardless of level of development. States and mutual benefit societies are now examining how to implement this political commitment because they face many challenges.

Chapter 4 analyses the **difficulties - often similar - that both public and mutual systems face**.⁴⁰

1. Contributions to both the social protection and mutual systems must be financially accessible.
2. The populations must be informed of the long-term advantages of belonging to a social protection system.
3. Health mutual societies must provide high-quality, geographically-accessible care.
4. The system must be self-financing.

4.1. The barrier of poverty

Poverty remains the primary barrier to implementing a social protection system or joining a mutual benefit society. Although the percentage of people living in extreme poverty has dropped in recent years, thanks primarily to development in Southeast Asian countries, 2.471 million people – **43 per cent of the world's population – live on less than US-dollar (USD)2.00/day**. Of that number, 1.289 million live in extreme poverty on less than USD1.25/day.⁴¹

In principle, membership in a mutual benefit society is voluntary. It thus depends on households' ability to contribute, which may be very limited in developing countries. Even moderate membership costs may still be too high for populations struggling to survive every day. A pilot project in Ghana initiated by the International Labour Organisation illustrates this problem. Although members receive a subsidy of 75 per cent toward their insurance, many people are unable to pay for the photograph required to obtain an insurance identity card.⁴²

4.2. Convincing and educating the population

Moreover, social protection is not a universally widespread notion. Families may assume this responsibility and cultural factors may explain why some people hesitate to join a social protection system, let alone a mutual benefit society. For example, all efforts in certain countries of the former Union of Soviet Socialist Republics (USSR) to pool resources in cooperative or mutual organizations have a negative connotation associated with the trauma of forced collectivization and Stalinism. Even in developed countries, independent workers and those in the professions have been slow to join public social protection programs.

⁴⁰ See: *Les mutuelles de Santé: acteur et partenaire de la couverture santé universelle*, Be-cause Health. 2011. Social Protection working group and Masmut policy document.

Masmut is the Belgian health micro-insurance/health mutual benefit society platform. It includes representatives of NGOs, mutual benefit societies, research institutions and the Belgian development cooperation agency. Its objective is to promote collaboration among member organizations and benefit from their complementary expertise to strengthen health micro-insurance systems and health mutual benefit societies in Southern countries.

Be-cause Health is the informal Belgian pluralist platform that addresses international health issues. It is open to institutions and individuals who are active and interested in issues of international and public health.

The Belgian Socialist mutual benefit society, which is a member of Masmut and participated in the writing of the report, *Les mutuelles de Santé: acteur et partenaire de la couverture santé universelle*, is also a member of AIM (the international umbrella organization of mutual benefit associations) and ISSA's Commission on Mutual Benefit Associations. These platforms have similar perspectives on the role of mutual benefit associations in extending social protection.

⁴¹ World Bank statistics cited by the Observatoire des inégalités in "La pauvreté dans le monde," 14 May 2012 article, <http://www.inegalites.fr/spip.php?article381>.

⁴² ILO. 2005. *Improving Social Protection for the Poor: Health insurance in Ghana. The Ghana Social Trust pre-Pilot Project*. Final report. Geneva.

Furthermore, populations are often unaware of their rights. In Tanzania, for example, districts are supposed to pay the poorest rural households' contributions to the Community Health Fund. However, a 2007 study by P. Kamuzora and L. Gilson showed that those citizens were unaware that they were not required to make that payment.⁴³

4.3. Protecting health means addressing the challenge of providing care

A social health system cannot develop and achieve acceptance unless the State organizes, or helps to organize, a high-quality system of care that is geographically accessible to population centres.

If high-quality health centres do not exist, individuals will see no reason to belong to any health insurance system. The State or the actors responsible for social protection must thus implement or participate in policies that improve the quality of care at an affordable price.

This is why, since the 19th century, **health mutual benefit societies have relied on or created care networks or entered into agreements with practitioners to ensure that their members receive high-quality, affordable health care.**

4.4. The sustainability challenge: A self-funded system

The final point to emphasize is that **a system must be self-financed if it is to be sustainable.**

The many efforts that have ended in failure, whether initiated locally or by international actors, show that there must be a balance between contributions to and expenditures for medical care if projects are to be viable. According to the Belgian Cera Foundation,⁴⁴ “if the total cost of all treatments is greater than the amount of individual contributions, an imbalance will result and the system’s viability will be threatened. If the system has established reserves or if an external partner covers the deficit, it may face a period of losses, hoping that risks will subsequently decline. If that does not happen, the system must achieve a balance between contributions and benefits, either by increasing the amount of contributions or limiting treatment and services.”⁴⁵

This common sense principle thus raises questions about projects that are funded entirely or in part by actors external to the members themselves.

The challenge of financial viability may be analysed with regard to two complementary aspects:

- maintaining the mutual society’s financial balance (contributions/payments and operating expenses); and,
- reducing financial risks through reinsurance, federations of mutual societies and legal action by the State.

⁴³ Kamuzora P. and Gilson L. *Factors influencing implementation of the Community Health Fund in Tanzania*. Health policy plan. 2007. 22(2): pp. 95-102.

⁴⁴ Cera is a Belgian financial cooperative group founded on the ideas of Friedrich Wilhelm Raiffeisen. In the late 19th century, he sought to address rural poverty through mutual aid and cooperation. <http://www.cera.be/fr/Qui-est-Cera.aspx>.

⁴⁵ Patrick Develtere; Gerlinde Doyen and Bénédicte Fonteneau. 2004. *Micro-assurances et soins de santé dans le Tiers-Monde, au-delà des frontières*, page 47. A publication of the Horizons series, CERA Foundation, Leuven, Belgium. www.cerafoundation.be.

How viable are micro-insurance entities supported by external funding?

Micro-insurance projects in many countries have relied on external financing to cover a portion of members' contributions. The advantage of this method of external funding is that it extends coverage to very poor populations, but it threatens the entity's structure because members' expectations do not reflect the actual level of care that the system can pay for. After several years, when funding ends, the structure collapses, leaving populations without coverage, leading to the conclusion that "social protection cannot be extended to the poor" or that "mutual benefit societies don't work".

The State may be able to respond to this dependence on external funding if it takes an active political role.

Example: Implementing GRET's SKY health microinsurance project in Cambodia⁴⁶

GRET launched the SKY project in 2006 to protect Cambodians' income and property and improve access to high-quality care. As of December 2011, it insured 70,000 people in Takeo province, a part of the province of Kampot and in Phnom Penh. The programme offers health insurance to Cambodian families and covers both primary care and hospitalization, via a third-party payer system.

Membership is family-based, with a contribution of USD4.50/month. SKY contracts with health centres and public hospitals.

However, contributions fund health care, not overhead. The system is thus in financial imbalance.

➔ With funding ending (primarily from the French development agency), an alternative solution was required.

Ultimately, the Cambodian government decided to fund the programme itself. The Ministry of Health took a dual approach, covering the contributions of the poorest Cambodians via an equity fund supported by donors and community-based health insurance schemes, which cover those who can afford to contribute⁴⁷ and it assigned local operators to manage the system under a "delegated management" approach.

SKY will be broken up and transferred to local operators, selected via a tender process. GRET created a local NGO and will set it up in certain districts.

Other governments have implemented proactive policies to co-finance access to mutual benefit societies (including Mali and Rwanda). Thanks to a compulsory membership policy, 90 per cent of the Rwandan population is now covered by "mutual" insurance.

⁴⁶ www.sky-cambodia.org and www.gret.org/projet/assurance-maladie-au-cambodge/.

⁴⁷ To avoid stigmatizing those supported by the equity fund and to limit management costs, the Ministry of Health sought one operator for the equity fund and the CBHIs. At this stage, it prefers not to contract with a more integrated system, as GRET had proposed.

Table 1:

	Mali ⁴⁸	Rwanda ⁴⁹
System	AMO, RAMED and mutual	Compulsory health insurance, co-financed by the State
Population	14.5 million	10 million
Does a social protection system exist?	<ul style="list-style-type: none"> - 17% of the population - civil servants, parliamentary delegates and salaried employees – is covered by a compulsory health protection system (AMO). - In addition, the State funds the RAMED programme, a health care assistance scheme for the poor (5% of the population). - 333,079 people are covered by mutual. 	<p>In 2007, Rwanda passed a law requiring complementary health insurance (including from mutual benefit societies).</p> <p>The increase in coverage was stunning:</p> <ul style="list-style-type: none"> - in 2003, mutuals covered 7% of the population; - by 2010, that figure had risen to 90%.
Do mutual benefit societies exist?	<ul style="list-style-type: none"> - 1 national federation - 9 regional federations - 60 unions - 703 communal mutual benefit society <p>Mali also belongs to West African Economic and Monetary Union (UEMOA) → UEMOA has created a legal status for mutual at the regional level.</p>	- 30 district health mutual societies (in 2012)
Who are the beneficiaries of the mutual societies?	Primarily the informal sector and agriculture	<ul style="list-style-type: none"> - Formal sector (10% of the population) - Informal sector (90% of the population)
How are the mutuals financed?	<p>Membership in the health mutual is co-financed:</p> <ul style="list-style-type: none"> - 50% by the member - 50% by the State (through a special fund) 	<ul style="list-style-type: none"> - the contribution to a mutual is set by the government at USD1.80/year - la contribution is co-funded by the population and the State - health services are also co-funded <p>The Global Fund fully funds the contribution for the poorest population (27% of the population) through its project, Assuring Access to Quality Care.</p>

These three examples show that the resolution and **will of the State are critical in achieving increased social protection for citizens:**

⁴⁸ See the study: *Mise en place de la couverture universelle santé au Mali*. A report of the joint mission. Appui conjoint du réseau P4H (Providing for Health). WHO. France/Switzerland. February. 2012. http://www.who.int/providingforhealth/countries/P4H-Rapport_conjoint_mission_Mali_Nov_2011_final.pdf.

