The role of the Health Mutual Organization and Health Co-op
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Global questions

1. How do cooperatives participate in providing social protection to their members and at what levels?

2. To what extent can cooperatives be complementary to other stakeholders' contributions in national social protectionschemes?

Health system components

- Importance to understand the 3 major components of health system[1] and the role of the actors:
    - Stewardship (Management): Public authorities
    - Funding: Social insurance system, Tax-funded System (public), private insurance for-profit, private insurance not-for-profit (including mutual), individual (in pocket)
    - Delivery (provision): Public, private for-profit, private not-for-profit (including co-op), informal

From a world-wide perspective, generally, health co-ops are on the delivery side even if in some case (Brazil, Spain, USA), health co-ops could operate inside a network or organization umbrella including health insurance component. As it was shown by United Nation survey in 1997 (annex 1), it is not simple to talk about health co-op since it depend if the business goals are primarily and solely concerned with health and social care. Moreover, at least, 3 types of health co-op operated: User-owned, joint user-and provider-owned (or multistakeholder co-op) and provider-owned.

The priority

Over the recent decades in Africa and other low income countries, it appear the most urgent need is the health or social protection for individual instead of only put the focus on organizing the health delivery which include health co-op. A report that has been released by ILO in 2007 explains the situation:

In recent decades, the growing trend towards the recovery of health services costs has heightened the need to protect individuals from the financial risks related to illness.

- *In most developing countries, social security systems cover only formal economy workers. Persons outside the scope of statutory schemes, most of who work in the*

[1] In the case of WHO report, related to the health system definition, they also included creation of resources e.g. human resources (training, recruitment, etc.), medical technology, etc.

informal economy, generally have no protection against social risks, particularly in the area of health.

- *In low-income countries– especially in Sub-Saharan Africa and Southern Asia – more than 90 per cent of the population generally has no coverage, while in middle-income countries this figure tends to range between 20 and 60 per cent.*
- *Large parts of the population in developing countries are thus unable to defend themselves against the financial impact of illness.*

In a publication of the World Bank (2006), it appears there has a huge gap between the expense and the health needs if we compare rich and poor countries. Gathering up to 84% of the world population, poor countries deal with up of 90% of illness but have only 20% of the GDP and 12% of world expense for health. The expense of rich countries per citizen, where 100 time higher with the one of poor countries. Last but not least, more than 50% of the health expense in poor countries are under the patient charge.

Why?

Expanding social (health) protection among individual in low income countries make sense for at least 3 main reasons in the view of Waelkens, Soors and Criel (2005) in a study that has been done for ILO:

- *First, there is an ethical reason. Social protection simply is a human right – just as is the case for access to basic health care.*
- *Second, there is a social reason. There is a strong and largely unmet demand for effective, affordable and non-discriminating systems of social protection. They are expected to reduce people's anxiety in case of health shocks, safeguard their dignity and self-esteem,and eventually improve their overall well-being.*
- *And third, there is a technical reason. There is today in sub-Saharan Africa little documented evidence on the specific impact ofsocial health protection on health status, poverty reduction and economic growth (it was pointed out in this review how difficult it is in methodological terms to actually prove such impact). But common sense invariably dictates us to invest in social protection, and evidence from OECD countries indicates that a comprehensive package of health and poverty reduction interventions, including social protection, succeeds in reducing poverty levels.*

How?

