

**MUTUAL HEALTH ORGANIZATIONS AND
MICRO-ENTREPRENEURS' ASSOCIATIONS**

GUIDE

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AND MICRO-ENTREPRENEURS'
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GUIDE

The programme “Strategies and Tools against social Exclusion and Poverty” (STEP) of the International Labour Organization is an instrument for extending the coverage and effectiveness of social protection throughout the world.

Following the conclusions of the World Summit for Social Development in Copenhagen, the STEP programme promotes the design and the implementation of innovative systems of social protection for excluded populations. Based on the principles of equity, efficiency and solidarity, these systems contribute to social justice and cohesion.

In its work, STEP combines different types of activities: knowledge development, the production of methodological tools and reference documents, concrete actions in the field and technical assistance for policy development and implementation.

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The InFocus Programme “Boosting Employment through Small Enterprise Development” (SEED) of the ILO addresses the worldwide need for creating and improving jobs in small enterprises. Millions of women and men find themselves left with nothing else but their own resources to obtain a job that provides for a sufficient income. But that job should also be freely chosen, safe from hazards and free from risks, and provide enough remuneration to secure good living conditions for the person’s dependants. Helping decent work to come about through promoting quality jobs in small enterprises is the driving motive for all of SEED’s work.

Governments, Trade Unions and Employers’ Organizations help setting and implementing SEED’s agenda. It includes good policies and institutional frameworks, best practices in business development services, improved market opportunities, more job quality, stronger business associations and good gender practices. Targeted strategies in all these areas are realized through advisory services, guidelines, background papers, training, workshops and technical cooperation projects. Other than the mentioned social partners, SEED also links up with local governments, community organizations, small business associations and support organizations.

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Foreword

The International Labour Organization's fundamental goal today is to help ensure that every woman and man can obtain a decent and productive job, in freedom, fairness, safety and dignity. The concept of decent work encompasses most aspects of improving the world of work: having an adequate job and income and access to social protection, enjoying fundamental rights at work and participation in decisions through social dialogue.

Combining job creation and social protection in a single approach is crucial to the promotion of decent jobs. This is not an easy combination when dealing with workers in the informal economy. Indeed, even where employment promotion strategies focus on developing micro-enterprises, their implementation still falls short when it comes to social protection issues.

In many developing countries, the majority of micro-enterprises are found in the informal sector, where the shortfall in social protection is most marked. This shortfall reaches considerable proportions in certain regions of the world. It is estimated, for example, that some 80 per cent of the population of sub-Saharan Africa does not have adequate access to primary health care.

The need to combine job creation and access to social protection has motivated the collaboration between the SEED and STEP programmes.¹ This Guide is one of the products of this collaboration. It is intended for all those interested in the creation of mutual health organizations by associations of micro-entrepreneurs.

Social protection is, first and foremost, the legitimate right of every individual. It is also a condition for social and economic progress. The absence of social protection may have serious consequences not only for the health of people working in micro-enterprises but also for the businesses. For example, to meet medical expenses, the micro-entrepreneur may be forced to sell part of her/his equipment or tools. A poor state of health may also lead to absence from work and loss of productivity. Since the micro-enterprise is often the major source of income for a whole family, this situation directly affects the well-being of many people.

¹ The SEED (Boosting Employment through Small Enterprise Development) programme operates in the Employment Sector, whereas the STEP (Strategies and Tools against social Exclusion of Poverty) programme operates in the Social Protection Sector of the ILO.

If extending social protection to all micro-entrepreneurs seems legitimate both from the point of view of fairness and efficiency, there are still question marks over how to achieve this. There is still little proven experience. In this area, there is a need for pragmatism and innovation to determine the most appropriate mechanisms for providing social protection for all.

The ILO, through its Social Protection Sector, operates at three levels with regard to these extension mechanisms:

- extension based on social security systems, public health systems and social assistance programmes promoted and created by the State;
- development of decentralized social protection systems resulting from local initiatives;
- linking decentralized systems with other social protection systems.

Mutual health organizations are the product of local initiatives. They combine the fundamental principles of insurance, participation and solidarity. They involve insurance because there is risk pooling, and by paying contributions, the member receives from the group as a whole an indemnity when a risk materializes. They involve solidarity, because all members contribute, but only those affected by a specific event benefit from financial support. They promote participation because membership is voluntary and all members have the right to participate, directly or indirectly, in various decision-making bodies and to control the operation of their mutual health organization.

Mutual health organizations built on associations of micro-entrepreneurs are still few in number. They are, however, the subject of growing interest among associations and promoters of micro-enterprises. This Guide provides the basic information these actors need to appreciate the benefits as well as the difficulties of creating a mutual health organization. In light of the relative novelty of the subject, these difficulties should not be underestimated.

In many cases, micro-entrepreneurs, especially those operating in the informal economy, are poor people. From an equity perspective, it is therefore legitimate that social protection mechanisms for these people receive financial support, in order to bring national solidarity into play. Although, in many countries, the possibilities for financial support are very limited or non-existent, this concern for equity is paramount for the future development of mutual systems.

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Introduction

Audience	This Guide is for all those interested in the social protection of micro-entrepreneurs and their workers. This includes those in charge of associations of micro-entrepreneurs, promoters of such associations (NGOs, projects, federations, etc.) and officials and experts of organizations or administrations working in the field of employment, social protection or health.
Objective	The Guide's objective is to enable readers to appreciate the benefits and constraints involved in the creation of mutual health organizations by associations of micro-entrepreneurs. It provides the basic information necessary to achieve this objective by presenting the elements that need to be taken into consideration. It does not, however, cover all the methods available for the creation of a mutual health organization by an association of micro-entrepreneurs in a particular context. Additional tools are necessary.
Contents	<p>Chapter 1, The situation of micro-enterprises, sets out the essential characteristics of micro-enterprises and their principal constraints. It also describes the process of creation of associations of micro-entrepreneurs and the services they provide.</p> <p>Chapter 2, Working conditions and social protection in micro-enterprises, underlines the scale of the health risks to which people working in micro-enterprises are exposed. It then assesses the lack of access to social protection for the majority of workers in micro-enterprises operating in the informal sector. Finally, it briefly describes the difficulties involved and highlights selected initiatives to extend social protection to the informal sector.</p> <p>Chapter 3, The role of trade associations in health protection, is devoted to the risk of illness and the means of tackling it. It describes two types of schemes: prepayment without risk-sharing and health insurance. Finally, it emphasizes the specific opportunities that associations of micro-enterprises have for carrying out activities in the field of health protection.</p> <p>Chapter 4, Services provided by mutual health organizations, covers the basic principles on which these organizations are based. It then deals with the nature of the services that a mutual health organization can offer its members, the conditions of access to these services and methods of delivering benefits.</p>

Chapter 5, **Organization and operation of mutual health organizations**, provides a model organizational structure for a mutual health organization: the functions and relationships of its main organs. It examines the forms of membership and the conditions under which certain beneficiaries/dependants may also benefit from the services of the mutual health organization. It then addresses the major risks related to managing a health insurance scheme. Finally, it gives an insight into the administrative and financial management of such an organization.

Chapter 6, **Setting-up a mutual health organization by an association of micro-entrepreneurs**, covers the conditions and the process of creation of a mutual health organization. It specifies the different stages of the creation of a mutual health organization and outlines the preconditions and the preparatory work prior to the start-up. The criteria to be taken into account in choosing the most appropriate mutual formula are defined.

1. The situation of micro-enterprises

1.1 Size, composition and importance

Micro-enterprises are defined as economic entities (individual or group-based economic activities) composed of 1 to 10 people working for profit, in all economic sectors outside agriculture (Haan et al., 1996). In most African countries, these micro-enterprises represent more than half the urban economically active population. Furthermore, the great majority of new jobs are created by micro-enterprises. In Asia, micro-enterprises in the informal sector provide 40 to 50 per cent of urban employment. In Africa and Latin America, employment in micro-enterprises is growing four times faster than formal employment in medium-sized and large enterprises (ILO, 2000).

In many countries, where it is difficult for women to access the formal labour market, self-employment or business creation is often the only route to employment and income. Women at present form the majority of micro-entrepreneurs in the informal sector in many countries. For example, in Zambia and Indonesia, they account for 72 per cent and 65 per cent respectively of those employed in the informal sector (ILO, 2000).

Since the privatization of state enterprises and the reduction of public expenditure, micro-enterprises have been playing a crucial role in reducing unemployment. By absorbing people entering the labour market, they act as shock absorbers in times of economic crises and during structural adjustment programmes. In the light of their important social and economic functions, micro-enterprises should be perceived as much more than just the last resort of those who are illiterate or of limited education.²

Even if opportunities for formal employment are rare, most micro-entrepreneurs cling to the hope of getting a better job. They adopt short-term strategies that do not always maximize the long-term profitability and expansion of the business. This makes it difficult to establish lasting relationships between the entrepreneur and his social and economic environment, and forms a serious obstacle to the introduction of health insurance schemes.

² This Guide primarily concerns micro-entrepreneurs in the informal sector and is less concerned with self-employment in liberal professions such as lawyers, doctors, etc.

Many micro-enterprises have become important players in the growth of the economy and provide the goods and services necessary to a large section of the population. They sometimes have links with larger enterprises, either as suppliers of goods and services, or as buyers and/or commercial agents.

One consequence of globalization for developing countries is the increased import of manufactured goods that compete with those produced by traditional indigenous industries. This situation causes problems to some micro-enterprises, especially in textiles, metalworking and pottery. Conversely, opportunities have been created in commerce and services such as photocopying, telephone kiosks, accountancy and management services and vocational training.

Micro-enterprises and their associations are also becoming partners in the management of public services – waste collection, maintenance of infrastructure – on a commercial basis. In India and Tunisia, for example, franchising of the public telephone service has created opportunities for thousands of establishments, mostly micro-enterprises.

The most striking feature of micro-enterprises is their great diversity, which must be taken into account when designing a mutual health organization aimed at this target group. They span the following diverse characteristics:

- they are found in almost all economic sectors – even if predominantly in services;
- they are scattered throughout the country – especially in urban areas;
- they are managed as much by women as by men – women are over-represented in certain sectors such as the agro-food industry;
- most are stagnant units with poor growth prospects, although some do succeed in developing their activities;
- their degree of economic integration and formal registration varies enormously.

I.2 Problems and constraints of micro-enterprises

a. Internal obstacles

Many micro-enterprise owners have received only primary education, the majority without completing it (ILO, 1998). Their workers and assistants also have very rudimentary technical knowledge. Vocational training schools do not really prepare for work in micro-enterprises. In Dar es Salaam (Tanzania), for example, only 8 per cent of the owners of micro-enterprises in manufacturing and 14.2 per cent of their employees have received a formal education (Mwinuka, J.B., 1996). Consequently, apprenticeships are the principal way of reinforcing their skills.