⁴⁹ Andreas Kalk; Natalie Groos; Jean-Claude Karasi and Elisabeth Gurrbach. "Health systems strengthening through insurance subsidies: the GFATM experience in Rwanda." *Tropical Medicine and International Health*, Volume 15 No. 1 pp. 94-97 January 2010. doi:10.1111/j.1365-3156.2009.02424.x.

- the Cambodian government took over the SKY project, thereby preventing its sudden termination;
- in Mali, the co-funding of contributions to mutual benefit societies encouraged the population to join. However, the system remains fragmented;
- by **requiring health insurance** and providing major financial resources on behalf of the poor (**funding from the State and an international donor**, the Global Fund), Rwanda enabled its poorest citizens to obtain access to a minimum level of health care coverage.

However, providing external funding to a mutual benefit society presents a major risk to its viability. Small, self-funded systems can produce equally encouraging results. **The package of health care services they offer may be smaller, but it may also be more sustainable.**

Rely on existing systems and solidarity arrangements and offer an appropriate level of protection

The caution expressed here regarding mutual societies that are co-funded by external initiatives does not mean that international cooperation cannot help such societies to emerge. However, cooperation must create a system that relies on local systems, while offering protection that is consistent with the community's actual financial capacity.

The examples show that solutions must be based on an existing economic sector. That is, the population is already organized, professional solidarity exists, the managers are known to the population and the sector has a predictable revenue stream. The sector may be organized at all levels: locally, to reach populations that are excluded from traditional insurance; regionally; and, nationally (for example, to sell a product nationally), which will allow the mutual benefit society to quickly achieve leverage in negotiating with the State and health care providers.

Example: The French Social Agricultural Mutual Benefit Association (MSA) creates agricultural health care benefit societies in Burkina⁵⁰

In 2009, MSA launched a project in Burkina Faso targeting the **informal sector**. The goal was to **create a regional network of mutual health organizations for cotton producers**. The European Commission provided five years' of funding and local partners also support it. The project offers technical assistance to Burkina Faso's national association of cotton producers National Union of Burkinabe Cotton Producers (UNPCB) to establish and create a network of three health mutual societies in Hoüet province (around Bobo Dioulasso), in the country's south-western region. The unique aspect of these mutual benefit societies is that they are **occupationally-based, not community-based**. The cotton producers' solid organizational structure, from the village to the national level, facilitates membership and collection of contributions. Producers are organized first into producer groups (GPC), then into departmental alliances (UDPC) and, finally, into a national cotton producers' union (UNPCB). Thanks to this structure, educational and awareness-raising activities can be carried out at all levels.

The European project follows on a pilot effort that MSA conducted between 2006 and 2008 with financial support from the French embassy. In 2007, the experiment led to the creation of the first health mutual benefit society in Karangasso Sambla department (Hoüet region). Since then, it has become part of the current European project, forming a network with the

⁵⁰ MSA, which is the second-leading compulsory social protection scheme in France, covers all non-salaried employees and some salaried agricultural workers. It is based on principles of mutuality – solidarity, accountability and democracy – to maintain vibrant rural communities.

three new mutual associations created in Péni, Satiri and Bama, with political and administrative management from the Central Fund of the MSA and support in the field from the UNPCB, the health mutual benefit society support network (RAMS) and, in France, from the Charentes MSA Fund (MSA 17). Each partner has a specific role: the UNPCB is responsible for the project's political aspects on-site and for all communications; RAMS is the local technical partner and handles awareness-raising events, via its branch in Bobo-Dioulasso; and, MSA 17 is the French technical partner, providing accounting, medical and IT expertise to support the local partners.

The project will end soon (December 2013) and the **findings are positive**. First, the three mutual societies were created and, together with the Karangasso Sambla mutual society, established the regional health mutual benefit society regional network. Thanks to this network, a single paid manager collects contributions and pays benefits for the four mutuels. Similar to MSA, each operates under a **mutual form of governance, with a general assembly, board of directors and executive office**. In addition, all have signed partnership agreements with the health and social promotion centres (CSPS), which provide community-based care to members. **Three of the mutual societies have already achieved viability or are in the process of doing so**. Only one is experiencing cultural and political difficulties that technical support cannot resolve.

This example is particularly interesting because it proves that mutual benefit societies can operate in developing countries. Key factors in insuring the project's success involve implementing several central principles:

- **compulsory membership via producer groups;**
- **contributions paid via withholding;**
- **gradual expansion of the membership base to include other occupational categories.**

To achieve this, efforts must focus on **raising awareness among the target populations – producers, elected representatives and health centre nurses**. The **quality of local partners** who will carry out these communications and information activities at all levels is thus critical. Thanks to the support of the Ministry of Public Service, Labour and Social Security and the potential participation of the mutual societies' network in implementing universal health insurance in Burkina, all actors and partners are working to ensure the project's viability after the European Union funding ends.

How can mutual benefit societies reduce financial risk?

The mutuels that are being created must also find ways to manage their own financial risks. These risks can be reduced by **federating with other mutual associations** (allowing risks to be distributed differently; that is, across different categories of individuals and achieving economies of scale) or by reinsuring.

Reinsurance allows a mutual society to protect against multiple and major losses. In addition, the society must maintain strict accounting records in order to be eligible. This has immediate benefits for its management.

By reinsuring with another insurance company, the mutual society ensures greater security for its own funds and guarantees solvency. Last, as the Cera Foundation emphasizes, reinsurance establishes a link between the local mutual societies and centralized authorities and resources (including donors and States). **“Instead of subsidizing local initiatives, the government or an NGO can pay the reinsurance premium and thus encourage the financial autonomy of micro-insurance institutions.”**

Rather than co-subsidize membership in a mutual benefit society directly, outside support can help these entities better analyse and distribute their risks by encouraging societies to work together in associations and providing expertise. External actors can also encourage mutuals to reinsure by educating them about this activity and putting them in contact with institutions that carry out this activity (for example, the *Achméa* mutual benefit society in the Netherlands).⁵¹

Last, to the extent that the State has not established a universal compulsory system for which it is responsible, directly or indirectly, it can draw on the development of the mutual's services. By developing an appropriate legislative framework, carrying out educational campaigns, becoming involved in the organization and the quality of care offered, and playing a regulatory role with regard to mutuals' services and (micro-) insurance in general, the State can establish the foundations of its own health protection system.

4.5. The challenge for countries with a health insurance floor: to maintain and extend it in the face of ageing and crisis

Current social protection systems are under considerable pressure from demographic changes (population ageing) and economic crisis. Their impact is being felt more quickly because of globalization.

The prospects currently facing mutual benefit societies are two-fold:

- In countries where the State does not provide social protection, how can mutual benefit societies participate in extending social protection? This issue was addressed earlier: mutuals can serve as a point of departure for social protection, requiring that a mutual solidarity system be organized and based, if possible, on sectors that are already organized or pre-existing groups, and that health care services exist. Mutuals can reduce their financial risks by expanding the base of their insureds and/or by reinsuring with other insurance companies. In addition, the State may create incentives to establish mutual societies through regulation or may fund a portion of the contribution for indigent families.
- Countries where compulsory social protection exists but where populations are ageing and becoming poorer must address the issue of funding for social protection systems and the role of mutuals.

4.5.1. An ageing population and an increase in chronic diseases

The proportion of retired persons is rising sharply because the population is ageing. The cost of their social benefits creates a significant financial burden on the current working population and the nature of those benefits is changing, too. As people live longer, long-term illnesses are emerging, raising the issue of old-age care. European nations have faced the significant issue of how to fund their social protection system since the 1980s.

Example: In France, long-term illnesses, which include 30 identified illnesses such as cancer, diabetes, and HIV, constitute 62 per cent of reimbursements under the general system.

The State reduced the compulsory health insurance system's reimbursement levels for routine health care (including drug reimbursements and a more rigorous revision of therapeutic

⁵¹ <http://www.achmea.com/>.

value) but the expenses associated with long-term illnesses are increasing, as is the cost of treating them.

Collective solidarity is thus focusing on the most serious illnesses.

As a result, **complementary health insurance, including mutual benefit societies, is increasingly covering routine and outpatient health care.** Mutual societies, which “complement” the public protection system, play a key role in providing access to care. In France, individuals who lack complementary insurance through a mutual society face real obstacles to obtaining care.

Example: In Argentina, mutuals develop primary healthcare networks:

The Mutual Association for the Protection of the Family (*Asociación Mutual de Protección Familiar (AMPF)*), in Argentina, respects WHO principles, developed in the Alma-Ata Declaration (International Conference of Alma Ata on Primary healthcare services, USSR, 6-12 September 1978).

Pan American Health Organisation (PAHO) recently published a leaflet on “The experience of a network of integrated health care services: the AMPF”, which describes the quality of the services, provided by the Argentinian mutual to its family members.

The document can be downloaded on PAHO website.⁵²

4.5.2. Increase patient accountability by increasing co-payments

Mireille Elbaum⁵³ notes that the perception of social risks is changing as they are coming to be seen as “life cycle risks.” “With the virtual certainty of reaching retirement age, (...) individual responsibility can be identified (in the case of health prevention or maintaining employability), the notion of those risks is changing towards a sense of better individual management (Ewald et Kessler, 2000).”