In order to combat social exclusion, in the comprehension of Develtere and Fonteneau (2002), *international agencies put forward three interrelated objectives:*

- *(a) conservation and improvement of the health status,*
- *(b) health care financing through systems of solidarity, and*

- *(c) respect for the dignity of the people concerned (OIT, 2001; WHO, 2000; World Bank, 1997, 2001).*

The idea of health care financing through systems of solidarity make sense with the African reality. For Abt (2004), a consultant firm collaborating with USAID and getting involved in diverse projects including in Ghana, Mali, Rwanda, and Senegal, *the community-Based Health Financing, an approach to health insurance arising from principles of solidarity and mutual assistance, appears to offer an alternative to poor women and their families who cannot afford health services.*

> *It is already clear that MHOs[2] have an important advantage over healthcare initiatives designed and organized by governments or NGOs. They are, Kelly says, viewed as "completely legitimate" because they are indigenous. "[MHOs] stem from existing solidarity links, organizations such as women's trade associations that already exist and are happening even in the absence of technical assistance from outsiders," Kelly observes. "The people themselves have decided this is how they want to access care.*

Moreover, for Develterne and Fonteneau (2002), in front of the current challenges in Africa, this notion of Mutual Health Organization makes sense because it base on the idea of decentralization and subsidiarity[3]. They pointed out the closed link with co-op notions base upon *member-based; Decision-making and control by members; Voluntary and open membership; Non-profit*. Finally being very close to the concept of self-help, MHO is running under the principle of *seeking social protection through risk sharing*.

Evaluation

Over the years, many efforts has been done in order to develop practical tool for the implementation and evaluation of HMO, for instance, under the ILO's, Strategies and Tools against social Exclusion and Poverty global programme (STEP). At the same time, many projects have been conducted on the ground level which results in the implementation of many HMO. Base on Waelkens, Soors and Criel (2005), what is the output coming from such actions?

- *First, there increasing indications that community health insurance improves financial access to health services, which may in its turn substantially contribute to better health.*
- *Second, people show growing acceptance of community health insurance, so demand is increasing.*
- *Third, community health insurance may be the best strategy available today to improve access to health care for the poor (Preker et al., 2002), thus opening a road to sustainable poverty reduction.*

The authors also noted that *the positive findings of improved access and growing acceptance of community health insurance schemes must however be contrasted with their current low coverage and limited financial capacity to cover expensive health care episodes*.

[2] MHO: Mutual Health Organization

[3] This notion (wikipidia) *is an organizing principle stating that a matter ought to be handled by the smallest, lowest, or least centralized authority capable of addressing that matter effectively.*

Abt (2004)pointed out few organizational challenges for HMO: *Long-term sustainability is still a looming question. Unsurprisingly, problems such as low collection rates for premiums, unwieldy record-keeping as MHOs grow, and a lack of administrative experience all challenges the survival of these home-grown organizations.*

Nevertheless, in a recent report about the development of co-ops in Africa(Develtere, Pollet, Wanyama; 2008), there is a strong affirmation of their positive role:

> *We have also learned from this study that the success of cooperative enterprises in Africa can significantly contribute to poverty alleviation in a number of ways. For instance, it has been demonstrated that cooperatives create employment and income-earning opportunities that enable members to pay school fees, build houses, invest in business and farming, and meet other family expenses. They also create solidarity mechanisms to re-enforce the traditional social security system, which is largely undeveloped, by setting up schemes to cater for expenses related to education, illness, death and other unexpected socio-economic problems. And by integrating the poor and the relatively well-off in the same income-generating opportunities, cooperatives also make a contribution to the reduction of exclusion and inequality.*

Finally, there is a large recognition that HMO can't overcome only by them the citizen's health access. As it explain in the 2010, WHO report, "WHO's Member States have set themselves the target of developing their health financing systems to ensure that all people can use health services, while being protected against financial hardship associated with paying for them". This report strongly support the idea that each WHO member State should moving quickly into the goal of universal coverage. But that could take time and the current reality is, in some case, far away from this ideal. So,under non-universal health coverage, HMO is an important component of a health insurance system but it can't play the role of the State including the coverage of extensive care illness (HIV-AIDS), the poorest citizens, etc. In the best case, HMO would benefit from the State and external donor support for diverse needs[4] but at the same time, State should try to enlarge their action in term of health coverage.On the delivery side, in the best situation, in order to promote main stakeholder involvement (users, providers), which is an idea promoted since many decades by WHO, and in the view of non-profit organization, it would be relevant to support implementation of health co-ops (Girard; 1999). The existing health co-op network around the world and the international apex organization, the International Health Cooperative Organization (IHCO), can be a source of lot of knowledge.