This lack of formal education is a major constraint for the development of micro-enterprises and leads to a conservative and defensive attitude in some areas. Most often, risk taking, market research, innovation, or the recruitment of qualified staff do not enter the micro-enterprise picture.

Another obstacle specific to their development is that micro-enterprises are often the only source of income for the entrepreneur's entire family. Due to the lack of a simple management system and inadequate knowledge of accountancy, the money earned is used for household expenses. This is especially true of enterprises managed by women, since they increasingly take charge of the family expenditure. Moreover, women often combine household tasks and management of the business, especially when they work at home or nearby.

b. Institutional environment

Conditions for the success of micro-enterprises are diverse, but depend to a large extent on the attitudes of public authorities and the accessibility of financing and advisory services.

Governments are increasingly promoting the private sector. However, their macro-economic and financial policies are not necessarily favourable to the development of micro-enterprises. Market liberalization policies favour large enterprises and fiscal regimes often discriminate against micro- and small enterprises³ (Maldonado, 1995).

At the local level, urban development policies often ignore the need to provide for appropriate sites for micro-enterprises. Added to irregular waste collection are other infrastructure problems such as the ageing road networks, lack of electricity, running water and drainage. Cumbersome procedures for issuing permits and registration as well as

³ Large enterprises benefit from tax exemptions while smaller units are heavily taxed through indirect taxation. The ILO has carried out several studies showing that, even if the informal sector does not pay taxes, it is subject to a large number of indirect taxes.

local tax policies are other obstacles to the development of micro-enterprises. In addition, these enterprises are also a favourite target for decentralized authorities, which increasingly need to mobilize resources at the local level.

Government initiatives such as establishing industrial sites and special credit funds or social security systems do not easily reach micro-entrepreneurs, partly because many businesses are not registered and prefer to remain invisible. The lack of communication and absence of information campaigns also contribute to the relative isolation of micro-entrepreneurs.

c. Access to financial and other support services

Lack of capital is one of the key problems for micro-entrepreneurs; the majority start up their activities using personal savings and informal family loans. The low management skills of many entrepreneurs aggravate an almost constant lack of funds. Consequently, the capacity to invest in new equipment, the search for new products or markets and the improvement of working conditions is extremely limited.

There is often a lack of appropriate financing services for micro-entrepreneurs. While there are generally highly effective informal savings and credit systems, few banks show any interest in micro-enterprises. NGOs and development programmes have created specialized banking services, which make short-term credit more accessible. Micro-finance systems are broadening their scope. However, long-term financial resources, especially for investments, remain hard to obtain.

For micro-entrepreneurs, the possibility of placing their money in a safe place, sheltered from requests for gifts and loans from members of the family, has contributed to the success of this service. The possibility of basing mutual health organizations on this saving capacity should therefore be considered.

Micro-enterprises need many other non-financial services. These include technical training, management training, market information, technological innovation, marketing support, creation of industrial networks and organizational support.

I.3 Associations of micro-entrepreneurs

a. Creation of trade associations⁴

Micro-entrepreneurs join trade associations for pragmatic reasons, usually related to their immediate working environment. As a group, entrepreneurs can achieve economies of scale which can enable them to offer lower prices, access larger markets or share equipment and tools which are too expensive for a single individual or micro-enterprise. In some cases, this situation leads to the creation of a common infrastructure where the members can access specific services more cheaply.

Fear of expulsion or other repressive actions by local authorities is also a major reason for forming associations. In many towns, the hostile climate and unpredictable attitude of officials have led micro-entrepreneurs to join trade associations.

The following factors contribute to the strength and durability of trade associations and will consequently have to be taken into account in promoting mutual health organizations:

- a charismatic leader;
- professional and democratic management;
- good internal mediation;
- adequate internal representation;
- an appropriate legal status;
- selective and appropriate (necessary, cheap) services for members;
- diversified and stable sources of income;
- good external relations;
- a sufficient degree of public legitimacy.

In addition, the external factors of the political, legislative and regulatory environment in which the associations operate must also be evaluated.

b. Sectoral, local and federal associations

Some associations, based on the same economic activity, offer services such as import licences or sales premises; they have access to state services or negotiate preferential tariffs. Other associations, formed on a territorial basis, share common services, such as water, drainage, waste collection, and thus contribute to a better working environment.

⁴ The term “trade association” is used to describe an organization that groups micro-entrepreneurs together to protect its members’ interests and provide common services. The terms “cooperative” or “grouping” are reserved herein for organizations actually managing economic activities shared by their members.

In some countries, associations based on different economic activities have created a national federation. In Mali, for example, the National Mali Artisans' Federation groups together over 50 associations, with more than 20,000 members, and has had a decisive influence on the Government's policy with regard to the development of micro-enterprises in their country.

c. Services provided by associations to their members

Services provided by associations include exchange visits, the search for new products or the brokerage of large orders. In the areas of management and transfer of skills, some associations organize training sessions for their members.

Other associations facilitate access to credit for their members, often in collaboration with banks and NGOs. Savings and credit clubs and cooperatives, especially Rotating Savings and Credit Associations (ROSCAs), mutual assistance funds, funeral funds, etc., are mechanisms often based on existing social networks, thus transforming neighbourhood solidarity into regular mutual support structures. These mechanisms have a very limited financial scope and their viability is not always guaranteed. It is therefore necessary to develop more substantial systems to meet the needs of micro-entrepreneurs.

Uganda: The Ntulume Village Women's Association (NVIDOMA)

The Ntulume Village Women's Association, registered as an NGO since 1987, has 72 women members who manage their own small enterprises. Many of them have a stall in the market, selling products ranging from tomatoes to second-hand clothing. Some breed poultry, make bread, grow mushrooms or make clothes. One of the founder members is the pillar and guide of NVIDOMA. The head office was built on her land by the members themselves.

The other elected members of the Committee are all experienced businesswomen. They act as financial and business advisers to the other members. The association manages its own finances, totalling some US\$3,500, and has concluded agreements with several micro-finance organizations to grant credits to members. The association provides part of the training in financial and business management, in return for a small financial contribution.

Job creation and income generation for women are NVIDOMA's principal objectives. With the support of organizations such as Mama Cash and Global Fund, the members have benefited from significant financial services for their enterprises.

2. Working conditions and social protection in micro-enterprises

2.1 Introduction

The downside of micro-enterprises is their working conditions. Most micro-entrepreneurs work long hours, at monotonous jobs and for derisory profits. When they hire employees, they often pay them below the minimum wage and do not draw up a contract of employment.

Many micro-enterprises work with unsafe equipment, in poor conditions and without access to social protection for illness, accident or old age. Their economic marginalization means that they cannot afford the investment necessary for efficient operation and development. The high level of illiteracy and ignorance among micro-entrepreneurs reduces their awareness of the risks they run.

When the owner of a micro-enterprise is injured or falls ill, the well-being of the entire family is immediately threatened. Moreover, the high costs of health care and the loss of vital income may restrain her/him from seeking immediate medical help. When s/he finally decides to visit a medical centre, the costs of care are higher because of his/her deteriorated physical condition.

As a result of the introduction of cost recovery and the general deterioration in public services in developing countries, the population must increasingly provide for its own social protection. District and trade associations can help to improve access to services such as child-care, education and medical care.

The introduction of mutual health organizations requires associations of micro-enterprises with a sufficient degree of trust between the potential members and good experience of collaboration and management. Furthermore, the transparent and credible administration of such organizations requires a simple collective management structure.

2.2 Poor working conditions

Working conditions in micro-enterprises are often unsafe: dusty and noisy, with poor lighting, lack of space, disorder in workshops, dangerous machines and tools.

A survey of 11 branches of the informal sector in Dar es Salaam (Forastieri et al., 1996), covering a wide range of activities, highlighted the following problems: exposure to dust, exhausting work, bad posture, long working hours under physical and mental strain, unsuitable means of carrying heavy loads, damp premises and lack of footwear on wet floors. Many accidents are due to the poor state of equipment and the lack of protective gear. The state of tools, poor maintenance of workplaces and poor organization further aggravate the situation.

The survey showed that most enterprises are without drinking water and drainage and do not have waste collection. No labour inspector had visited workplaces to promote preventive measures, and only a few enterprises had a first-aid box.

The health complaints frequently encountered among micro-entrepreneurs and their workers are back pain, hernia, joint and muscle pain and headache.

Absence of safety in the micro-enterprise workplace is caused by lack of awareness, poor management capacity and a lack of financial means to permit the introduction of protective measures. Government policies have largely ignored the specific difficulties of micro-enterprises and shown no interest in improving their working conditions, despite demanding their compliance with high government norms or national standards.

Examples abound of how working conditions can be improved without excessively increasing costs (Kogi et al., 1989). Training material published by the ILO, such as the I-WEB Training Guide "Improve your work environment and business for micro-manufacturers" and the PATRIS "Guide to participation for workers in the informal sector" deal with the specific needs and absorption capacity of micro-enterprises. They use audio-visual methods and are based on local practices. Equipment suppliers could also play a more active role, by combining their marketing activities with advice on the correct installation and proper use of their machines.

However, despite increased awareness and better access to preventive instruments and methods, many entrepreneurs and workers do not adopt them. In order to remedy this situation, entrepreneurs should realize the high and invisible costs of accidents and the positive impact of prevention of accidents and diseases on profits and productivity.

2.3 Social protection in the informal sector

In the field of health care, it is estimated that exclusion from social protection now affects 80 per cent of the population in most countries in sub-Saharan Africa and southern Asia, and almost half the population in many Latin American countries and elsewhere in Asia. In Eastern Europe, despite contrasting conditions from one country to another, there is still considerable exclusion from social protection, which is even rising in many countries under the combined effect of the growth of the informal sector and increasing job insecurity in the formal sector.

Exclusion is the result of multiple factors: type of job, limited capacity to contribute, legislation, quality and volume of supply of health care, geographical distribution of health services, ethnic or sex discrimination, taboos, etc. Excluded people are often the victims of several of these factors.

In the informal sector, the shortfall in social protection is greatest⁵ and, more generally, the quality of employment is lower. This sector has rarely been taken into account in designing social security systems that have mainly been aimed at salaried employees in the formal economy. Indeed, as little as twenty years ago, some thought that the informal sector would gradually disappear and that, by the same token, all workers and micro-entrepreneurs would become integrated in the formal sector and thus benefit from its social protection systems. The reality is different. The trend in most developing countries is towards an increased share of informal activities in total employment. It is forcing every country concerned to improve its people's social protection to make greater efforts to develop systems that can reach people working in the informal sector and their families.

Some middle-income countries have in recent years undertaken substantial reforms of their social protection systems. This has allowed them to make significant progress in terms of coverage of the informal sector. The conditions which allowed them to carry out these reforms and the values that motivated them are not shared by all countries. Experience shows that extending the coverage of existing social security systems to the informal sector is very difficult. It is not easy to reconcile the characteristics of the informal sector (job insecurity and mobility, irregular and low incomes, dispersion, etc.) with those of social security systems which were originally not designed for that target group.