The understanding of “risks” is changing and advocates of reform are pushing for **greater personal accountability**. “Support for the partial privatization of social risks has been highlighted in the discussions on dependence.”⁵⁴

States are trying to create greater accountability among patients and practitioners, including by reducing the amount of drugs prescribed and launching information campaigns on antibiotics. They are also raising the amount of co-payments⁵⁵ by increasing the patient’s share of expenses for treatment and drugs.

⁵² www.paho.org/hq/index.php?option=com_content&view=article&id=8737%3Aexperiencia&catid=3316%3Ahss-0101-hss-publishing&Itemid=3562&lang=es.

⁵³ Elbaum. 2011. p. 156.

⁵⁴ Idem. p.156.

⁵⁵ In France, cost control of mandatory schemes has focused on raising the amount of patient co-payments since adoption of the 1987 Seguin Plan.

4.5.3. How can health care costs be controlled?

Policies that target the insured person and the insurer have a more limited impact than those that focus **on medical care itself**. Today, countries must address the issue of funding medical treatments.

In France, for example, doctors contracted under sector 1 (doctors who bill for services at the social security reimbursement rate) are becoming increasingly rare in certain specializations and geographic areas. More than 40 per cent of specialists are in sector 2, where the rate exceeds the social security-contracted rate by an average of 54 per cent. Many French people are finding it difficult to access care and must have complementary insurance that covers higher fees (with the risk or negative effect to encourage them).

To create incentives for thriftier coverage, in 2004 the French government instituted complementary agreements described as “responsible.” These agreements do not reimburse certain expenses or fees that exceed the established schedule in order to influence patient behaviour.

Systems based on universality and solidarity must be maintained in this context. Efforts by commercial insurance companies to segment the market – offering more expensive contracts for the elderly and less expensive ones for individuals who are still working – should be rejected. Such contracts reduce collective solidarity and threaten coverage for the poorest, the young and the elderly. To maintain inter-generational solidarity, some observers are calling for greater State regulation.

Rising co-payments and the increasing role of complementary health insurance thus call for public intervention.

5. How can mutual benefit societies help to extend social security?

Given the challenges described in Chapter 4, how and under what conditions can mutual benefit societies help to extend social protection? The objective of mutual societies is not simply to develop, but to develop the broadest social security system possible. Their role is thus **complementary to and interdependent with the public social security system**. As the public system changes, mutual societies adapt to a new context and redefine their benefits.

Types of insurance that private insurers can provide (commercial or mutual, depending on the country):⁵⁶

- Private health insurance as the **primary source of health coverage**: this situation exists in countries without social security systems (developing countries) or where such systems are limited to a minority of the population (Medicare/Medicaid in the United States).
- **Duplicate** private health insurance: this offers a private alternative to the public system where citizens may choose between the two. In Australia and Ireland, 50 per cent of the population chooses private health insurance, compared to 10 per cent of the population in Germany.

⁵⁶ OECD. 2004. *Private Health Insurance in OECD Countries (Summaries)*. ISBN: 9264015655.

- **Complementary** private health insurance: this insurance complements the public scheme, covering the share that falls to patients under that scheme (90 per cent of the French population has such insurance).
- **Supplemental** private health insurance: this finances goods and services that the public scheme excludes (very common in Canada, the Netherlands and Switzerland).

While experience varies greatly from one country to another, creating a social security system is a lengthy process. It is not linear and evolves constantly as policy, politics and the population's needs change. This chapter addresses the following points:

- Mutual benefit societies offer **basic social protection** before it is provided or regulated by the State;
- when the State establishes a public social protection system, mutual benefit societies must shift their coverage. In general, they refocus on **complementary or supplemental coverage**;
- Mutual societies offer many benefits to their members;
- Mutual societies extend social protection because they are committed to collective solidarity, which distinguishes them from charitable organizations.

5.1. Mutual benefit societies can “prime the pump” – a starting place for social protection

Mutual benefit societies, which are organizations of persons based on principles of solidarity, are an initial form of social protection when the State offers no or little protection. In Europe and Latin America, mutual societies were the first providers of basic social security. This situation has continued for more than 100 years.

5.1.1. Mutual aid associations launched solidarity-based social protection systems in 19th-century Europe

In countries where mandatory, national, solidarity-based systems do not yet exist, mutual societies have historically constituted a starting point for mutual aid, implemented on a limited scale (for example, solidarity within a company, an occupational sector or geographic region). In Europe, social security systems were established gradually and they absorbed or integrated the mutual aid associations over time.

It is difficult to summarize the historical development of mutual societies in a few lines. Researchers such as Patricia Toucas have devoted entire books to this subject. However, this chapter will outline the emergence of social protection in Europe through the evolution of mutual benefit societies.

The premises of mutual aid

The first embryonic “mutual benefit” organizations date back to ancient Greece.⁵⁷ At that time, they were most often based on a craft community and operated on principles of reciprocity.

⁵⁷ Patricia Toucas-Truyen. 1998. *Histoire de la Mutualité et des assurances, l'actualité d'un choix*, Paris, Syros.

Starting in the 10th century, the first mutual entities began forming around craft guilds (*compagnonnages*). They operated as welfare funds and provided a pooled savings fund to address risks faced over the course of members' lifetime.

Definition: *Compagnonnages* developed as associations or guilds of workers in the same trade to provide apprenticeship, instruction and mutual assistance. The system expanded dramatically in France, particularly around the construction of churches in the Middle Ages. These guilds are also found in Belgium, Germany and Canada in slightly different forms.⁵⁸

Starting in the 17th and 18th centuries, solidarity-based provident funds were organized throughout Europe, primarily as "corporations." The primary risk covered was fire or death of a member, with the pooled funds used to provide a dignified burial.

In 1663, a millers' mutual society was created in the Netherlands.

In 1706, the British Amicable Society for Perpetual Insurance Office was founded in the United Kingdom.⁵⁹

The development of mutual societies in the 19th century

In the 19th century, Europe's gradual **industrialization** had a profound impact on these associations and the existing forms of solidarity. "Mutual aid societies," which were occupationally-based mutual aid associations (composed of workers, railway workers and, somewhat later, teachers), formed to respond to the industrial revolution's new risks and to the weakening of traditional family and village solidarity.

These mutual societies included both provident and health organizations, which democratized access to medical care.

Examples of the growth of the first mutual health and social associations in 19th and 20th century France:⁶⁰

- The Kerpape sanatorium opened in the Morbihand region in the summer of 1918;
- The first mutual pharmacy was established in Marseille in 1853. Other mutual pharmacies later developed in cities between World War I and World War II (including in Bordeaux, Saint Nazaire and La Rochelle);
- the first dental clinic was established in the Hérault region in the 1920s, allowing individuals of modest means to obtain treatment that had previously been limited to a privileged minority;
- Between World Wars I and II, mutual societies administered both the mandatory scheme (through insurance funds) and the complementary insurance system. Mutual societies were also the only form of social protection available to independent workers (including artisans and farmers).

Germany's mandatory social insurance system was developed in the 1880s. It was established by Chancellor Bismarck to strengthen the legitimacy of the state within the working class. It included:

⁵⁸ François Icher. 1994. *La France des compagnons*, Editions La Martinière, (ISBN 2-7324-2091-3).

⁵⁹ See the study by the European Commission. 2012, page 38.

⁶⁰ *Mutualité et protection sociale entre les deux guerres*, Réponse. March 2012. Number 123, pp. 12-17.

- Health insurance laws (1883) which required that the contribution paid 2/3 by the worker and 1/3 by the employer;
- workplace accident coverage (1884); and,
- disability and old-age insurance (1889).

Various kinds of organizations were assigned to manage the system, including “mutual” entities (company, occupational and local funds), managed autonomously and often with majority worker membership. Today, the VdEK, the German statutory health insurance funds, is considered a member of the mutual benefit system and participates actively in the International Association of Mutual Benefit Societies (*Association internationale de la mutualité (AIM)*)⁶¹, although it is a manager of the mandatory health insurance system.⁶²

The Bismarckian system inspired Austria and the Scandinavian countries, while Belgium, Switzerland and the Netherlands developed models based on unrestricted pension plans.

Mutuals today account for 26 per cent of the insurance sector in Europe.

5.1.2. Development of mutual benefit societies in Latin America

Mutual societies in Latin America developed with the waves of immigrants who arrived from Europe in the 19th century. Long before the governments of the Americas acknowledged social security as a right, these communities organized by affinity – often by country of origin or occupation – to protect themselves **on the basis of the reciprocity principle** to address life-cycle risks on the American continent.

The *Union de Secours mutuels* was founded in Argentina in 1854, the *Asociación española de Socorros Mutuos* in 1957, and *Unione e Benvolenza* in 1858, *San Crispin* (a shoe manufacturing corporation) in 1856 and *Tipografica Bonaerense* in 1857, among others. According to Roberto Di Stéfano,⁶³ the proliferation of associations (most of them mutual benefit societies) starting in the 1860s played a significant role in building republican institutions in Argentina.

In 1880, State action in the areas of health and education reduced the scope of mutual societies’ activities. The government began building public hospitals, undertook vaccination campaigns and, in general, improved access to medical care. As part of the same movement, it initiated efforts in education and financed construction of better schools than the mutuals’ schools that accompanied the emergence of the association movement of the 1860s. Mutual societies thus turned their energies toward managing health care centres and providing services that complemented and duplicated those of the public system.

⁶¹ The VdEK currently serves as vice-president of AIM (2011-2014 terms). www.aim-mutual.org/print.php?page=12®ion=EU.

⁶² Mireille Elbaum. 2011. *Economie politique de la protection sociale*. Presses universitaires de France, p. 37.