[4] For instance, base on Wanyama (2008) suggestion, *the provision of low-interest credit for capital-intensive investments; marketing of cooperative produce, particularly through fair trade arrangements; facilitating the creation of suitable legal and policy environment for cooperative enterprises; and facilitating educational and training programmes in cooperatives, among others.*

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Annex[5]

Summary of detailed classifications of health and social care cooperative

1. Cooperatives whose business goals are primarily or solely concerned with health and social care[6]
   - 1.1. Health cooperatives (providing health services to individuals)
     - 1.1.1. User Owned
     - 1.1.2. Joint user-and provider owned
     - 1.1.3. Provider owned
       - 1.1.3.1. Primary
       - 1.1.3.2. Secondary
   - 1.2. Social care cooperatives (providing social care services to individuals)
     - 1.2.1. User-owned
     - 1.2.2. Joint-user and provided-owned
     - 1.2.3. Provider-owned
   - 1.3. Cooperative pharmacies (retailing medicines and equipment needed for individual health and social care)
     - 1.3.1. Primary user-owned
     - 1.3.2. Secondary
       - 1.3.2.1. User-owned
       - 1.3.2.2. Provider-owned
   - 1.4. Health and social care sector support cooperatives (providing goods and services to other enterprises in the health and social care sector)
     - 1.4.1. Primary
       - 1.4.1.1. Labour contracting
       - 1.4.1.2. Other
     - 1.4.2. Secondary
       - 1.4.2.1. Provider- (worker-) owned
       - 1.4.2.2. Enterprise user-owned
   - 1.5. Health insurance purchasing and service delivery cooperatives owned by non-cooperative enterprises
2. Cooperative whose business goals include but are not limited to the health and social care sectors
   - 2.1. Cooperatives in primary production
   - 2.2. Cooperatives in secondary processing and manufacturing
   - 2.3. Cooperatives in tertiary service provision (other than health)
     - 2.3.1. Retail distribution
     - 2.3.2. Funeral cooperatives
     - 2.3.3. Insurance cooperatives
     - 2.3.4. Saving and credit and cooperative banks
     - 2.3.5. Housing and community development cooperatives
3. Cooperatives whose business goals do not include health or social well-being but might include provisions of operational support to health and social care cooperative
   - 3.1. Financial cooperatives
   - 3.2. Research and development cooperatives
   - 3.3. Media cooperatives
   - 3.4. Educational and training cooperatives

[5] UN. 1997. *Cooperative Enterprise in the Health and Social Care Sector A global survey*, New-York, United Nations

[6] Some of the cooperatives in all types provide to members, employees and their dependents health and social security insurance and/or access to the enterprise's own facilities

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Expert in collectives enterprises such co-op and NPO and having more than 25 years of experience in teaching and research related to this organizational model in diverse universities in Canada and Africa (universitéShengor), Jean-Pierre Girard develop a special interest for such organisation in health and social care field since 1996 under diverse roles: Researcher, consultant, organization and leading of Studies Tour, author or co-author, speaker. That included mandates with OECD, CGSCOP (France), Welsh Co-op Party (Wales, UK), the Government of Canada, the Quebec Co-op and Mutual Council. He prepare business plan for diverse health co-op including Aylmer Health Co-op, the first case in Canada where co-op buying an existing medical clinic. He also led training sessions on health mutual with SOCODEVI staff, a Canadian NGO specialist of co-op development in poor countries. Among diverse voluntary engagement, since 2001, Jean-Pierre sits on the board of the International Health Co-operative Organization. Since 2 years, he is also a panel member of the 3M Canadian Health Leadership Award.