⁵ By way of example, an ILO survey into the informal sector of Metro Manila (1995) showed that only 15.5 per cent of micro-enterprises were registered with the social security system; 9.6 per cent belonged to a private insurance scheme, 1 per cent of which were with a commercial insurance company. Reasons given were: the low level of activities (36 per cent) but also the fact that registration was not required (8.9 per cent); there was cover through another job (8.1 per cent); or workers did not see the point of registering (8.3 per cent). (Joshi, 1997).

In many countries, initiatives have been taken to fill the social protection gap through players other than Governments: workers' and employers' organizations, NGOs, associations, communities, cooperatives, and associations of micro-entrepreneurs.

The systems created on the basis of these initiatives are very diverse⁶ and are often not formalized. They are frequently aimed at people with limited resources. From an equity perspective, some resource redistribution in favour of these systems benefiting poor people should be developed (subsidies for service provision or the administration of insurance, for example). This redistribution should allow solidarity to operate in a wider context than just at the level of the group of members. Without appropriate redistribution mechanisms, such systems can only be considered as temporary forms of mutual protection.

The emerging trend is that, within the same country, social protection is increasingly provided by several complementary systems. It is likely that these different systems will reflect initiatives by the State and the social partners, as well as civil society and the private commercial sector. This multiplicity of systems requires good coordination of social and economic policy in order to make the existing and future systems more coherent and more effective. Such coordination is also necessary to allocate available resources in an optimal manner, maintain the attractiveness of the envisaged measures and reduce fraud and abuse. It requires strengthened cooperation between public institutions (finance/health for example) and other players involved in the various social protection mechanisms as well as the reinforcement of the regulatory function of the State.

⁶ Micro-insurance systems come into this category.

Some Initiatives by Civil Society

In the Philippines, the NOVADECI cooperative set up its own health insurance programme known as the NOVADECI Health Care Programme (NHCP) in 1993. The majority of the members are small market vendors, nearly 85% are women. They are provided with free medical consultation, free child delivery, free annual medical check-up and discounted laboratory examinations, dental and optical services, which are all provided by NOVADECI's in-house medical clinic and laboratory.

More than 150 families in Cambodia, with about 700 members in total, are participating in a rural Health Insurance Programme. The current scheme was launched in 1999 with the support of the international NGO GRET. It provides coverage for child delivery, medical consultations (free for children) and pays a compensation in case of death.

In Indonesia, a community health care insurance scheme called the Takaful Muhammadiyah Health Fund was set up in 1994. It covers up to 7,500 people living mainly in urban areas through decentralized services in 26 provinces. The services provided by the fund cover primary health care, referral services and in-patient care.

In Uganda, mutual health assistance groups have been formed. In these groups, the payment of regular contributions to a common health fund facilitates access to primary health care. In all, over 5,000 people are covered by this system.

In Cotonou, Benin, the National Union of Motor-cycle Taxi-Drivers has set up a mutual health organization, ALAFIA, which reimburses the cost of health care to its members. It has concluded an agreement with a health centre in the capital.

In Senegal, at Thiès and Dakar respectively, the union of the PROFEMU (Urban Women's Programme) network is seeking to meet the socio-economic needs of its 3,000 women members, by establishing a savings and credit agency, a housing cooperative and a mutual health organization.

In Guinea, the AGBEF (Family Welfare Association), with the support of ILO/STEP, has established a mutual health organization at Youkounkoun based on the regional health centre. Besides providing health insurance, the mutual health organization has also improved the quality of health care, especially the availability of medicines.



Photo: Paco Rodriguez

3. The role of trade associations in health protection

3.1 Security for medical expenses

Owners of micro-enterprises, their families and their workers or apprentices are not immune to illnesses or accidents, which occur at unpredictable times and involve medical expenses of unforeseeable amounts. Individuals, like the enterprises they own or work in, may suffer disastrous consequences:

- the illness may result in temporary, lasting or even permanent incapacity to work and thus loss of income to the family;
- the cost of medical care and medicines are added to the family's other financial expenses.

Illness is a risk, the ultimate impact of which can not only damage health but also result in major financial damage. For the micro-entrepreneur, illness is often at the root of permanent poverty, especially when:

- covering medical expenses from the funds of the business may limit its production capacity (for example, purchase of medicines instead of purchase of raw materials);
- for major expenses, such as hospitalization, the entrepreneur may be forced either to sell some production tools or become heavily indebted;
- having taken out a loan for the business, the entrepreneur may be tempted to divert it away from its original purpose, which may create problems in repaying it.

Families try to meet financial risks related to illness, individually or collectively, in either one of the two following ways:

- either wait until illness occurs to seek the resources necessary for its treatment, or
- take measures in advance to meet this type of expense before the onset of illness.

The first way is not a case of protection against the risk since the uncertainty of dealing with the financial implications is still very high. A family faced with illness and without the money necessary to pay for treatment may adopt a variety of alternatives: sale of property; resorting to money-lenders; drawing funds from the family business, from mutual aid and solidarity between friends, within the family or within an association.

The second way anticipates the financial consequences of illness and makes these easier to overcome, by making security arrangements to protect oneself against health risks.

3.2 Two security mechanisms: prepayment and insurance

In all societies, the majority of individuals are risk averse. That is why men and women everywhere have developed provisions to protect themselves against risks. These provisions have been improved throughout the course of history, notably with the development of insurance schemes, the most effective tool for protection against risks.

a. Prepayment without risk-sharing

Prepayment without risk-sharing, the most common example being the subscription card, covers a set of simple mechanisms which allow an individual to pay for future care at a time when s/he has sufficient income. It is mainly a savings product. It may be beneficial to those with irregular income, who consequently may be faced with medical expenses at a time when they have no resources. In case of illness, however, these people will only be able to consume treatment up to the amount they have “prepaid”. The protection is individualized. There is no pooling of resources to cover risks.

Prepayment systems, without risk-sharing, are most often offered by health care providers for whom they are relatively advantageous and simple to set up. They are protection mechanisms appropriate for medical expenses considered to be certain, such as, for example, consultations that are frequent and relatively inexpensive (“minor risks”). For the entrepreneur, prepayment allows medical expenses to be spread out over the whole year.

The restriction of the coverage to the amount of care prepaid (sometimes slightly augmented by interest) does not allow coverage of major risks that require a financial input beyond the scope of an individual. This restriction reduces the attraction of such systems.

b. Insurance

Insurance is an instrument that allows several people to share the risks. Risk pooling provides compensation to individuals and groups that are adversely affected by a specified event or risk. The resources of the insured are pooled and are used to cover the expenses only of the people affected by the risk. Those harmed by such an event benefit from the contributions of those who are not affected and, as a result, they receive compensation that is greater than the amount they themselves have invested in the insurance. The insured, in return for payment of their contributions (or premiums), obtain from the insurer the guarantee of financial reimbursement. They renounce ownership of the contributions paid and cannot therefore reclaim them if the risky event has not occurred.

In other words, insurance allows those who are not affected by the risk covered to share in covering the expenses of those who are affected. They accept to do so because they know that they too are exposed to the risks covered by the insurance. They are strongly risk averse and are not in a position to cover the risks individually.

Insurance is particularly suited to secondary and specialist health care. Both are linked to unforeseeable events that are unlikely to occur but the treatment of which is very expensive and threatens the business or welfare of the family. This is a clear case of risks that can be shared by a large number of individuals. The contribution or insurance premium will thus be low for the insured individual, compared with the expenses s/he would have to meet if not covered in the event that a risk materializes.

In addition to the benefit of spreading expenditure over time (see Section a), insurance – as a result of the principle of solidarity protects – the entrepreneur from major expenses related to problems of health and accidents at work.

Insurance differs from traditional forms of mutual aid, which are supported by modest contributions, the amount of which is fixed arbitrarily and unrelated to the financial consequences of the risks covered. It takes various forms:

- compulsory health insurance, introduced by the government but more or less inaccessible to micro-entrepreneurs in many countries;
- commercial profit-making insurance companies, which often impose restrictions on membership in order to avoid including people with a high risk of illness. Even if micro-entrepreneurs can join, the premiums are often too high;
- micro health insurance: this term covers a fairly wide range of systems which are aimed at poor populations not covered by compulsory health insurance schemes and who do not have access to normal commercial insurance. Insurance provided by health service providers, other forms of non-profit insurance, as well as mutual health organizations are notable examples of this type.

3.3 The mission of trade associations: Meeting members' needs

The need to find schemes to face health expenditure which meet the specific needs and capacities of micro-entrepreneurs emerges more and more clearly from various studies and surveys of this target group. Women micro-entrepreneurs – who make up the majority in this sector – are very interested in these schemes, which allow them to cover the health care needs of both themselves and their children. Trade associations, which seek to meet several of their members' needs, are thus increasingly called on to play a predominant role in this area.

Trade associations that possess the following characteristics are well positioned to introduce micro-insurance schemes:

- dynamic leaders and managers;
- the trust of their members;
- experience in administration, accounting and financial management (e.g. contributions, small loans);
- developed contacts with local and national authorities;
- contacts with funding agencies or the government to finance development activities;
- regular meetings between their members creating a sense of belonging to a social movement; the result is a social control able to limit or even eliminate potential abuse or fraud.

Direct and regular contact with members allows the trade association to develop a micro health insurance scheme that takes its members' needs into account. The social control and the lower transaction costs allow the development of an effective scheme with a minimum of abuse.

India: The Self-Employed Women's Association (SEWA)

The SEWA is an organization of women in the informal sector. When it started in 1972, the organization concentrated its activities in the field of employment and support for income-generating activities. It set up nurseries and organized vocational training. SEWA-Bank has been granting micro-credits to women since 1974.

Some ten years ago, SEWA created a system of protection for its members. SEWA members were seeking protection against catastrophic events which drove them into poverty. Furthermore, the SEWA Bank found that among the causes of non-repayment of loans, health problems of the woman entrepreneur or a member of her family were very frequent.

SEWA's social protection system includes health insurance, life insurance and insurance against loss of home or essential capital goods. The system now covers over 30,000 members.

A trade association that wishes to enter the health field has various options:

“Intermediation or negotiation” function

- the trade association may enter into negotiations with service providers for priority access for its members to health care on beneficial terms. It may also act as intermediary or agent for local insurance companies;

“Service provision” function

- the association may form and manage a sales point for medicines or a health services centre;

“Security” function

- the association may, in collaboration with service providers, establish a prepayment scheme for regular health services. Micro-entrepreneurs who are members of the scheme do not pay for health services but sign a receipt against which the service provider is reimbursed by the trade association which manages the financial contributions;

- if the service provider or providers have developed their own prepayment scheme, the association can negotiate more favourable payment terms for their members.