⁶³ Roberto Di Stéfano. 2002. “Orígenes del movimiento asociativo: de las cofradías al auge mutualista”, in Roberto Di Stéfano; Hilda Sábato; Luis Alberto Romero and José Luis Moreno. “De las cofradías a las organizaciones de la sociedad civil – Historia de la iniciativa asociativa en (la) Argentina” - 1776/1990, *Edición de Gadsis*, Grupo de análisis y desarrollo institucional, Buenos Aires.

Example: Catholic Workers' Circle of the Uruguay Mutual Fund (*Círculo Católico de Obreros del Uruguay Mutualista*)⁶⁴

The first *Círculo Católico* hospital was founded on June 21, 1885 in Montevideo to improve the quality of life for workers and their families.

Limited initially to workers, the **mutual benefit society adapted in response to Uruguay's historic and social evolutions**. The country's health system is now composed of networks in which public and private organizations interact (including the *Círculo Católico*).

Today the system includes four sanatoria (two in Montevideo and two in the interior of the country), 43 branches, pharmacies, laboratories, support services (specifically in the area of domestic violence) and social services. It is a complex organization that is part of Uruguay's integrated national health system, which covers 78,800 members.⁶⁵

- 89 per cent (71,193) belong to a mutual society via FONASA, the national social security system's health fund; and,
- the remaining 11 per cent (7,687) belong on a voluntary and direct basis.

As the European and Latin American examples show, **mutual benefit societies historically constituted the starting point for social protection there**. However, they adapted to provide other services when a public system was established.

5.2. When the State organizes a public welfare system, mutual benefit societies can provide complementary or supplemental coverage

Mutual societies play a role in extending social protection while **adapting continually to their environment**. Their **purpose is not to replace public social security systems**. Rather, they play a complementary role and honour the values of universal access to social security. These are associations of people. They seek members' satisfaction and **their purpose is not to increase their turnover** – except to meet legal reserve and solvency requirements and social obligations and cover guaranteed risks. Their surpluses are used primarily to meet members' needs.

As shown earlier, mutual benefit societies are a starting point for social protection when the State does not provide social security or when only the formal sector benefits from social insurance. In societies where mandatory social protection does exist, **mutuals provide complementary or supplemental protection** by organizing social services (including health, support and social services) and mutual-based insurance.

A movement towards mandatory social security systems emerged in the late 19th century:

- In the 1880s, Bismarck established mandatory social security in Germany;
- in 1919, the ILO recommended that States establish mandatory social protection systems; and,
- in 1945, the growth of salaried employment and the shock of the Second World War challenged the role of mutual societies in William Beveridge's Great Britain.

Shaken by these changes, mutual benefit societies were forced to adapt to this new context and redefine their areas of activity.

⁶⁴ See a video on the Circuito Católico: http://www.circulocatolico.com.uy/index.php?option=com_content&view=article&id=69%3Avideoinstitucional&catid=34%3Ainstitucionalgeneral&Itemid=41.

⁶⁵ 78,800 members on 30 June 2013.

With the **emergence of mandatory health protection systems, mutual societies responded in three ways:**

1. **They focused on providing services:** With the adoption of mandatory social insurance, mutual societies disappeared or stopped providing mandatory health insurance, turning instead to offering health care services to their members.

This occurred in Great Britain, where under the influence of William Henry Beveridge, mutual health and retirement insurance schemes were abolished in 1948, when the National Health Service (NHS) began. However, mutual societies continued to exist in the area of “non-essential” services, such as sanatoria, private rooms and dental care. In general, they had a strong local presence and roots.

Example: Great Britain’s Benenden⁶⁶ mutual society

This society began operating in 1907, when the Benenden Hospital was established to treat post office workers with tuberculosis.

As tuberculosis disappeared, **the hospital turned gradually to cancer.** Today, it provides cutting-edge treatments in a variety of medical specialties. It is open to private sector workers and has more than 900,000 members.

2. **They maintained a role in risk coverage:** In other cases, as in France, facing the gradual implementation of public social security systems, mutuals continued to play a significant role, but positioned themselves as providers of “**complementary**” or “**supplemental**” health insurance.

Example: The French government recognizes health mutual societies as a contractual partner in agreements

The role of complementary health mutual societies has grown dramatically in France since the 1980s. Thirty-eight million French citizens are covered by a mutual society that belongs to the *Mutualité Française* (National Federation of French Mutual Benefit societies). Mutual societies play a key role in access to medical care.

The State thus acknowledges them as actors in health protection in France and has established unions of health insurance funds to represent them at the national level.

Protection provided by complementary coverage was “widely acknowledged in the 2004 health insurance reform, which established coordination between mandatory and complementary insurance entities by creating two unions of health insurance funds, UNCAM (the national union of health insurance funds) and UNOCAM (the national union of private complementary insurers). Under the 2009 French Social Security Financing Law, those unions are established – although not unequivocally – as contractual partners.”⁶⁷

In 2013 Article 1 of the draft national occupation agreement law Accord National Interprofessionnel (ANI) acknowledges the essential role of complementary insurance in ensuring access to medical care and recommends that it be extended to all salaried employees, by contracts negotiated at branch or at enterprise level.

⁶⁶ <http://www.benenden.org.uk/about-us>.

⁶⁷ Cf. Ginon and Trépreau. 2011. cited in Elbaum’s *Economie Sociale et Politique*.

Argentina offers an example of supplemental coverage (risk not covered by the public system).

Mutual coverage benefits members by supplementing the public social security system: The mutual society for family protection in Argentina helps to redesign living spaces for the elderly and disabled

The Argentine mutual society for family protection has helped its elderly members adapt their housing to their illnesses and ease daily life since 2008. Their living areas are redesigned to remove barriers to mobility and adapted equipment is installed. The society also provides trainings for grandchildren and other family members.

The goal is to allow the elderly to age in place safely and comfortably and to remain independent.

Thanks to its positive results, ISSA designated this initiative a “Good Practice” in 2009.⁶⁸

3. **They became managers of the mandatory scheme:** in Germany, mutual societies have become public law entities (*Krankenkassen*⁶⁹). In Sweden, mutual societies operate regionally and are integrated into the mandatory health insurance system.⁷⁰

Krankenkassen in Germany

In Germany, the mandatory legal system, which covers 90 per cent of the population, is managed by not-for-profit organizations, *Krankenkassen*, which are non-exclusive and non-discriminatory. Insured persons and employers are represented equally on their board of directors.

They work with the State to administer the national health program (*Gesetzliche Krankenkassen*). The Germans refer to these funds as “Substitute Health Insurance Funds.” There are six federations:

- *Verband der Ersatzkassen (vdek)*: Employee fund
- *Allgemeine Ortskrankenkasse (AOK)*: General regional funds
- *Betriebskrankenkasse (BKK)*: Company-based health insurance funds
- *Innungskrankenkasse (IKK)*: Guild health insurance funds
- *Knappschaft-Bahn-See (KBS)*: Miners’ and sailors’ health insurance funds
- *Landwirtschaftliche Krankenkassen (LKK)*: Farmers’ health insurance funds

Because of their mutualist background, some *Krankenkassen* federations have strong ties to the mutualist movement and belong to the International Association of Mutual Benefit societies (vdek, IKK, and KBS).

Mutual societies changed considerably in the 20th century, adjusting to the adoption of mandatory coverage and addressing the population’s new needs. While some have chosen to develop their health activities (health care in Great Britain), others have changed sectors entirely, developing insurance for a range of risks, including automobile and home insurance (for example, Matmut and MAIF in France).

⁶⁸ <http://www.issa.int/esl/Observatorio/Buenas-practicas/Asistencia-para-el-Desempeno-Funcional>.

⁶⁹ Vdek, a member of the international AIM association, is a good example. <http://www.vdek.com/>.

⁷⁰ See page 39 of the European Commission Study.

5.3. The benefits of health mutual benefit societies

This section provides examples of the benefits that health mutual societies provide.

5.3.1. Mutual societies reduce financial barriers

Whether they offer third-party payment or reimburse the employee directly, mutual societies allow members to **avoid direct payment**. The contribution thus makes it possible to “prepay” for the medical procedures covered by the mutual insurance.

In addition, membership in a mutual insurance society **distributes the financial risk** among all insureds and avoids catastrophic expenses in connection with the package of health care services defined by the mutual scheme.

Last, because mutual societies are **not-for-profit**, any surplus are reinvested and used to improve coverage offered to members. Reserves are established to smooth earnings from one year to the next.

5.3.2. They seek to meet members’ needs

Mutual societies **do not choose the risks covered or select the members who join**. They are organizations of persons and do not belong to shareholders. Their objective is to **meet members’ needs**, not seek profits. For that reason, they may **cover populations considered to be “unprofitable”** in economic terms.

Mutual benefit societies are committed to principles of solidarity, which means that populations defined as “at risk” by virtue of their age or health status receive the same services as healthy individuals. However, in a competitive market, this situation is tenable only if mutual societies have a strong financial base or if regulation allows for compensation of the costs of contributions or greater risks.

5.3.3. They increase access to health care and help control patients’ costs

The purpose of the mutualist system is to ensure its members’ access to care.

The examples below, from Mali and Benin, show how membership improves:

- patient access on healthcare;
- information and accountability of patients.

Mali - greater likelihood of obtaining treatment

In 2008, the WHO conducted a study of 817 households in two districts in Mali. The study, “**Effects of mutual health organizations on use of priority health-care services in urban and rural Mali: a case-control study**”,⁷¹ concluded that mutual health organization (MHO) members whose premiums were up-to-date were:

⁷¹ <http://www.who.int/bulletin/volumes/86/11/08-051045/en/>: “**Effects of mutual health organizations on use of priority health-care services in urban and rural Mali: a case-control study**”, *Bulletin of the World Health Organization* Volume 86, November 2008, 817-908.

