Are education professionals always vectors for the development of solidarity-based social protection systems?

Analysis of health and social protection based on a distance pilot study

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1. Introduction

1.1. Global access to healthcare – challenges, future prospects and opportunities for solidarity-based social protection organisations

Social protection – a continuing challenge

"Access to adequate social security and health care protection are two fundamental human rights. However, these rights are far from being achieved worldwide. For example, up to 80 per cent of the population in sub-Saharian Africa and some parts of Asia live without such protection. This problem is exacerbated by uneven needs: the living and working conditions of informal economy workers and rural populations expose the most to health and accident risks, however, they are the groups most often excluded from social security." (Coheur, Jacquier, Schmitt-Diabaté & Schremmer, 2007: 1).

"Exclusion from social security has a devastating impact on the individual and his/her family. The World Health Organization (WHO) estimates that every year 100 million persons enter into a vicious circle of ill health and poverty due to health care costs. What is more, it also reduces opportunities for economic growth and social development and makes countries more vulnerable to the consequences of health shocks." (*ibid*: 1). It is estimated that every year 150 million people are faced with catastrophic health expenditures.

"In many low-income countries OOP serves as the key financing mechanism for health care – up to 80 per cent of total health expenditure in countries such as Myanmar, the Democratic Republic of the Congo, Guinea and Tajikistan. Remaining expenditures are usually financed by taxes and to a small extent by social and community-based health insurance schemes" (International Labour Organisation (ILO), 2007: 15).

Key indicators of social protection and health expenditure in low- and middle-income countries:
- close correlation between income levels of countries, access to health services and mortality;
- low share of health expenditures dedicated to social protection in terms of GDP and total health expenditures;
- low share of public financing in terms of total health expenditures;
- low level of solidarity in financing and insufficient pooling of risks;
- large share of private health financing, thereby directly shifting the burden to households;
- limited financial protection which leads to high levels of out-of-pocket payments and consequential poverty sustained by health problems.

According to different sources, the percentages of poor people without access to healthcare range between 5% (Arab world) and more than one-third in Africa and Asia (United Nations Development Programme (UNDP), 1997).

Mostly (in more than half of cases) healthcare services in low- and middle-income countries are still paid for by users in the form of out-of-pocket payments. This financial burden means that they go without treatment, have only restricted access to it or face crippling debts (World Health Organisation (WHO), 2008: 24). In some African countries, out-of-pocket payments by patients represent 40% of healthcare expenditures (ISSA, 2008b: 2). In low-income countries out-of-pocket payments constitute up to 60% of such spending while in high-income countries out-of-pocket payments amount to 20% of healthcare expenditures (ISSA, 2008a) or 10% according to other sources (ILO, 2007: 15).

Composition of health expenditures in high-, middle- and low-income countries, population-weighted averages, 2002

	Total health expenditures (% of GDP)	Public health (% of total health expenditures)	Social security expenditures (% of total public health expenditures)	Private (% of total health expenditures)	Out-of-pocket (% of private health expenditures)
East Asia and the Pacific	5.21	35.29	39.35	64.71	91.86
Eastern Europe and Central Asia	5.93	61.33	41.35	38.67	85.10
Latin America and the Caribbean	7.04	50.27	32.50	49.73	74.28
Middle East and North Africa	4.83	44.92	23.60	55.08	84.77
South Asia	5.45	23.66	8.04	76.34	97.08
Sub-Saharan Africa	5.32	39.58	1.92	60.42	79.17

Source: World Bank, 2006, *Health Financing Revisited, A Practitioner's Guide*, p. 41

Privatisation, cost recovery, user contributions: strong trends and varied solutions

In developed and emerging countries with a social-democratic or republican tradition, non-public and charitable organisations with private or non-profit status had a large part in constructing national systems to finance and administer social security and are recognised and included in these national systems, but have remained distinct from the public authorities. In many cases they are associated with organisations representing certain categories of workers, ideological currents or religious beliefs, and in some instances offer a wide range of medical care services.

Governments in Europe and also in other countries (including Tunisia, Morocco and Algeria) have defined the activities performed by mutual benefit societies. The legislation in these countries enables these organisations to implement in the social and health domains mechanisms recognised by the public authorities.

"The difficulties which have arisen in countries where compulsory sickness insurance is one hundred percent in the hands of the public sector, are making such countries consider the new role which could be played by non-profit organizations which fall between the public and the private commercial sectors" (Coheur, 2008: 10-11).