“Insurance” function

- it may establish its own health insurance system to serve its members;
- it may collaborate with other trade associations to create a mutual health organization aimed at all their members.

“Prevention of occupational accidents and diseases” function

- it can organize information and training sessions for micro-enterprises on improving working conditions;
- it can develop a system of incentives for entrepreneurs who take active steps in this area, for example by reducing premiums for apprentice workers.

The initiatives which have been launched by trade associations in the area of health insurance are still few in number and fairly new. These initiatives are characterized by a participatory and innovative approach to arrive at a health insurance scheme which best meets the needs of this type of enterprise and offers the best prospects in terms of viability and sustainability.

3.4 Defining the mutual health organization

A mutual health organization is a non-profit voluntary association of people, operating on the basis of solidarity between all its members. By means of its members' contributions, and based on their decisions, the mutual health organization organizes insurance, mutual aid and solidarity measures aimed at insuring against risks related to illness, bearing the consequences and promoting health.

A mutual health organization combines the two fundamental principles of insurance and solidarity. Through this solidarity, the members of a mutual health organization express their desire to deal with their problems themselves, through assisting each other. The contribution underpins the principle of mutual assistance and solidarity within the mutual health organization. Members in good health accept that their contributions are used to cover the expenses of ill members. It involves sharing of risks between the micro-entrepreneur members. An individual cannot receive benefits from her/his mutual health organization if s/he is not up to date with contribution payments.

4. Services provided by mutual health organizations

4.1 Basic principles

The basic principles of a mutual health organization resemble those of many organizations created to solve problems common to a group of people who live in the same area and work in the same trade.

a. Solidarity between members

The principle of solidarity is the true foundation of mutual health organizations, which rejects financial discrimination and risk selection. The methods of fixing contributions – an equal contribution for all or proportional to the members' financial means (e.g. percentage of salary) – do not depend on the risk incurred by the member.

Solidarity is also a dynamic concept: its implementation and the methods and mechanisms to achieve it must evolve with the society in which that mutuality develops. It is reflected both at the financial level and by voluntary commitment to those who are elderly, disabled or most deprived.

b. Democracy and participation

The mutual health organization, like most trade associations, is the fruit of freedom of association. Everyone is free to belong to a mutual health organization without racial, ethnic, sexual, religious, social or political discrimination. All members have the same rights and obligations.

This democracy is expressed in structures that guarantee that members participate in decision-making and have the opportunity to control the functioning of their mutual health organization.

c. Autonomy and freedom

A mutual health organization is a free organization and, consequently, must be able to take decisions without seeking the prior approval of the public authorities. This flexibility allows services to be adapted to evolving needs. It is this right to take the initiative that allows creativity in defining objectives and efficiency in the use of resources. This right cannot be exercised unless the members of the mutual health organization are made responsible.

Independence and autonomy mean that there must be no interference in the management of a mutual health organization and the decision-making process, but it must comply with laws and regulations such as those on registration, accounting, audit, control, etc. In some African countries, a code of mutual health organizations already exists (Mali, 1995). In other countries, in the absence of specific legislation,

mutual health organizations are registered as associations or cooperative groups. To fill this gap, laws are under preparation in several countries.

A mutual health organization does not only need to be autonomous with regard to the State, but also vis-à-vis political parties or pressure groups.

d. Personal development

Respect for human dignity in all its aspects is another basic principle of mutual health organizations. The pursuit of personal development should lead to greater independence and responsibility for oneself and others.

e. Non-profit objective

While trade associations often develop economic activities in favour of their members, a mutual health organization cannot have a profit objective. Any pursuit of profit is incompatible with its nature and its mission to devote its activities to the service of its members. However, this does not mean that covering operating costs is not an absolute imperative. Economic considerations and good management principles cannot be ignored, for they contribute to the collective well-being.

A surplus of income over expenditure may, once a reasonable reserve has been created, allow the improvement of existing services, meet members' other needs, or even reduce contribution levels. Such surpluses should not be redistributed to members in the form of dividends.

f. Responsibility

Solidarity, participatory democracy, autonomy and even personal development always presuppose that the mutual health organization and its members behave in a responsible manner. Ultimately, all the other principles of mutuality will have no value if the mutual health organization is not properly managed, if the members do not behave responsibly with respect to their health and that of others, in the way they use the mutual health organization's resources or by the decisions they take.

g. Dynamics of a social movement

It is clear from the foregoing that members of mutual health organizations are not passive "consumers" but people committed to a process of individual and collective development. They are members of a social movement, i.e. a group of people who want to protect the common good and collective interests.

A mutual health organization is based on the local dynamic of mutual assistance and solidarity as well as development. That is why mutual health organizations vary enormously in their organization and operation. They all strive, however, to achieve the same objective and can link up, within a region or a country, in order to strengthen the protection of their members.

4. SERVICES PROVIDED BY MUTUAL HEALTH ORGANIZATIONS

Mutual health organizations could thus play an important role in the co-management of public health structures, in the framework of the Bamako initiative,⁷ and in defining local and national health policy.

Finally, a mutual health organization can be part of a large structure or network, in which trade unions, women's movements, youth or elderly groups, for example, are the other participants. It has an interest in collaborating with other organizations to achieve its objectives.

4.2 Nature of the services offered

The function of a mutual health organization is to provide a number of insurance, mutual assistance and solidarity services to its micro-entrepreneur members. The success or failure of the mutual health organization will depend, in part, on the value its members attach to these services. In this respect, the enrolment of new members or, conversely, the withdrawal of existing members will be a significant indicator of the success of the mutual health organization.

A fledgling mutual health organization should initially offer only a limited number of services. Once it has built up experience and set up a strong management system, it can then, if appropriate, increase the number of services offered. Each new service provided by a mutual health organization entails an additional benefit for its members but also an increase in their contribution. In a micro-enterprise environment where incomes are low and/or irregular, a mutual health organization must ensure that it sets contributions consistent in the long term with its members' ability to pay.

For mutual health organizations founded by trade associations, training and information for their members on improving working conditions and preventing accidents are an important task. Making micro-entrepreneurs aware of the "hidden" cost of illness (decline in productivity, loss of productive capacity) should also be included in the programme of activities of such organizations.

⁷

This international agreement concluded in 1987 suggests, among other things, that users of health centres should make a financial contribution to cover the cost of services they use.

Examples of services that can be provided by a mutual health organization

Insurance and financial provision concerning social risks

- ✓ Reimbursement of medical expenses
- ✓ Payment of indemnities in case of accidents and disabilities

Protection of members' interests

- ✓ Negotiation of health policy
- ✓ Negotiation of price and package agreements with health care providers
- ✓ Protection of members' individual rights

Health education and information for members

- ✓ Prevention campaigns
- ✓ Information on health and health care
- ✓ Information on members' rights and obligations

Mutual assistance and solidarity

- ✓ Assistance to youth, elderly, ill or disabled persons
- ✓ Assistance to families
- ✓ Loan of medical equipment
- ✓ Care of sick children

Organization of health care

- ✓ Care at home
- ✓ Health centres
- ✓ Polyclinics
- ✓ Dental surgeries
- ✓ Hospitals
- ✓ Pharmacies

4.3 Types of care that can be covered by a mutual health organization

A mutual health organization for micro-enterprises must find a formula that takes into account the specific needs of micro-entrepreneurs such as the coverage of accidents at work. It may be the only scheme for covering its members' medical expenses or it may complement the coverage provided by other systems and may cover one or more categories of care.

a. Basic health care or "minor risks"

Basic health care is day-to-day health care, most often provided in health centres, the population's first point of contact with the health system. It consists of:

- preventive care and health education: vaccinations, and child care, family planning, etc.;
- curative treatment: consultations, nursing care, medical care.

4. SERVICES PROVIDED BY MUTUAL HEALTH ORGANIZATIONS

- b. Hospital treatment**

This care includes both hospital accommodation and medical, surgical, technical services and medicines. Bearing in mind the high cost of hospital services, they are often classified under the heading of “major risks”.
- c. Specialized treatment**

Specialized treatment includes consultations with specialist doctors (gynaecologists, paediatricians, surgeons, dentists, etc.) and medical interventions such as radiology and clinical biology which are carried out either during hospitalization or during an external consultation (patient visit).
- d. Medicines**

With respect to medicines, it is important to define the list of those that will be reimbursed by the mutual health organization. Given the difference in price between brand medicines (specialities) and generic medicines, it is advisable to reimburse the latter when available or the corresponding specialities based on the price of the generic equivalent.
- e. Other**

Several mutual health organizations also cover other expenses such as the cost of transport of the sick. A mutual health organization of a trade association could perhaps consider paying a flat-rate basic income to compensate for the loss of income of the hospitalized head of family, although such a service would require a large contribution by the insured.

4.4 Partial coverage of medical expenses

A mutual health organization may take responsibility for paying, in full or in part, the expenses incurred by their members. The principal mechanisms used to assign only a part of the medical expenses to members are as follows:

- a. Co-payment**

This mechanism represents that part of the medical expenses which is not covered by the mutual health organization and should thus be paid by the member him- or herself. It is expressed as a percentage. Its main purpose is to limit the tendency to over-consume.

Example: *The mutual health organization pays for 80 per cent of the costs of consultation, so co-payment is 20 per cent. For a consultation costing 2,000 shilling, the mutual health organization will reimburse 80 per cent of 2,000 shilling, i.e. 1,600 shilling, while the member must pay 400 shilling as co-payment.*
- b. Deductible**

When a mutual health organization only covers amounts higher than a sum fixed in advance, this sum is called a deductible, which is generally fixed in relation to the services covered.

Example: The mutual health organization fixes the deductible for hospitalization at 5,000 shilling per day. A member with a bill of 12,000 shilling will only be reimbursed up to the amount of 7,000 shilling. If his bill had been 4,000 shilling, there would not have been any contribution by the mutual health organization.

c. Maximum coverage

The mutual health organization may limit its liability to a maximum amount for a particular intervention. The member is responsible for the proportion of the costs above that amount. The maximum coverage allows the mutual health organization to limit its costs and protect itself from exceptionally costly cases that could lead to the organization's insolvency.

Example: The mutual health organization fixes the ceiling for hospitalization at 30,000 shilling. If a member has a bill of 40,000 shilling, s/he will only be reimbursed the sum of 30,000 shilling, and will have to pay the remaining 10,000 shilling.

4.5 Methods of granting benefits to members

Generally, the costs of health services are shared between the patient and the mutual health organization. This creates a relationship between the member, the mutual health organization and the health care provider. The principal methods of granting benefits are as follows.

a. Payment for treatment by the member

The mutual health organization may ask its members to pay services, which are then reimbursed. In that case, the member pays in accordance with the methods adopted by the health care provider (payment per treatment, illness or consultation) and in accordance with the rates agreed with the mutual health organization.

For the micro-entrepreneur, the disadvantages of this form of payment are: first, the need to have available the entire sum necessary to pay for the treatment and, second, the need to take further steps to obtain reimbursement.