- 1.7 times more likely to seek treatment for fever in a modern facility than those who were not members of an MHO;
- three times more likely to seek treatment for their children's diarrhoea in a modern facility and/or treat them with oral rehydration therapy at home; and,
- twice as likely to make at least four prenatal visits during pregnancy and, among children under five or pregnant women, to sleep under insecticide-treated mosquito nets ($p < 0.10$ or greater in all cases).

However, the distance to the closest health facility was a significant predictor of health-care seeking behaviours, particularly with regard to assisted childbirth. No significant association was observed between family or individual membership in a mutual health society and socio-economic status (except for the wealthiest quintile).

Benin - the power to say "No"

A 2011 University of Montreal⁷² study, *Thanks to health mutual societies in Benin, users can say "No"* *Grâce aux mutuelles de santé au Bénin, les usagers ont le pouvoir de dire non*, illustrates the benefits of membership:

- **Members in Benin have greater access to health care** than non-members;
- **The cost of health care for members is lower** than for non-members:
 - for example, hospitalization costs 40 per cent less for members (less than franc CFA (XOF)30,000 for members, compared to XOF46,000 for non-members); and,
 - Labour and delivery costs around XOF9,000 for members, which is approximately 30 per cent less than for non-members (XOF12,500).
- Health mutual societies develop **relationships of trust within the community**; and,
- Mutual members have the power to act and **say "No."** This may have been the most unexpected impact. The study showed that **members are organized and better informed of their rights**, which enables them to refuse and criticize abuses by medical personnel (with regard to waiting periods and under-the-table payments) and thus improve the quality of their treatment.

5.3.4. They encourage social ties

Because mutual societies are often organized on the basis of pre-existing social solidarity (for example, within a community or on an occupational basis), they encourage **social ties and accountability**.

Mutual societies are associations of people and operate in accordance with the democratic principle of "one person, one vote." Insured persons have the right to vote and elect their representatives. They may also run for office themselves. They are thus stakeholders in their mutual society, so they learn more about their rights and make decisions regarding their future, either through the general meeting, directly or by delegation.

⁷² V. Ridde; S. Haddad; X. Ducandas; I. Yacoubou; M. Yacoubou; M. Gbetie. 2011. "*Grâce aux mutuelles de santé au Bénin, les usagers ont le pouvoir de dire "non,"*" in partnership with USI, CHUM, IRDC- CRDI, CIHR-IRSC, CIDR, AIMS and the Swiss Confederation, November 2011.

5.3.5. They cover all population segments, including the at-risk and low-income

In France, a study by the Centre for Research and Documentation in Health Economics (CREDES)⁷³ found that people older than 65 and those with chronic illnesses (“at-risk” categories) were under-represented by commercial insurers. They are more likely to be covered by mutual societies than by commercial insurers because mutuals are not-for-profit and do not select members on the basis of the risks that members may present.

In Italy, a study by Gianonni-Mazzi⁷⁴ found that people with moderate or high incomes tend to belong to for-profit health insurance schemes, while those with moderate or low incomes choose mutual insurance societies.⁷⁵ This is because mutual societies’ membership policies are inclusive and **their purpose is to cover all members of the population**. Indeed, a large membership is a pre-condition of their viability. As explained earlier, mutual societies offer coverage on the basis of solidarity and reciprocity.

5.3.6. They are more resilient to economic crises

Unlike for-profit private insurance companies, health mutual societies do not rely on the financial markets. As a result, they have shown considerable strength in the face of the current economic crisis. The European Parliament’s July 2011 report, *The role of mutual societies in the 21st century*,⁷⁶ thus notes that “since mutuals only acquire capital through their members and not via capital markets, they appear to be **more resilient to financial and credit crises** and, hence, to demonstrate **higher sustainability**.” The European Commission shares this view, stated in its November 2012 report, *Study on the current situation and prospects of mutual in Europe*.⁷⁷

Both reports rely on the analyses of agencies such as AM Best and Moody’s. The 2009 Moody’s Insurance study, *Revenge of the mutuals: policyholder-owned U.S. life insurers benefit in harsh environment summary opinion*, finds that mutual societies in the life insurance sector have shown greater resilience.⁷⁸

- Mutual associations have a stronger capitalization. Most mutual companies have more and better quality capital (they generally have smaller amounts of debt in their capital structure) to absorb unexpected shocks;
- their business focus and product offerings are less risky;
- they are involved in less financial/public disclosure and headline risk (i.e., since they are not publicly listed, less dependent on constantly changing stock exchange markets, they are less vulnerable to headline stories and short-term blizzards of adverse

⁷³ Sandier, Ulman. 2001. Cited in *Voluntary Health Insurance*, Elias Mossalos; Sarah Thomson. 2002. P.39-40. May be downloaded at www.euro.who.int/__data/assets/pdf_file/0006/98448/E84885.pdf.

⁷⁴ Giannoni, M. 2001. “Voluntary Health Insurance” in: *Health Care Systems in Transition: Italy*, European Observatory on Health Care Systems. WHO (World Health Organisation) Copenhagen, pp. 46-49.

⁷⁵ European Parliament study: *The role of mutual societies in the 21st century*, Directorate-General for Internal Policies, Committee on Employment and Social Affairs, European Parliament, IP/A/EMPL/ST/2010-004, EP 464.434, p. 40 French version – p. 35 English Version.

⁷⁶ Idem. 2011. EP study *The role of mutual societies in the 21st century*, page 9 of the French and English versions.

⁷⁷ European Commission study, pages 41-43.

⁷⁸ Cited in the European Parliament report: *The role of mutual societies in the 21st century*, page 63 (English version)/page 75 (French version).

- publicity, which can potentially hurt a company's overall business position and financial strength);
- they have diminished access to capital markets but, as a consequence, are less dependent on it; and,
- they have a greater alignment of owners and creditors/policyholders with a longer term orientation.

As the European Parliament, the European Commission and the mutualist associations (AIM, ICMIF, the Association of Mutual Insurers and Insurance Cooperatives in Europe, and AMICE, the International Cooperative and Mutual Insurance Federation) agree, the **economy is improved when its structures and risks are diversified**. In other words, the mutualist model – a stakeholder in and founder of the social economy – enriches and diversifies the economy.

Finally, the European Commission also cites the negative impacts of Great Britain's demutualisation in the 1990s as an argument in favour of the diversification of the economy that by mutual societies provide.⁷⁹

5.3.7. They operate over the long-term

Unlike for-profit insurance companies, mutual societies do not have shareholders. They are thus not required to focus on short-term profits, which may negatively affect members. Mutual societies protect populations over the long-term, which creates a sense of collective solidarity that is mutually advantageous and sustainable.

5.3.8. Mutual benefit societies are actors, not just payors – they promote patient information and education

The role of mutual societies is also changing (see AIM's 2008 report, **Health protection today: structures and trends in 13 countries**).⁸⁰ While mutual societies are particularly active in the area of drug reimbursement, socio-economic changes and what is sure to be the withdrawal of the State have led them to expand their role. They are not limited to serving simply as "payors;" rather, their role of "actor" is strengthened.

To improve disease prevention, they are providing more and better information to patients:

- The National Federation of French Mutual Benefit Societies⁸¹ offers a mutual health priority service, *Priorité Santé Mutualiste (PSM)*, to its members. The service includes a telephone platform, internet site and regional meetings⁸² on the following topics:
 - prevention;
 - screening;
 - illness;
 - drugs;
 - support during and following an illness;
 - medical and social concerns (including loss of autonomy); and
 - rights and procedures (including social security and patients' rights).

⁷⁹ Page 40 of the European Commission study.

⁸⁰ *Health protection today: structures and trends in 13 countries*, AIM Health System Reform Group, published in 2008. May be downloaded from the AIM site: <http://www.aim-mutual.org/>.

⁸¹ The National Federation of French Mutual Benefit Societies (*Mutualité française*) is the national federation of approximately 600 French mutuals. Its member organizations cover 38 million people in France, primarily in the area of health. <http://www.mutualite.fr/La-Mutualite-Francaise>.

⁸² <http://www.prioritesantemutualiste.fr/psm/accueil>.

- The Irish VHI Healthcare⁸³ mutual insurance company provides its members a website offering information about illnesses and treatment and advice on healthy living (diet and nutrition, exercise and fitness, lifestyle and well-being, travel health, workplace health and addiction). In addition to this online information, VHI Healthcare offers round-the-clock telephone and email consultations with a nurse who can answer health-related questions and schedule appointments. VHI Healthcare can also send a text to remind patients to take medication.
- Some Belgian mutual insurers (including the Christian and Socialist mutuals) allow patients to compare their share of hospitalization costs by using a module with data on hospital rates.
- In 2011, the National Federation of French Mutual Benefit Societies launched *Tensioforme*, an innovative, experimental educational treatment program to reduce hypertension risks. Seven French mutual societies are participating.⁸⁴

Mutual societies are also developing innovations in the area of the organization of medical care (coordination between primary and secondary levels and among medical care, long-term care and social services, disease management and the division of roles among service providers, e-health and telemedicine). In that regard, the French Agricultural Mutual Benefit Societies have created multidisciplinary rural health centres. Their staff members include a wide range of health professionals (nurses, therapeutic masseurs, pharmacists, paramedics, pedicurists, midwives and dentists), who offer improved treatment coordination and permanence and continuity of care. The Belgian *Mutualités libres belges* have also made considerable progress in implementing good practices that promote disease management.⁸⁵ In 2005, they established platforms to improve treatment coordination for chronic illnesses.