For the mutual health organization, the advantage of this system is that it limits over-consumption, the tendency to abuse, or fraudulent invoicing. The disadvantage is increased administration and thus higher administrative costs.

**b. Direct payment
by the
mutual health
organization**

In most cases, the member only pays her/his share to the service provider. The mutual health organization pays the balance directly to the provider on presentation of an invoice. This system is called “third-party payer” because it is not the member who pays, but the mutual health organization that is considered to be a third party. This system is often used for “major risks”, which involve high expenses which the member cannot meet (hospitalization, surgery, etc.).

The third-party payer system is clearly more beneficial to the micro-entrepreneur: the problems of available finance, procedures to be followed or the long delays for reimbursement of expenses do not arise. The entrepreneur thus has no need to have financial resources available for major expenses and can continue his economic activities.

This system can be administratively less costly (grouping of payments by provider instead of by patient), but controls to ensure that treatment has actually been delivered are more difficult. Moreover, the risks of over-consumption and cost escalation are higher.

5. Organization and operation of mutual health organizations

5.1 Organization

The mutual health organization is the result of freedom of association and membership. All members have the same rights and duties. These include the right to participate, directly or indirectly, in the various decision-making organs. This democratic life of the mutual health organization can only come about if the members exercise their rights and take on their responsibilities in full knowledge of what is involved. The mutual health organization must therefore ensure that it provides appropriate training as well as reliable and complete information which can be understood by all.

a. Internal organization

The classic organization chart of a mutual health organization shows the following structure:

- a General Assembly;
- a Board of Directors;
- an Executive Committee;
- an Oversight Committee.

However, each mutual health organization must ensure that its organizational structure is suited to its own particular situation:

- a small mutual health organization may, for example, combine the Board of Directors and the Executive Committee in a single body;
- in a large mutual health organization, simple mechanisms for representation of its different groups (geographical, professional, etc.) should be established to allow effective members' participation in the decision-making process, without involving too many costs.

The General Assembly

The General Assembly is the mutual health organization's highest decision-making body. It determines its general policy. Its decisions are binding on all its members. It must be convened at least once a year to approve the annual accounts and the budget.

With regard to changes in contributions, the General Assembly may delegate its powers for a defined period to the Board of Directors. This allows decisions to be taken quickly if the financial situation so requires (changes in prices of medicines, inflation, etc.).

The Board of Directors

The Board of Directors is responsible for the management of the mutual health organization. It exercises all the responsibilities apart from those that are explicitly assigned by law or its statutes to the General Assembly or the Supervisory Committee. In specific terms, the Board of Directors must constantly monitor the management of the mutual health organization and deal with any problems that arise. It may delegate part of its responsibilities to the Chairman or one or more administrators. The Board of Directors proposes the admission and exclusion of members to the General Assembly. Once adopted, these proposals are implemented by the Board of Directors.

The members of the Board of Directors are all volunteers who agree to make their qualifications and part of their time available to the service of the organization.

With respect to the day-to-day operation and implementation of the decisions of the General Assembly and its own decisions, the Board of Directors may delegate certain responsibilities to the Executive Committee.

The Executive Committee

The Executive Committee, established by the Board of Directors, is responsible for implementing the decisions of the General Assembly and the Board of Directors.

Depending on the size of the mutual health organization, two situations may arise:

- in small organizations, the Executive Committee may be appointed from within the Board of Directors. This allows flexible operation and quick decisions. It will consist of at least the chairperson, the general secretary and the treasurer;
- in larger organizations, the Executive Committee may consist of salaried staff to whom the Board of Directors entrusts the day-to-day management of the mutual health organization. One of its members, the director or manager, will participate in the Board of Directors to report on its management. In most cases, s/he will attend on a consultative basis and will not participate in voting.

The Oversight Committee

The mandate of the Oversight Committee, elected and mandated by the General Assembly, is to monitor the implementation of the latter's decisions, propose improvements and ensure the efficient functioning of the mutual health organization's organs other than the General Assembly.

b. Structure of mutual health organizations

The structure of the mutual health organization will reflect the structure of the trade association that created it. Depending on its size and area of activity, a mutual health organization may be structured along several levels (or divisions). For example, if the trade association has district divisions, it is worth organizing members' representation in the mutual health organization along district lines.

A mutual health organization in a village or district will have its assembly, in which all members can participate, in order to take part effectively in the life of the mutual health organization. Because of its geographical proximity to where its members live, this assembly can meet more regularly to follow the evolution of the mutual health organization.

If the mutual health organization covers all or part of a region containing several towns, villages or districts, the mutual health organization may be structured in local sections representing different entities as appropriate: regions, villages, hills, neighbourhoods, etc. Each of these sections must be represented in the mutual health organization's higher levels in order to participate in important decisions.

With respect to collaboration between different trade associations in creating a single mutual health organization, it should be noted that large size, in terms of number of members, has advantages for a mutual health organization: spread of risks over a larger number of individuals, economies of scale at administrative level, etc. However, it may involve threats to internal democratic processes if members of local sections risk being excluded from decision-making bodies.

A mutual health organization may maintain links and working relations with other mutual health organizations in the framework of a regional union for advisory support services and the creation of a common guarantee fund. It may also be a member of a confederation of mutual health organizations in several countries.

5.2 Membership

a. Membership criteria and obligations

Any person who has reached the required minimum age may belong to a mutual health organization, as determined by the customs and conditions of the country or region, without discrimination based on state of health, sex, race, ethnicity, religion, philosophy or politics. For mutual health organizations of micro-entrepreneurs, members must obviously meet other criteria fixed by their respective trade associations.

A contractual relationship links each member to her/his mutual health organization. Illness risk coverage is the member's principal entitlement, guaranteed by the mutual health organization. To benefit, members must fulfil their obligations to the mutual health organization:

- they undertake to respect the basic principles of the mutual health organization and its statutes and rules;
- they pay the membership fees or membership card;
- they regularly pay their contributions at intervals determined by the mutual health organization (daily, weekly, annual, etc.) even if they have not received any benefits.

b. Beneficiaries

The micro-entrepreneur member may extend the entitlement to the mutual health organization's benefits to certain persons who are directly dependent on her or him, who are called "dependants". These are:

- spouse;⁸
- children up to a certain age (if they are studying, the age limit is often higher);
- officially adopted orphans (children under guardianship);
- parents;
- workers and apprentices.

Members of the family will only be considered as dependants if they are actually financially dependent on the member. When the spouse or a child works independently or becomes employed, and thus acquires an income, that person is no longer dependent and must register as a member.

The responsibility of the entrepreneur towards her/his employees and apprentices depends very much on the cultural context in which s/he works and the availability of skilled labour. With respect to medical expenses, in many cases the entrepreneur shares in covering major risks and accidents at work, while regular health expenses ("minor risks") are borne by the worker.

The thorny problem of parents also almost always arises. Their affiliation, as part of the member's family, must be examined carefully, because these are elderly people whose needs for health care are normally higher than those of the average population. Usually they are considered as a separate family, and must pay separate contributions.

⁸ In the case of polygamy, it is generally deemed that there are as many families as there are spouses. For each spouse, contributions are payable as for a beneficiary with dependants.

5. ORGANIZATION AND OPERATION OF MUTUAL HEALTH ORGANIZATIONS

In all cases, the types of coverage must be discussed, taking into account local conditions. The impact of each option on the viability of the mutual health organization must be carefully examined. Normally, broader coverage implies higher premiums. The risk for abuses will be reduced by the social control exercised by members who, in the context of trade associations, often know each other well. However, this control weakens as the mutual health organization enlarges.

As far as possible, family relations determining the status of dependants must be certified by official documents.

The following three examples show the range of possible coverage in terms of type and number of beneficiaries:

Beneficiaries of a mutual health organization's services: three examples

I. Niédougou Mutual

In the Niédougou Mutual dependants are the descendants of the member and his or her spouse(s). The contribution covers:

- ✓ the member;
- ✓ his or her spouse(s);
- ✓ his or her children.

II. Foumké Mutual

The Foumké Mutual covers:

- ✓ the member;
- ✓ his or her spouse(s);
- ✓ all his or her children and those officially in his or her care;
- ✓ his or her father and mother.

However, at each consultation, all these persons contribute with a co-payment of 300 shilling (except children under 10 years).

III. Bellange Mutual

Membership is on a family basis. A single person pays the contribution for the whole family. The Bellange Mutual covers:

- ✓ the member;
- ✓ his or her spouse(s);
- ✓ all children up to higher education;
- ✓ the member's father and mother;
- ✓ the spouse's father and mother.

c. Categories of people whose membership might cause problems

In principle, membership is not conditioned by the individuals' state of health. However the membership of certain persons may cause financial problems to the mutual organization. These include "burdensome cases" which increase the cost of coverage of certain beneficiaries: elderly or chronically ill persons (diabetics, sufferers from hypertension, cardiac weaknesses, HIV/AIDS carriers, etc.).

Coverage of elderly persons

A very delicate question is that of setting a possible age limit for initial membership of a mutual health organization. Under the principle of solidarity, the contribution should never be based on the member's age or state of health. However, some mutual health organizations require a higher contribution for members over a certain age who are joining for the first time. This is justified by the fact that the person has not demonstrated solidarity in that s/he did not join earlier when health was better and there was less need to resort to the mutual health organization.

Coverage of chronically ill persons

Illnesses requiring several months or even years of treatment (leprosy or tuberculosis) or infections requiring long, costly, repeated treatment (sickle-cell anaemia, diabetes, AIDS, etc.) constitute a major risk for the mutual health organization.

In some countries, treatment of illnesses such as tuberculosis or leprosy are covered by special state programmes or external donors (international organizations), and do not cause major problems for mutual health organizations.

For countries where there is no coverage for these illnesses, the mutual health organization may intervene within the limits of its resources. Given the very high costs of covering these chronic or incurable diseases, the mutual health organization will have to strike a balance between its desire to help its most needy members, and the imperative of financial viability and sustainability of the organization.

Several forms of coverage can be envisaged:

- payment for medicines only;
- maximum benefit for each beneficiary (monthly or annually);
- coverage of hospitalization only at the acute stage;
- annual flat-rate coverage per type of illness;
- creation of special funds separate from the principal fund (e.g. AIDS solidarity fund) whereby interventions are limited to the amounts available in the special fund.

d. Procedures of enrolment into a mutual health organization

Enrolment of a new member into a mutual health organization generally involves several stages:

1. Application for membership

An application for membership must be made in writing, generally by completing a form containing basic information about the applicant and her/his dependants. In the application, the new member undertakes to respect the statutes and rules of the mutual health organization.

2. Payment of an enrolment fee and contribution

When the application is accepted, the member pays an enrolment fee and the contribution for the relevant period. The enrolment fee may be replaced by the sale of a membership card.