Last, in light of the pressure to reform social security systems, mutual societies can help to monitor health systems and act as advocates, both nationally and internationally.

5.4. Solidarity not charity: mutual benefit societies are social enterprises with a universalist vision

Mutual societies promote a solidarity-based vision of society. Indeed, their objective is to provide coverage to an entire population. This broad base allows them to implement their vision of solidarity because it pools the “good” and “bad” risks that they insure. **Mutuals are not created to cover only vulnerable, excluded and marginalized populations.**

This universalist vision has been challenged by many actors, including the European Union. The EU has become increasingly interested in the “social” economy, but it neglects the fundamental values of a broad-based solidarity across all population segments and of democratic governance. It is developing European standards for social entrepreneurship, that is, forms of entrepreneurship that focus on vulnerable population groups or integrating these groups into their operations. These preferred forms of social enterprises may receive subsidies if they focus on and serve **only** at-risk populations.

⁸³ <https://www.vhi.ie/index.jsp> .

⁸⁴ <http://www.mutualite.fr/L-actualite/Sante/Tensioforme-un-programme-personnalise-contre-l-hypertension-arterielle> and <http://www.mutualite.fr/L-actualite/Sante/Hypertension-arterielle-Tensioforme-en-ordre-de-marche-!>

⁸⁵ <http://www.mloz.be/fr/publications/fax-medica> .

The International Association of Mutual Benefit defends the social economy enterprise model, emphasizing the social role of mutual societies. “Social entrepreneurship cannot be limited to vulnerable groups ... Mutual benefit societies cannot be limited to activities and services focused on vulnerable groups ... as proposed by the European definition. Mutual societies are solidarity organizations and their objective is to protect the population as a whole, not just disadvantaged individuals. For example, mutual societies play a major role in the society through their large network of services and institutions ... throughout the entire country (including rural and suburban areas) that serve everyone. **Their primary objective is to ensure that the number of vulnerable persons does not increase in the future. To that end, mutuals play a critical role in promoting the prevention principle.**”

Mutuals are associated with the notion of universal social protection, which protects an entire population, not portions of it (whether poor people, young people or others). This notion, advocated by, among others, Nicolas Duvoux, a sociologist at the University of Descartes, seeks to avoid “the paradox of redistribution;” the idea that redistribution targets economically disadvantaged populations only after the fact and does not prevent others from becoming disadvantaged.⁸⁶

In addition, in the Anglo-Saxon view of “social business,” social enterprises are considered to be small-scale, but their “social” nature should not limit the entity’s size.

The existence of mutual societies is under severe challenge in Europe because European Union rules tend to deny their specific identity. Many of their unique characteristics are not well-known or are misunderstood, thus compromising their ability to operate in the market under the same terms, conditions and rules of competition as other operators (**mutual benefit societies do not exist legally at the European level**). **As a result, they cannot develop on a transnational or European basis as mutual societies (an organization of persons)**. They may do so in another form but that could cost them identity as mutual societies. If the European Union does not recognize them, mutuals could disappear. As noted earlier, this would threaten access to medical care for a large portion of Europe’s population.

Mutual benefit societies are advocating for recognition and encouragement for multiple forms of business entities, consistent with the European Parliament’s statements:

- It is often acknowledged that “mixed sectors containing both mutuals and stock holding companies create a systemic advantage, since a diversified landscape of ownership structures contributes to a more competitive and less risky market than an environment solely populated by either mutuals or joint-stock companies.”⁸⁷
- “(...) the Commission should propose adequate solutions to those problems in order to better recognise the contribution made by mutual societies to the social economy, including a Statute”.⁸⁸

⁸⁶ Cited in the article, “*Considérer la protection sociale comme un investissement*,” *Alternative économiques* No. 319, December 2012, pp. 65 and 66. See also Nicolas Duvoux. 2012. *Le nouvel âge de la solidarité. Pauvreté, précarité et politiques publiques*, Paris, Seuil/La République des idées.

⁸⁷ Excerpt from the European Parliament report. *The role of mutual societies in the 21st century*.

⁸⁸ Excerpt from Luigi Berlinguer own initiative report. Report adopted by the European Parliament on 14 March 2013, with **recommendations to the Commission on the Statute for a European mutual society** (2012/2039(INI)), Committee on Legal Affairs, p.4.

6. Mutuels at risk of “demutualisation”: The challenge of achieving recognition

The role of mutual benefit societies is under pressure (see chapters 4 and 5) for a host of reasons. This poses a challenge to their existence on all continents.

First, many States in Africa and Latin America support the creation of social protection floors and **question the role of mutuels in this extension**. Mutuels are often seen as a way to reach populations in the informal sector, but are often hampered by low member contributions, small size and an image tarnished by incidents of lack of professionalism, inefficiency and management problems.

Second, States that are suffering from the economic crisis, such as in Europe, are pulling back from traditional mandatory social protection systems, transferring the largest costs to private health insurance companies or mutual benefit societies. However, they have not provided the latter the legal and statutory tools that will allow them to compete on a level playing field. **Mutuels are likened increasingly to commercial insurance companies** and are threatened by the loss of their values. Legislators - for example, the Argentine government and the European Commission – tend to see them akin to “any other operator” that must adapt to the market, but do not take into account their social role, specific governance characteristics or significance in terms of market share.⁸⁹ The mutual model is losing its specific character. This trend is accelerating in the context of economic globalization, with most current regulation based on capital-based companies.

This lack of recognition challenges the continued existence of mutual benefit societies.

6.1. Achieving recognition for the mutualist movement in Africa

A movement that is taking shape ...

The small size of mutual societies in sub-Saharan Africa has often been referred to, particularly in the Joint Action Network’s analyses,⁹⁰ as a significant obstacle in the context of medical care and discussions with governments.

For that reason, the International Labour Organization’s STEP⁹¹ programme (Strategies and tools against social exclusion and poverty) strongly encourages health mutuels to coordinate their activities. However, lack of resources (particularly computer-related) has made it difficult to implement such coordination (for example, the *Union des Mutuelles de Dakar*).

The Joint Action Network Among Development Actors in Health Mutual Societies in Africa is an interesting example of an effort to organize the mutualist movement. This platform of meetings and information exchange among actors involved in developing this movement was created in April 1999 after a workshop in Abidjan on strategies to support health mutual societies in West Africa. Its purpose was to define strategies supporting the emerging

⁸⁹ As emphasized in the November 2012 European Commission report, two out of three insurers in Europe are mutuels (all sectors – including health and miscellaneous risks - combined).

⁹⁰ The Network’s Internet site no longer exists, but several online references are still available. See http://tribune.tmp38.haisoft.net/index.php?option=com_content&view=article&id=81:le-forum-africain-de-la-concertation-des-promoteurs-de-mutuelles-de-sante-se-tiendra-a-yaounde&catid=1:actualite&Itemid=3.

⁹¹ <http://www.ilo.org/public/french/region/afpro/dakar/activities/projects/step.htm>.

mutualist movement. The network was active in Senegal, Mali, Burkina Faso, Niger, Côte d'Ivoire, Benin, Mauritania, Cameroon, Guinea, Chad, Togo, Congo, Rwanda and Burundi.

This was a political, strategic, legal and mutualist effort to promote the mutualist model and its values to develop solidarity-based social protection systems.

Unfortunately, when the international organizations (USAID, GIZ⁹² and the ILO) withdrew, the STEP programme ended, leading to the termination of the network. Today, the African mutualist movement is trying to organize as part of a larger framework, in connection with the International Association of Mutual Benefit Society's (AIM) cooperative relationships with Latin America and the *Union Africaine de la Mutualité* (UAM). In February 2012, AIM and the UAM organized a session, the "Carrefour mutualiste," to jointly define the priorities for the emerging mutualist movement in Africa. In April 2013, a meeting to assess progress was held in Rabat, Morocco, in connection with the second international gathering on mutualism, the *2e Carrefour international de la mutualité*, which focused on the role of mutual benefit societies in the development of a social, solidarity-based economy.

... and must seize opportunities to grow and develop social protection floors in Africa

If African mutual benefit societies could strengthen one another, they would benefit from two key advantages of the current context: **the development of social protection floors and strong economic growth on the African continent.**

Social protection floors are being promoted just as Africa is experiencing strong economic growth (5.5 per cent on average since 2000). Poverty has fallen from 42 per cent to 31 per cent and a middle class is emerging (300 million people). Economists, including Nicolas Baverez, predict that "the middle class will double, reaching 600 million people in 2050."⁹³ Historically, mutual benefit societies have their base in the middle class. If it were strengthened in Africa, that would constitute a genuine opportunity to develop social insurance.

Mutual societies must now address these opportunities by strengthening their unity and implementing the priorities that emerged from the *Carrefours* in Abidjan and Rabat. This will allow them to advocate more effectively nationally, regionally and internationally, exchange experiences and work in coordination with government.

6.2. Mutual societies and the risk of "demutualisation"

This trend involves primarily European and American countries, where mutual societies have expanded significantly since the late 19th century. In the early 20th century, capital-based companies even experienced a shift toward "mutualisation" (particularly in the United States (U.S.)). But starting in the 1980s, and particularly since the 1990s, mutual societies in the Anglo-Saxon countries have come under challenge and many restructured themselves as capital-based companies to "increase efficiency, gain access to capital to grow and increase flexibility. This "demutualisation" should provide benefits to members, employees and future shareholders – at least according to the claims."⁹⁴ The 2011 study, *La Mutualité, une valeur*

⁹² GIZ (formerly GTZ) is the German cooperation Agency (*Die Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)*) <http://www.giz.de/>.

⁹³ Statistics cited in "L'Afrique est bien partie," by economist and historian Nicolas Baverez, in the *French daily newspaper Le Monde*, Wednesday, 3 April 2013, page 2.