3. Entry in the register of members

The new member is entered in the register of members and receives a card showing when s/he becomes entitled to benefits.

4. Information to the member on the constitution and rules

Admission is the proper time for information on the rules of organization and procedures of the mutual health organization and members' rights and obligations. Some mutual health organizations provide their members with a copy, sometimes in summary form, of the statutes and rules.

5. Waiting period

The new member must respect a waiting period before receiving benefits. During this waiting period, new members pay their contributions but are not yet entitled to benefits from the mutual health organization. Its purpose is twofold: to ensure that people do not join only when they are ill, and to allow the mutual health organization to build up financial reserves to cover the costs of benefits to its members.

5.3 Major risks related to health insurance

Any mutual health organization which offer services to the whole population without discrimination is exposed to the following major risks, for which certain preventive measures must be taken.

a. Risk of adverse selection

Adverse selection occurs when people with a higher than average health risk join an insurance scheme in a proportion higher than they represent in the population as a whole. This situation may compromise the financial viability of the scheme through excessive costs per member.

b. Moral hazard

Moral hazard is the commonly observed situation where members or their dependants, once insured, tend to consume the service abusively or more than normal. The fact that the contribution is independent of the amount of expenses incurred encourages beneficiaries to consume a maximum of care to make their contributions “profitable”.

To reduce this risk, the following measures may be taken:

- introduction of cost-sharing through co-payments, a deductible or benefit ceiling;
- introduction of a compulsory referral system before accessing to a higher, often more expensive, level of care. Beneficiaries may be allowed, for example, to go to hospital solely upon the recommendation of a general practitioner of a local health centre.

c. Risk of over-prescription

Health care providers may cause a sharp rise in costs by prescribing unnecessary treatment without opposition from the patient, simply because the provider knows that the latter is insured.

The following measures can help to minimize this risk:

- flat-rate remuneration by person or by illness;
- standardization of treatment models and control of compliance by the supervising doctor;
- obligation on providers to prescribe essential generic medicines (“essential drugs”) or limitation of reimbursement of certain medicines contained in a list established by the mutual health organization;
- introduction of ceilings on health care coverage (e.g. the mutual health organization may decide to cover only a limited number of days of hospitalization, the remainder being paid for by the member);
- introduction of waiting days or a deductible in the case of hospitalization (e.g. the first day of hospitalization is borne by the patient to avoid non-essential hospitalization).

d. Fraud and abuse

A mutual health organization is exposed to risks of fraud and abuses by its members, especially if it is a large one. Fraud and abuses often result from pressure on a member from his or her family, circle of friends or neighbours.

A member may make a selection within the family and not contribute for all her/his children. Should a child who is not covered fall ill, the temptation arises to pass him off as a dependant who is registered on the membership card.

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To counter this risk, the following measures can be applied:

- provide controls prior to treatment: before seeking treatment, the patient goes to the officials of his or her mutual health organization and is issued a guarantee letter;
- provide controls after treatment: the officials of the mutual health organization check that the persons for whom the providers have invoiced treatment actually became ill during the relevant period. Fraud is not prevented, but it can be detected and punished;
- identity control: affix an identity photo of the member and all dependants to their membership card. This solution, however, often proves cumbersome and may discourage membership.

e. Explosion of costs

This risk concerns mutual health organizations that cover major risks without maximizing their benefits. It happens essentially when a mutual health organization is starting up or in case of catastrophes: if an exceptionally high medical expense occurs suddenly, the mutual health organization may very rapidly face a financial crisis.

One way to address this risk is to establish financial reserves, for example through the application of an observation period before accepting liability for medical expenses.

In addition, access to a guarantee fund or the possibility of re-insurance can provide effective protection. Collaboration between different mutual health organizations is worthwhile in this area, especially to cover medical expenses that exceed the financial capacity of the individual mutual health organization. Donor agencies may also be asked to participate in such a guarantee fund.

5.4 Management

The “social objective” of the mutual health organization in no way relieves it of the requirements of efficiency demanded of any service organization. Furthermore, it should be noted that health insurance is a complex financial instrument requiring sophisticated management. Rigorous and efficient management is important on two counts:

- **Trust**

Good management encourages members’ trust. This is particularly important in mutual health organizations where the members are required to pay regular contributions without drawing an immediate benefit. Indeed, members only benefit from the mutual health organization’s services when a risk materializes, i.e. often several months after the payment of their first contributions. They must be sure that the mutual health organization will be in a position to help them when in need. Efficient management also encourages

service providers' confidence in the mutual health organization. They must be sure that the mutual health organization will always be able to pay the invoices for treatment provided to beneficiaries.

● **Viability of the scheme**

A mutual health organization manages an insurance scheme against risk of illness. It is a financial instrument which is relatively complex to manage: by definition, the concept of risk involves a degree of uncertainty and this, as well as the coverage of risks, often involves changing the behaviour of members and service providers (adverse selection, moral hazard, over-prescribing, etc.). A mutual health organization must therefore equip itself with budgeting and control mechanisms, accounting and financial management tools and strict and efficient monitoring to meet any eventuality and be in a position to fulfil its commitments towards its members and service providers.

The management of a mutual health organization must be well prepared before it starts its activities. Among other things, this will have an impact on its organization (responsibilities of different organs, etc.), operation (documents used and tasks of the various people involved, etc.) and collaboration agreements with service providers.

The experience of existing mutual health organizations shows that when management mechanisms are poorly prepared, the mutual health organization is very likely to experience serious problems which will force it, during its early years, to revise its organizational and operational methods. Very often, the result is an irreversible loss of credibility in relation to potential members and service providers.

a. Management of human resources

In the context of a mutual health organization, the human resources that are needed depend on the size of the organization and the amount of contributions that can be asked of members.

The operation of a mutual health organization with few members will rely mainly on volunteers, even if the administrative and management functions are sometimes demanding and burdensome. The mutual health organization must motivate its volunteers, distribute tasks and responsibilities and put in place simple administrative and financial procedures.

In large mutual health organizations, a substantial part of the activities may be assigned to salaried staff or the Executive Committee. Rigorous procedures for recruiting, contracting, managing and assessing staff must be applied in such cases.

b. Management of material resources

Unlike a manufacturing company, which must equip itself with machines and tools, a mutual health organization needs a minimum of equipment. As a "service company", a mutual health organization essentially manages financial and information flows and needs adequate means for doing this.

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Depending on the mutual health organization's activities, size and financial resources, these means will consist essentially of :

- office premises;
- computer equipment (possibly);
- transport (cars, motorcycles, bicycles);
- office furniture (desk, chairs, safe, etc.);
- office supplies (files, paper, pencils).

c. Management of financial resources

To ensure its operational and financial viability, a mutual health organization has to put in place management tools and assign these to its various organs.

Management of enrolment and benefits

Management of enrolment and benefits covers tasks related to the registration and monitoring of membership, collection and recording of members contributions, monitoring and payment of benefits. These tasks are particularly important because contributions and benefits respectively are the main income and expenditure of a mutual health organization, which may, for example, lose much of its income if it does not have effective systems and mechanisms for collecting contributions.

The tools for managing enrolment and benefits also provide all the information necessary for monitoring and analysing the mutual health organization's performance. Such analysis is impossible if the mutual health organization does not know the exact number of its members, the quantity of benefits paid and their distribution between different types of treatment and different service providers.

Tools for managing enrolment and benefits:

- ✓ membership card;
- ✓ register of members and beneficiaries;
- ✓ guarantee letter;
- ✓ certificate of treatment;
- ✓ service provider's invoice;
- ✓ service provider's record sheet.

Accounts management

The purpose of accounts management is to record, classify and process the mutual health organization's various operations in terms of incoming and outgoing resources. It follows the various stages of the mutual health organization's activities over a given period (generally one year) known as the accounting period.

Accounts management relies on methods and documents common to all organizations regulated by legislation. The accounting system may, however, be adapted to the size, activities and other characteristics of each mutual health organization.

Accounting management tools:

- ✓ cash book;
- ✓ bank book;
- ✓ general ledger;
- ✓ supporting vouchers;
- ✓ income and expenditure account;
- ✓ balance sheet.

Financial management

The purpose of financial management is to ensure the long-term financial viability of the mutual health organization. It involves budgeting and control of the mutual health organization's expenditure and income, analysis of its financial situation, management of investments, etc.

The management of available financial resources is an important element in the mutual health organization's financial viability. The mutual health organization may enter into an agreement with a financial institution for the deposit of contributions or operational funds.

Financial management tools:

- ✓ income and expenditure account and balance sheet;
- ✓ budget;
- ✓ cash-flow plan;
- ✓ financial ratios.

Monitoring

The establishment of a monitoring system is very important. The system must allow monitoring of admissions, service providers, pattern of benefits paid out (e.g. flows over the year), average cost of benefits, financial ratios, etc. Monitoring must allow problems or significant trends to be identified quickly so that the Board of Directors can take the necessary decisions in a timely manner.

5.5 Maximizing prospects for sustainability and viability

A mutual health organization must be well managed. It must keep its operating costs as low as possible, maximize collection of contributions and keep good track of medical expenses. It must as far as possible adjust the treatment covered by the insurance to the ability of its target group to contribute. The mutual health organization must as far as possible have a competent and honest staff and its decision-making organs must closely monitor its performance.

6. Setting-up a mutual health organization by an association of micro-entrepreneurs

6.1 Stages in the creation phase

The creation of a mutual health organization is often a slow process that goes through several phases and encounters many difficulties, which are reinforced by the lack of information concerning both the health situation and the financing involved.

This initial phase of the mutual health organization is crucial. Any error in the choice of activities, the design of the organization or the calculation of contributions will affect its viability for a long time.

The establishment of the mutual health organization will be followed by a growth phase, which will continue until it reaches an equilibrium point. In this second phase, usually lasting at least two to three years, the assumptions adopted at the initial phase are refined, based on the experience gained during the first years of operation.

If the mutual health organization has been set up with the necessary care and rigour, its growth can be expected to be quicker and easier.

The creation phase has several stages:

- **Stage 1:** Recognition by micro-entrepreneurs – i.e. the potential members – of the difficulties and shared needs relating to health and the decision to put in place a common solution: the mutual health organization. This stage involves several phases:
 - ▶ raising awareness and motivating the target population;
 - ▶ verifying that the preconditions for the establishment of a mutual health organization are present;
 - ▶ formation of a working group.
- **Stage 2:** Background study to gather all the information necessary to determine the characteristics of the future mutual health organization.

- **Stage 3:** Definition of the most appropriate mutual formula in terms of the services provided, organization and operation of the mutual health organization. This is the time for:
 - ▶ choosing which risks to cover and which services to provide;
 - ▶ choosing health care providers and negotiation of financial terms;
 - ▶ defining the internal organization;
 - ▶ defining operational procedures;
 - ▶ establishing the budget.
- **Stage 4:** Creation of the mutual health organization and start-up of activities:
 - ▶ preparation and organization of the constituent general assembly;
 - ▶ start-up of activities.