⁹⁴ *La Mutualité, une valeur sûre*, Association of Mutual Insurers and Insurance Cooperatives in Europe, 2001.

sûre (Mutuality, a sound investment), published by the Association of Mutual Insurers and Insurance Cooperatives in Europe (ACME),⁹⁵ provides an in-depth analysis of the demutualisation of the 1990s and its impacts, concluding that the shift has not had positive effects on the market or on consumers over a 10-year period. Rather, most of the mutual insurers were purchased or absorbed and the study found no benefits with regard to premiums or efficiency.

The search for critical size

In the 1990s in Europe, mutual societies began to experience competition that was heightened by globalization and community integration. “Demutualisation refers to the process by which a mutual insurance company changes its legal status and becomes a publicly-traded company.”⁹⁶

As Stéphane Mottet wrote in an article titled, “La démutualisation,” the economic reasons for that phenomenon - “deregulation, euphoria in the financial markets, the coming together of the banking and insurance industries and the international opening of the economy (which was very significant in Europe)” - were highlighted in the 1990s. “These changes resulted in rapprochements at the national and transnational levels via mergers and acquisitions and cooperation agreements in an effort to achieve a critical size and economies of scale.”⁹⁷ **According to Mottet, this search for critical size and competition led many mutual societies to demutualise.**

Demutualisation occurred many times in the 1990s-2000s, including in Great Britain (Scottish Mutual in 1992 and Norwich Union in 1997), Finland (Sampo in 1987), Sweden (Trygg-Hansa in 1989), and Switzerland (Swiss Life in 1997).⁹⁸ Elsewhere, radical demutualisation was also underway in the U.S. life-insurance sector (State Mutual Life in 1995), Canada (Mutual Life in 1999), and Japan (Mitsui Life in 2002).⁹⁹

The process was easier in the Anglo-Saxon countries, where regulation allows change of legal status. That move is more complicated in countries such as France, where such changes are prohibited or costly (referred to as the *verrou français*, or “French lock”).¹⁰⁰

European legislation ignores the mutual model

Keen to comply with free competition and proper management of insurance companies within its territory, the European Union laid down rules with a significant impact on the

⁹⁵ Founded in 1975, the Association *des assureurs Coopératifs et Mutualistes européens* (Association of Mutual Insurers and Insurance Cooperatives in Europe, ACME) is the regional association of the International Cooperative and Mutual Insurance Federation (ICMIF). In 2008, ACME merged with AISAM to become AMICE (Association of Mutual Insurers and Insurance Cooperatives in Europe).

⁹⁶ Mottet Stéphane. “La démutualisation”. In: *Revue d'économie financière*. No. 67, 2002. *L'avenir des institutions financières mutualistes*, p. 111.

⁹⁷ Mottet Stéphane. “La démutualisation”. In: *Revue d'économie financière*. No. 67, 2002. *L'avenir des institutions financières mutualistes*. pp. 111-120. *Url: http://www.persee.fr/web/revues/home/prescript/article/ecofi_0987-3368_2002_num_67_3_3576*.

⁹⁸ Source: ACME. http://www.amice-eu.org/what_is_amice.aspx?lang=fr.

⁹⁹ Source: ICMIF.

¹⁰⁰ This phenomenon was thoroughly documented in the Anglo-Saxon academic literature. For example, the study by Erhemjamts and Leverty. 2010. Addressed the 1995-2004 period, confirms the trend toward demutualisation in the life insurance sector observed in the United States by Zanjany. 2007. In addition, these questions were originally discussed in the French context. Roth. 1998. See: *Crise et régulation des marchés financiers : Quel impact sur les formes mutuelles dans l'assurance?* Fabrice Rot. halshs-00692342, version 1-3 May 2012: <http://hal.archives-ouvertes.fr/docs/00/69/23/42/PDF/Article.pdf> Page 9.

regulatory framework governing mutual societies and social protection in Europe. Since the 2000s, the tax and social protection schemes of both mutual and for-profit insurers have been aligned, thus weakening the unique identity of mutual benefit societies.¹⁰¹

As AIM has emphasized,¹⁰² the lack of European-level law could lead to another round of demutualisation. Indeed, while mutual societies in some countries may establish federations and other joint structures, legal tools vary by country. This limits the visibility of the mutual groupings and **prevents European mutuals and European mutual societies from forming.**

Thus, establishment via subsidiaries in another European Union country “must take the **form of a capital-based company** (generally, a public limited company) that is controlled and governed by shareholders or partners, which is contrary to the objective of mutual associations.¹⁰³” Establishing a European mutual benefit society in the form of a group would provide for increasing the size and the amount of own funds available by creating mechanisms to transfer own funds among mutual entities.

European law encourages convergence with commercial insurers

As a result of European law, mutual societies that managed health insurance were thus required to transpose the European law on insurance¹⁰⁴ and, specifically, the solvency scheme (including the Solvency 2 regulatory proposal still under negotiation). One of the key obstacles blocking the creation of mutual societies in Europe is the threshold requirement for own funds, which is set quite high.

To meet high solvency standards and the required reserve fund ceilings and to address increased competition from commercial insurers, mutual societies have come together and merged, while others have made the radical choice to demutualise or have ceased operations.

In addition, mutual societies have had to separate management of their complementary insurance activities from that of their social endeavours (including clinics, pharmacies and vacation centres).

Belgium: The changing role of mutual benefit societies¹⁰⁵

In 2006, the Belgian private commercial insurance companies’ trade association, ASSURALIA, filed a complaint with the European Commission. It alleged that mutual societies were required to conduct their supplemental insurance activities under the same terms and conditions as commercial insurers and that European directives 73/239/EEC and 92/49/EEC had not been transposed into Belgian law.

Following that complaint, the Commission sent a formal notice to the Belgian government on 15 December 2006,¹⁰⁶ noting that it considered these directives to be applicable to Belgian mutual societies when the latter offer supplemental sickness insurance.

¹⁰¹ Etienne Caniard and Christine Meyer. “Les complémentaires et la crise: menace ou opportunité ?,” in *Les Tribunes de la santé*, 2012/3 No. 36, pp. 55-66. DOI: 10.3917/seve.036.0055, p. 57. Downloadable on <http://www.cairn.info/revue-les-tribunes-de-la-sante-2012-3-page-55.htm>.

¹⁰² AIM argument in favour of the Statute for a European mutual society. 2012. http://ec.europa.eu/internal_market/consultations/2012/company_law/additional-information/fnmf-roam-additional-comments_fr.pdf.

¹⁰³ Idem. AIM Arguments in favour of the SEM.

¹⁰⁴ Lisbon Treaty. *Treaty on European Union*, article 2.

¹⁰⁵ Alain Coheur. 2012. *Solidaris/* Belgian National Federation of Mutual Benefit Health insurance Funds (UNMS) “The mutuality in the Belgian health insurance system”, pp. 15-16, *Solidaris*.

¹⁰⁶ (Infraction No. 2006/4293, opinion C2008/1458).

The notice did not involve the role of mutual benefit societies in mandatory sickness insurance but, rather, their activities in the supplemental sickness insurance market.

According to the Commission, compliance with European insurance law required strict **application of the same rules**, regardless of the insurer's status and independent of the fact that mutual societies also provided mandatory insurance.

After a long process that concluded in 2012 with a modification of the law governing mutual benefit societies, those entities were required to create distinct legal entities – mutual insurance societies (*sociétés mutualistes d'assurance (SMA)*) – to develop their optional supplemental insurance activities (for example, products covering hospitalization costs). The SMAs thus compete with commercial insurers. However, mandatory supplemental insurance activities are considered to be mutualist operations when they meet a set of 10 criteria.¹⁰⁷ In applying these criteria, mutual societies operate in the general interest, the activities offered to their affiliates are not of a commercial nature and, thus, they do not compete with the commercial private sector.

The trend towards standardization of the insurance sector is thus underway, as the European Parliament report notes. “(T)he insurance market is likely to become more uniform in the future and mutuals may gradually be forced to behave like stock-holding companies or demutualise.” That is, unless the draft Statute for a European Mutual Society (EMS) provides mutual societies with the legal recognition essential to extend the mutual model in Europe and to cross-border federations and activities.”

6.3. Advocating for mutualism

If mutual benefit societies are to continue to play a role in providing social protection to their members, they must address their own approach, values and efficiency. **Great Britain offers several interesting examples of ways to re-energize the mutual model** and its values, specifically via Mutuo,¹⁰⁸ which advocates for mutual societies, and think tanks such as *ResPublica*.¹⁰⁹

- Created in 2001, Mutuo brings together the different wings of the British mutual and cooperative sectors to promote a better understanding of mutual societies and encourage mutualist approaches to business and public policy. They work together to

¹⁰⁷ The 10 criteria:

- (a) Registration with the service is mandatory for all members of the mutual insurance company;
- (b) All members of the mutual insurance company have access to this service regardless of age, gender and health status. No member may be denied service based on age or health status.
- (c) The service provides for continuity of coverage of persons who, before changing mutual insurance company, were members of a similar service. The Office of Supervision shall determine the meaning of similar uses of “hospitalization” and “daily compensation”;
- (d) Contributions are made on a lump-sum basis. Contributions may not be broken up but contributions may be differentiated based on household composition or social status within the meaning of Article 37, §§ 1st, 2nd, and 19, of the law on mandatory sickness insurance and compensation, coordinated on 14 July 1994;
- (e) The guarantee covers pre-existing conditions;
- (f) The guarantee is the same for all persons who belong to the service unless the social status referred to in point e) is taken into account, in which case the guarantee may be increased;
- (g) Financial management is based on distribution/pooling. Consequently, no reserves are established. Allocation of benefits depends on the resources available at any given time. Mutual insurance companies must manage their operations with due care in accordance with the instructions and under the oversight of the Office of Supervision;
- (h) contributions to the service are not capitalized;
- (i) the service is a not-for-profit entity; and
- (j) the benefits of the service, as approved by the general assembly, are set forth in the bylaws.