A trade association wishing to create a mutual health organization may organize a survey of its members to assess their expenditure on health, their opinion on various service providers, and their willingness to pay a contribution to health insurance. For large trade associations, it is also important to mobilize different divisions and sections before launching the initiative.

The mutual formula which is adopted, especially its internal organization, will be influenced by the strengths and weaknesses of the trade organization. The choice of service providers will be influenced by members' experience of health services and the location of their economic activities. An analysis should also be undertaken of the extent to which the creation of the mutual health organization will attract micro-entrepreneurs who are not yet members of the trade association.

6.2 Raising awareness and motivation

The first stage in the process of establishing a mutual health organization is the organization of meetings to raise awareness and motivate people, especially among:

- local associations: particular attention should be paid to mutual aid groups (women's associations, savings clubs and groups with mutual assistance funds);
- local authorities: traditional, administrative and religious.

The objective is to involve the target population in a process of reflection based on observation and analysis of health needs as expressed by those concerned.

Raising awareness and motivation are permanent activities and take place during all stages of the establishment of the mutual health organization. They play an important role in the third stage where the target population must participate actively in the choice of benefits and the related contributions.

6.3 Verification of preconditions

A mutual health organization is not always the most appropriate security mechanism in a given context. A first activity is to verify a certain number of preliminary conditions required for the creation of a mutual health organization.

- a. **Bonds of solidarity must exist between the future members**

Solidarity is an essential factor in a mutual aid group. The bonds of solidarity necessary for the establishment of a mutual health organization may derive from a number of situations, such as: inhabitants of a village or district, micro-enterprises of the same size or working in the same sector, workers in the same company, or members of a social movement.
- b. **Potential members must be experiencing financial difficulties in accessing health care**

The future mutual health organization will mainly address the financial problems of accessing and obtaining quality health care. This difficulty is the primary element which may ground the creation of a mutual health organization.

If the target population is to feel that there is a real value in the mutual health organization, it must not only meet a real need, but the need must be seen as a priority. Since this condition is not always met at the beginning of the project, the target population must be helped to clarify and express its needs without artificially encouraging them.
- c. **The target population must trust the initiators of the project**

The micro-entrepreneurs who may join the future mutual health organization must have confidence in their trade association, which is initiating the health insurance scheme. After all, they are going to entrust their contributions to this organization. Thus, the background of relations between the micro-entrepreneurs and their trade association will be important elements in appraising the possibilities for creating a mutual health organization.

Members' confidence will also be conditioned by the successes or failures encountered in the same area or in similar areas (service cooperatives, savings and credit schemes, etc.). These must be analysed to assess the feasibility of creating a mutual health organization and to define the steps that should be taken.

The attitude of local authorities (official, traditional, religious) towards the initiative will be equally important. The trade association should therefore make early contact with them. However, a positive attitude on their part is not an essential precondition for the launch and development of the mutual health organization.

d. Quality health services must be available

The mutual health organization must be able to rely on the provision of health services to meet the principal needs of its beneficiaries. These services may be provided by health centres, hospitals, or health professionals in the private sector, working individually or as private enterprises (doctors, midwives, nurses, physiotherapists, etc.). These medical facilities must not be too distant from the micro-entrepreneurs' homes and workplaces and must be of good quality.

The primary reasons why micro-entrepreneurs have limited access to health care must be of a financial nature (i.e. inability to pay for treatment). However, it could be that certain service providers are not well appreciated by communities because, for example, they are regularly faced with shortages of medicines or because client reception is not always as it should be (often related to low staff wages, poor state of equipment, etc.). If so, the mutual health organization should consider whether it can provide an answer to these deficiencies (improved availability of finance to maintain a stock of medicines, higher wages to motivate the medical staff, etc.).

The mutual health organization may only create its own health centres or hospitals if there are no local providers of quality health services. If such services exist but are too expensive, the creation of medical units attached to the mutual health organization can also be considered. In that case, it is necessary to analyse why the costs of existing health centres are high and ensure that the mutual health organization can reduce them without affecting the quality of the treatment provided.

Medical units created on the initiative of the mutual health organization which are set up by a trade association must have a distinct legal personality. Moreover, it is important to know and keep separate the financial results of each function of the association, and separate their respective management.

e. The socio-economic situation is dynamic

The existence of a dynamic economic environment, especially in rural areas, facilitates the introduction of mutual financing of health services. Profitable economic activities provide communities with financial resources that, while insufficient to provide full individual coverage of the cost of their health care, are enough to do so collectively, on the basis of solidarity between the sick and those in good health.

6.4 Background study

For any organization wishing to initiate a mutual health scheme, it is important to fully understand the context in which it will operate, by means of information on demographic, socio-economic, health, financial and legal aspects. This information is necessary to appraise the overall feasibility of the initiative, and more especially to determine the population's specific needs, make financial projections and define the services to be covered.

This research should be strictly limited to practical information that is useful in establishing a mutual health organization. In many cases, experience shows that this precaution is overlooked and much information is accumulated which is not used (because it is irrelevant, superfluous or unusable).

Before undertaking any survey, various institutions – administrations, university institutions, local authorities, documentation centres – should be contacted to gather information that is already available.

6.5 Choosing the most appropriate form of mutual health organization

The purpose of the background study is to collect all the information necessary to define the activities, organization and operation of the mutual health organization. The next step is to analyse this information so as to identify the form of mutual health organization most suited to local needs, the local environment and local customs.

To carry out this analysis, a working group may be set up within the trade association, possibly with external support. This analysis should be shared regularly with the micro-entrepreneurs through promotional meetings in order to:

- gather the views of all potential beneficiaries;
- obtain better knowledge of the micro-entrepreneur's perception of their health situation, their difficulties, etc.;
- directly involve future members in preparing the future choices or options, as this involvement will facilitate decision-making in the constituent general assembly;
- learn about the successes and failures of other mutual health organizations in the region.

Background study: Types of information to be gathered

Demographic aspects:

- ✓ size and growth rate of the target population;
- ✓ distribution of the population in the area by age group and sex;
- ✓ average size and composition of families (men, women, children, other dependants);
- ✓ migration.

Economic aspects:

- ✓ number of micro-enterprises;
- ✓ people working in these units, by sex;
- ✓ profitability of these enterprises distinguishing between growth-oriented and subsistence units;
- ✓ number and size of associations of micro-enterprises;
- ✓ economic activities of the population, by sex;
- ✓ the nature of agricultural production, distinguishing between commercial and subsistence;
- ✓ income levels, distribution and trends in purchasing power.

Forms of solidarity and organization of the population:

- ✓ present and past forms of organization of the population (basic communities, district committees, cooperatives, associations, savings clubs, etc.);
- ✓ organization and functioning of local mutual aid associations: organs, methods of collecting contributions, difficulties, etc.;
- ✓ existing practice of mutual aid and solidarity in health care.

Health needs and expenditure on health care:

- ✓ priority health needs;
- ✓ type and frequency of use of health services;
- ✓ the annual family budget and the proportion allocated to health spending;
- ✓ responsibilities for health expenditure within the family;
- ✓ most frequent infections;
- ✓ morbidity, mortality rates, malnutrition, etc.

Health care provision:

- ✓ number and distribution of health service providers;
- ✓ nature of health services (consultation, maternity, hospitalization, etc.);
- ✓ quality of health care;
- ✓ number and qualifications of health staff;
- ✓ the population's perception and use of the providers;
- ✓ the physical distances between service providers and the target population;
- ✓ distribution channels for medicines, availability of essential and generic medicines.

Financing of health care:

- ✓ methods of operation and financing of health costs;
- ✓ cost of health care;
- ✓ initiatives relating to financing of health care.

Legal and institutional framework:

- ✓ legislation allowing a mutual organization to have legal personality;
- ✓ legislation on health policy: organization of health services, prevention, etc.;
- ✓ legislation on medicines policy (including price-setting laws and regulations).

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The choices to be made before the mutual health organization starts its activities concern:

- geographical coverage: neighbourhood, village or region;
- target group: only micro-entrepreneurs (men and women) members of the trade association or a larger population;
- risks to be covered, benefits and the related premiums;
- service providers with which the mutual health organization will conclude an agreement;
- internal organization of the mutual health organization;
- practical operational methods of the mutual health organization.

During this formulation stage, a programme of action as well as a budget will be prepared, reflecting the totality of the choices made and the financial inputs required.

The choice of treatment to be covered and the calculation of contributions are two very important points at this stage and deserve particular attention.

a. Choice of treatment covered by the mutual health organization

A mutual health organization does not address the cost of treatment as such, it only modifies the manner in which treatment is paid for through a provision of security and mutual protection against risks.

In other words, the contribution asked from members must correspond to the treatment costs that will be covered by the mutual health organization as a whole. Consequently, it is not very realistic to cover all types of treatment and health care, since that would require too high a contribution, and would thus make the organization inaccessible to members with the lowest incomes. It is therefore necessary to select, with all the potential members, the health care to be covered by the mutual health organization. This choice will determine the mutual health organization's viability.

In order to fully understand the impact of this choice, it is also necessary to reflect on the reasons that motivate a micro-entrepreneur, man or woman, to join a mutual health organization. There are four motives which may encourage him or her to pay a contribution:

- to protect the members of his/her family and him/herself against certain risks (individual motivation);
- to meet commitments to workers and apprentices in the case of accidents at work or serious illness;
- to protect the business from losses due to illness;
- to participate in a mutual aid and solidarity movement that provides collective protection (collective motivation).

These different motives are closely linked. Will individuals be prepared to commit to solidarity and adhere to mutualist values if they do not consider gaining some benefit in satisfying their own health needs? Solidarity will be all the more durable when everyone concerned sees the organization primarily as a means of satisfying their own interests.

Health care coverage must be relevant

The choice of health care to be covered must meet certain criteria if the recommended mutual formula is to be viable and attractive. They should be relevant, visible and affordable.

The health care that is covered must correspond to the risks perceived by the micro-entrepreneurs. These risks generally fall into two main categories: minor risks (which entails primary health care) and major risks (which entails secondary and tertiary health care). The promoters of a mutual health organization are frequently divided as to the relevance of covering one or the other of the two categories of risk.

Primary health care is the initial entry point to the health system. The cost is relatively low. Covering minor risks is primarily intended to ensure rapid access to treatment, in order to avoid deterioration in the patient's health. However, covering primary health care by an insurance scheme faces two major constraints:

- because of the frequency with which such risks occur, it requires a high level of contributions. Because of this, access to the mutual health organization will be difficult for the most deprived families;
- covering minor risks is particularly prone to adverse selection and moral hazard. The financial viability of the mutual health organization will consequently be weakened.

Conversely, covering major risks provides protection in respect of the most expensive treatment, which causes the greatest financial difficulties for families, especially in the case of serious illness and emergency medical operations.