¹⁰⁸ Also see “The age of the Mutual?” by Jason Hesse, published in *Business Voice*, November 2012. <http://www.mutuo.co.uk/>.

¹⁰⁹ <http://www.respublica.org.uk/about-us>.

promote their shared interests and speak with a single voice to the government, media and other decision makers.

- *ResPublica* published a report, “Making it Mutual: The ownership revolution that Britain needs”,¹¹⁰ which calls for a greater role for cooperatives and mutual societies in all sectors of British society (including health, culture, infrastructure, and education).

Mutuals organize transnationally to gain recognition and call attention to the interests of their members. For example, AIM works actively to improve the rights of and respect for patients with regard to drugs, medical devices, personal data privacy and cross-border medical care.

Table 2. Overview of the major international mutual organizations:*

Organization	Features
<p>AIM International Association of Mutual Benefit Societies <i>Association Internationale de la Mutualité</i> www.aim-mutual.org</p> <p><i>“Healthcare and social benefits for All”</i></p> <p>Headquarters in Brussels</p>	<p>Umbrella organization of federations of mutual benefit societies and mandatory and obligatory health protection organizations (health & social protection).</p> <p>48 members (national federations) in 27 countries: - Europe: 1/2 of AIM’s members, representing 70% of the individuals covered by mutual in Europe. - Africa: 1/4 of AIM’s members - Latin America: 1/4 of AIM’s members</p> <p><i>Objective:</i> analyse changes in Europe and internationally in the areas of social protection and health care; exchange information among members; conduct advocacy with European and international organizations (drugs, medical devices, personal data privacy and the European Mutual Statute); promote mutuals’ values (universal social protection, non-profit, no risk selection, democracy).</p>
<p>AMICE Association of Mutual Insurers and Insurance Cooperatives in Europe www.amice-eu.org/</p> <p>Headquarters in Brussels</p>	<p>Umbrella organization of mutual benefit societies and insurance cooperatives at the European level. AMICE is ICMIF’s European member. 120 members (1/3 of the European insurance market).</p> <p><i>Objectives:</i> serve as the voice of the mutual and cooperative insurance sector in Europe; ensure that its members’ interests are taken into account in securing a level playing field for all insurers in Europe, regarding of their legal form.</p>
<p>ICMIF International Cooperative & Mutual Insurance Federation www.icmif.org</p> <p>Headquarters in Manchester</p>	<p>Umbrella organization of mutual and cooperative insurance companies at the international level. ICMIF is a member of the Insurance Sector of the ICA (International Co-operative Alliance). 221 members in 74 countries: - 1/3 of members in Europe - 1/3 in the Americas - 1/3 in Asia, Oceania, Africa and the Middle East.</p> <p><i>Objectives:</i> promote the identity and values of mutual and cooperatives; conduct statistical analyses of the sector; advocacy/lobbying. ICMIF has also established a Development</p>

¹¹⁰ Making it Mutual: *The ownership revolution that Britain needs*, Caroline Julian (ed.). 2013. <http://www.respublica.org.uk/item/Making-it-Mutual>.

	Committee to address ways to improve access to insurance for the poor.
UAM African Mutual Union/ <i>Union Africaine des Mutuelles</i> www.uam.org.ma Headquarters in Rabat	Umbrella organization for 21 mutuals in 16 African countries in the health and social protection sector. <i>Objective:</i> as part of a “South-South” cooperative effort, to distribute, in all African countries, the principles on which the mutual approach to health insurance, provident savings, retirement and other social protection sectors, jointly with North-South cooperation.
ODEMA Regional Integration of Mutuals in the Americas/ <i>Organización de Entidades Mutuales de las Américas</i> www.odema.org Headquarters in Buenos Aires	Umbrella organization of 91 mutuals in 18 American countries (including 45 members in Argentina), in the health and social service sectors. <i>Objectives:</i> promote and strengthen mutual entities in the Americas, create the conditions for improving capacity, exchange good practices and strengthen the movement’s unity.
AMA Alliance of the Mutuals of America/ <i>Alliance du Mutualisme d’Amérique</i> www.amamutualidades.org Headquarters in Montevideo	Umbrella organization of 10 federations and union of mutuals (approximately 15 million members) in six South American countries in the health and social development sectors. <i>Objectives:</i> promote mutual values, exchanges among members, represent them internationally and implement social actions.

* Mutual benefit societies and federations of mutual societies also belong to the International Social Security Association with regard to the management of their mandatory scheme.

With the active support of the European Parliament, mutuals are organizing at the European level to obtain European legal status. Such a status already exists in Africa under Regulation 07/2009/CM/UEMOA, which regulates social mutual funds within the West African Economic and Monetary Union (*Union économique et Monétaire Ouest Africaine (UEMOA)*).¹¹¹

In January 2013, the European Added Value Unit of the Directorate-General for Internal Policies of the European Parliament conducted a study on the added value of mutual societies in Europe. It found that mutual societies represent two-thirds of insurers (all risks combined) in Europe and that they provide added social, economic and legal value.¹¹² Even so, unlike insurance companies, mutual societies are never referred to in European treaties and are not adequately taken into account in decisions involving them (for example, the Solvency II directive, which challenges the governance of mutual societies). The European Commission offers another important example. The Commission has shown a growing interest in social business and established an expert group on this topic, GECES.¹¹³ The group did not include a representative from the mutual sector, although mutuals are recognized as key actors in the social economy. Thanks to a long and coordinated lobbying, the European Commission finally included two mutualists (from MGEN/ France and Solidaris/ Belgium). Another potential step forward is the announcement of the European Commission on 10 July 2013, to launch an “Impact Study” on the European Statute for Mutuals, prior to any possible legislative proposal.

¹¹¹ http://www.uemoa.int/Documents/Actes/reglement_07_2009_CM_UEMOA.pdf.

¹¹² European Added Value Assessment (EAVA), 01/2013. *A Statute for a European mutual society*, EP 494.461, ISBN: 978-92-823-4073-8, [http://www.europarl.europa.eu/RegData/etudes/etudes/join/2013/494461/IPOL-JOIN_ET\(2013\)494461\(PAR00\)_EN.pdf](http://www.europarl.europa.eu/RegData/etudes/etudes/join/2013/494461/IPOL-JOIN_ET(2013)494461(PAR00)_EN.pdf).

¹¹³ Information and minutes of the GECES meetings may be found at: http://ec.europa.eu/internal_market/social_business/expert-group/index_fr.htm.

Despite some progresses, the lack of recognition is common to all continents. During the 3 and 5 April 2013 meeting of the health mutual societies at the Rabat Carrefour de la mutualité, organized by the African Mutual Union with support from AIM and the presence of American representatives from ODEMA and the AMA, participants called for mutual societies to participate in sickness insurance implementation committees, particularly in African countries. To extend social protection floors, mutual societies, which often cover populations excluded from mandatory schemes in Africa, must join with sickness insurance funds in discussions with governments.

7. Conclusion

Attention is focused today on social protection floors. This approach reflects political leaders' recognition of the need to invest in social security at a time when the economic crisis has demonstrated the limits of an all-encompassing free-market approach and when citizens have also rejected an all-encompassing State approach. The social business sector, which includes mutual benefit societies, thus has a greater role than ever to play in providing social security. The history of mutual benefit societies has demonstrated their ability to address populations' social needs, based on their strong values:

- Autonomy (better expressed by the Anglo-Saxon term, "empowerment"), democracy and citizen responsibility;
- Solidarity between the healthy and the sick and between rich and poor;
- "Sustainability," in keeping with a long-term, stable approach. Mutual societies do not seek an immediate return on investment but, rather, redistribution based on principles of solidarity among their members; and,
- Complementarity with public social security systems. Mutual benefit societies offer solutions that complement, but do not take replace government's responsibility.

Anticipating the collective organization of response to risk, mutual benefit societies inspired our modern social security systems. They participated, and continue to participate, in extending social security around the world. Thanks to their long and rich experience, mutual societies are leaders in developing relevant solutions adapted to the needs of the populations.

However, mutual societies face many challenges. They have the resources to participate in creating social protection floors and finding solutions to this challenge if they can demonstrate the relevance of their model. They must continue to professionalize (particularly in developing countries) and unite nationally, regionally and internationally while ensuring solid management, participative democracy and sustainable financing.

In conclusion, quoting the European Parliament¹¹⁴ and extrapolating its conclusion focused on Europe, to mutual societies worldwide:

- Organizations based on mutuality make a major contribution to the European economy and society, in the large sense of the word, and should occupy a strong position in Europe.
- "(M)utuals still have a reason to exist and have an added value for the European economy and for society as a whole. (...) Moreover, with a view to maintaining sustainable, affordable social protection systems in line with the European Union's strategic objectives, there is a growing need for economic operators with social responsibility deeply rooted in their organization."¹¹⁵

¹¹⁴ European Parliament study. *The role of mutual societies in the 21st century*, on page 11 (FR) and page 10 (EN).

¹¹⁵ *The role of mutual societies in the 21st century*, on page 11 (FR) and page 10 (EN).

Given the current challenges, mutual benefit societies must redouble their efforts to preserve the foundations of their governance and democratic management so that they may legitimately demand national and international recognition and play a leading role in extending social protection around the world.