Covering only major risks allows contributions to be set at a lower level, despite the cost of benefits, because frequency is low. On the other hand, covering major risks is subject to the following constraints:

- the frequency of hospitalization and surgical operations is low. Depending on the context, it can be estimated that 4 to 8 per cent of insured persons may require secondary health care during the year. The mutual health organization will then have a low profile, resulting in a possible loss of member motivation;
- if families have difficulty in paying for primary health care, the mutual health organization will not solve the problem of delay in seeking treatment, with an aggravation of the illnesses as a result;

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- a mutual health organization that is just starting up (or is small in size) may become insolvent as a result of successive, expensive hospitalizations.

Co-payment and deductibles (see section 4.4 above) can limit risks of over-consumption and adverse selection.

An effective mutual health organization can diversify the services it offers to its members and, for example, develop a combination of coverage for minor risks and major risks to meet the needs of micro-entrepreneurs. In some cases, micro-entrepreneurs might ask for total coverage for themselves and their family, while workers and apprentices would be covered only for major risks.

The protection provided must be visible

Even if the members have understood the principles of mutual aid and security, they must still see for themselves that the system is working, because:

- Payment of a regular contribution imposes a certain discipline: one must “dip into one’s pocket” frequently or pay a fairly large sum of money each year.
- The contribution is paid to a common fund and many groups in the past have experienced bad management, voluntary or otherwise. There is a risk that distrust will rapidly set in if few benefits are paid.
- One of the basic principles of the mutual health organization is its democratic management. To be effective, this requires regular meetings of its members. The members, however, will have little incentive to participate if their mutual health organization is not very active or visible.

Consequently, the mutual health organization that chooses to cover risks which rarely materialize (major hospitalizations, surgery) is at risk of lacking dynamism and ultimately becoming unattractive. Conversely, a mutual health organization that covers minor risks will be very active, and thus very visible, but will be less accessible to the poorest families and more difficult to manage.

In order to ensure a certain visibility, a mutual health organization should ensure that a sufficiently large number of families receive at least one benefit each year. Covering the costs of minor hospitalizations and births meets this criterion satisfactorily.

The contribution must be affordable

The protection that a mutual health organization may offer to its members largely depends on their income, especially their ability to contribute and, more generally, their purchasing power regarding health.

A contribution that is too high will be prohibitive to the vast majority of members. Conversely, the mutual health organization that provides all primary and secondary health care services without any co-payment by beneficiaries would be very attractive, but not economically or financially viable.

Like any business, a mutual health organization is faced with the classic phenomenon of price elasticity of demand for a product or service: the higher the price, the less potential buyers are interested. Consequently, a contribution level that is too high tends to discourage membership. Conversely, mutual health organizations whose contributions are too low have the largest number of members. However, elasticity of demand is also influenced by the target population's perception of their financial risks: the more risks they see, the higher the price they are prepared to pay for protection.

When selecting the health care to be covered, members must assess the consequences of a particular choice on the level of contributions and ensure that they remain affordable for all. Moreover, the level of the contributions also depends on the percentage of the medical expenses that are covered, given that an insurance scheme generally only covers part of the expenditure (see above on co-payment).

b. Calculation of contributions

Calculating the contributions (or premiums) is the most difficult part of establishing a mutual health organization. It is also fundamental, since the amount of contributions directly determines the future viability of the organization:

- if the contribution is too low, the mutual health organization will be in deficit with a risk of insolvency if it does not succeed in mobilizing additional resources (subsidies, exceptional contributions, guarantee funds, etc.);
- if the contribution is too high, the mutual health organization will be financially inaccessible to a large number of potential members.

The calculation of contributions is based on an estimate of the frequency that the risks of illness materializes and the costs of treatment. Unfortunately, in most cases, there is little reliable data available to make accurate estimates. The amount of contributions to be calculated will therefore be rather imprecise. It is essential, especially in the early years, to closely monitor contributions and the costs of benefits in order to make necessary adjustments.

Several methods are used by mutual health organizations to calculate and determine contributions. The following is the most used method and the most rigorous. It is important to recall that these contributions are used for:

- reimbursing medical expenses (co-payment left aside) for treatment covered by the mutual health organization;

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- constituting reserves to increase the financial strength of the mutual health organization over successive accounting periods;
- financing the mutual health organization's operating costs.

This first method divides the calculation of the contribution into three elements:

$$\text{Individual contribution by health care covered} = \text{risk premium} + \text{safety margin} + \text{operating unit cost}$$

Risk premium:	Expected frequency x (average cost of service less co-payment by patient).
Safety margin:	Often fixed at 10 per cent of the risk premium. It is related to the uncertainty concerning the calculation of the risk premium.
Operating unit cost:	Estimate of total operating costs divided by the number of expected beneficiaries. It may also be fixed as an initial approximation at about 10% of the sum of the risk premium plus the safety margin. This alternative is, however, much less precise.

To these three elements is added a factor E which defines the unit amount of surplus to be achieved to constitute the financial reserves.

If several types of health care services are covered, the total individual contribution is equal to the sum of contributions calculated for each type. In most mutual health organizations, the family contribution is equal to the individual contribution multiplied by the average number of members per family.

These calculations result in an estimate of the annual contribution. It can then be divided into days, months, etc., depending on the periodicity of payment of contributions most suited to the income of micro-entrepreneurs. In general, the lower their income, the higher is the contributor's preference for making regular payments of a small

sum instead of a large periodic annual payment. In cases where income is seasonal, payment schedules may be adjusted accordingly.

The process leading to the final choice of the contribution asked from members involves three stages:

1. The contributory capacity of the target population is estimated, i.e. the average amount that each individual or family could afford to pay. It should be noted that this contributory capacity depends very much on the value micro-entrepreneurs place on health care spending. The awareness of the population and the usefulness of the service offered thus also have an impact on their willingness to pay a certain contribution.
2. The contribution corresponding to each type of treatment to be covered is calculated. Several scenarios of health care cover are then prepared, by combining the coverage of the different types of care. The total amount of contribution for each scenario must be compatible with the contributory capacity of the target population.
3. These different scenarios are presented to the target population, which thus participates in the final choice of the activities and benefits provided by their future mutual health organization. A single scenario will finally be adopted, based on which the promoters of the mutual health organization will be able to design the mechanisms and tools for covering the costs and establish a budget for the mutual health organization.

7. Conclusions

This Guide focuses on how the needs for health protection among micro-entrepreneurs can be rightly addressed by mutual health organizations. Indeed, micro-entrepreneurs fulfil the principal requirements for the establishment of such an organization.

- The need for protection against the risk of illness is real, where it is related to:
 - ▶ the individual's state of health: the low level and irregularity of the micro-entrepreneurs' incomes, and those of their apprentices and workers, which constitute financial limits on their access to health care;
 - ▶ the family's source of income: when illness involves temporary or permanent stoppage of work or when enterprise funds are used to meet a major and urgent health care expense, income is severely threatened.
- Micro-enterprises are strongly rooted in traditional society, and in the mechanisms of mutual aid and solidarity, which they particularly mirror. The examples of solidarity funds, savings clubs, burial societies and other mutual aid mechanisms, established in a workshop or among traders in a market, are myriad. Thus, the bonds of solidarity on which the mutualist movement can grow already exist.
- Associations of micro-entrepreneurs demonstrate a dynamic of socio-economic development. These associations represent an important potential for achieving social objectives such as the establishment of health protection schemes. They also permit the sharing of the risk of illness between large numbers of individuals.

In addition, the mutual health organization offers organizational and operational flexibility that distinguishes it from other insurance systems and allows it to adapt to the diversity of situations encountered in the realm of micro-enterprises.

The mutual health organization is established and administered by its members. The members themselves define the forms of membership, contribution, organization and the services provided by their mutual health organization.

The establishment of a mutual health organization with the aim of organizing a system of social protection for micro-entrepreneurs has many benefits. However, in the setting-up and operation of an organization, obstacles are often encountered and serious difficulties can arise, such as:

- The establishment of a mutual health organization is a long process, sometimes poorly comprehended or accepted by its potential members, who are accustomed to speedier results.
- A mutual health organization goes through a growth phase, generally over several years, during which it has to revise its original assumptions in the light of experience. These changes are sometimes perceived by members as the result of management errors, potentially leading to discouragement and abandon.
- The mutual health organization is a self-administered organization that requires considerable and voluntary work from its administrators and managers, on top of their own economic activities. When the burden of work is too much, it often leads to their demotivation, with all its consequences for the operation of the mutual health organization. It is critical for the mutual health organization to achieve a level of financial viability that allows it to recruit a minimum of staff to carry out its day-to-day activities.
- Perhaps most importantly, current experience shows that, first, mutual health organizations frequently have a very low rate of penetration of their target population and, second, they have problems in continuing to collect contributions from their members. These difficulties, depending on the situation, result either from a lack of motivation among potential members, from organizational problems within the mutual health organization, from benefits unadapted to the needs of families, or because contributions are simply too high.

Given the significance of these difficulties, this Guide has attempted to define and show the principal factors for the success of a mutual health organization, suited to the specific nature of micro-enterprises and able to meet the needs of micro-entrepreneurs. These factors are:

- The continuous involvement of members in the life of the mutual health organization, by promoting democratic and participatory management. This factor has also been equally crucial in associations of micro-entrepreneurs. Apart from its very members, all the actors surrounding the mutual health organization must be actively involved. These particularly include service providers, whose attitude and behaviour towards cheap or expensive services will partly determine the viability of the mutual health organization.

- To ensure effective member involvement, special emphasis must be placed on continuous awareness raising, sensitization and information, so that members understand the choices to be made during the establishment and development of their mutual health organization.
- Health needs are important, but the establishment of a system of protection is limited by its members' capacity to contribute. In such conditions, a mutual health organization must pay particular attention to its choice of benefits. It must seek to strike a balance between the best possible health coverage in areas that cause the greatest difficulties to its members, and a contribution they can afford financially. The trade-off between affordable contributions and valued benefits is an issue on which a mutual health organization typically needs expert advice.
- If the insurance is to play an effective role in sharing risks between the members, the number of members must not be too small. Mutual health organizations with only a small number of members will be either exceedingly fragile or will be forced to ask high contributions. The desirable increase in the number of people protected also allows economies of scale and provides for greater negotiating power vis-à-vis health care providers.
- The social objective of a mutual health organization in no way relieves it of the need for efficiency. Rigorous management is an essential element in the viability of a mutual health organization, and tools and methodologies must be suited to the skills of the mutual health organization's administrators.

The management of an insurance scheme is technically difficult, the more so when it takes place in an environment where statistical data are rare and unreliable. This Guide offers those who might be interested in establishing a mutual health organization the information necessary to confirm that interest, but it is not intended to be used on its own. In addition to the information contained in the Guide, frequent, well-informed and qualified support is indispensable for all those wishing to initiate mutual health organizations among micro-entrepreneurs.

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