The development of profit-making organisations in the healthcare sector together with the liberalisation of the prices of services (in certain European countries) illustrate "a comparative trend towards growing commercialisation in healthcare" (Hermesse, 2008: 7), and of course now private non-profit organisations are facing competition of various types from private insurers.
In most cases the idea behind letting insurers and healthcare providers compete amongst themselves is to improve the value for money of the care provided. Patients are increasingly being regarded as customers who form part of a market-based system. In the Netherlands, patients choose their insurers and the type of cover they want, and in the United Kingdom they can select the care provider based on information on the quality of care given, the cleanliness of the establishment and even parking facilities.
The main danger of such practices lies in the performance targets pursued by insurers, whose approach runs a high risk of leading to the selection of applicants for their services, leaving the most high-risk 'customers' or treatment in the hands of non-profit associations or, as a last resort, of the public sector. However, some of the countries concerned are putting "in place various corrective mechanisms to offset this risk" (Hermesse, 2008: 10). Moreover – in Europe in particular – non-profit public or private institutions which are stakeholders in social security systems, legislation, collective agreements, etc. are implementing a range of tools which are managing to contain or keep tabs on this competition from the private sector.

Undoubtedly, emerging countries and their city-dwelling middle classes (like to some extent their counterparts in developing countries) could provide new prospects for private insurers. With only a minority of civil servants who are still covered by existing social security systems but who could opt for complementary services (provided by private, community-based or non-profit organisations) and poor communities of no interest to private insurers, the target group is far from negligible and the range of services needed is relatively wide. Teachers have a key role to play in this context, both as a target audience and in terms of informing and training young people.

But for most people living in poor countries, competition is a flawed argument because they have insufficient funds to make a creditworthy request. Governments can provide funding, albeit limited to basic treatment. Meanwhile, in many cases private insurers offer complementary services to the higher echelons of the middle classes, who are entitled to a contact organisation (cooperative, trade union or mutual society) or a direct offer of social security from the public services.

Be that as it may, cover of health risks today is still on the whole a long way from being the norm worldwide.

Composition of health expenditures in high-, middle- and low-income countries, population-weighted averages, 2002

	Total health expenditures (% of GDP)	Public health (% of total health expenditures)	Social security expenditures (% of total public health expenditures)	Private (% of total health expenditures)	Out-of-pocket (% of private health expenditures)
Low-income countries	5.30	29.14	6.18	70.86	92.84
Lower-middle-income countries	5.60	41.59	35.55	58.41	86.02
Higher-middle-income countries	6.18	56.27	53.43	43.73	82.93
High-income countries	10.37	65.15	43.95	34.85	55.78

Source: World Bank, 2006, *Health Financing Revisited, A Practitioner's Guide*, p. 41

These key findings hold ground whatever divergences there may be in the figures. Over the last twenty years, the public health debate focused on the sustainability of caregiving organisations. The notion of 'cost recovery' via user participation (Bamako Initiative in 1987) has played a key role. For a short while now, the limits and perverse effects of the applications of this notion have been publicly discussed, with a specific focus on the most vulnerable population groups.

Lessons learned from a number of recent initiatives

Our focus here is on protection mechanisms based on prepayments (deduction at source or contributions) via an organisation that is distinct from the care provider and where the prepayment is linked to a capitalisation or allocation mechanism (the distinction is not always clear and hybrids are possible combining allocation for specific treatment and capitalisation for complementary treatment).

There are many obstacles preventing access to healthcare. Its cost is one of them. "That is why extension of the supply of services has to go hand-in-hand with social health protection, through pooling and pre-payment instead of out-of-pocket payment of user fees." (WHO, 2008: xvi).

Low-income countries have little or no stable tax revenue, which make it virtually impossible to put in place a national health system financed through taxes. Furthermore, as we will see, crucial issues and draconian restrictions still surround systems involving a personal, family or community contribution.

In addition, sickness insurance systems covering the formal sector such as civil servants or employees only cover a small percentage of the population since most of the population work in the informal sector.

Community-based health protection systems which were developed to cover the informal sector only affect a very small proportion of this part of the population. Moreover, in many cases too few people take part (or their numbers grow too slowly) to make them viable (ISSA, 2008a: 3). Looking at the situation in African rural communities for example, community health microinsurance (HMI) schemes only impact on approximately 1% of the population in West Africa (Waelkens & Criel, 2004). Membership and penetration rates remain very low, rarely exceeding 10% of the target group (De Allegri et al., 2006).
Many other factors also hinder small-scale community initiatives based on voluntary prepayment towards an allocation system (mutual health organisations) or capitalisation system: a lack of financial resources on the part of the communities and also the precarious and irregular character of the income; the lack and unreliability of healthcare provider organisations; inadequate quality of the healthcare provided; lack of understanding and mismanagement from the organisations and funds; a lack of trained personnel and skills and motivation on the part of the local managers – most of them volunteers (Fonteneau & Galland, 2006); limited[1] extent or inadequacy of risk coverage vis-à-vis potential local care providers or the local medical community (Gbénahou, 2008; Nyssen, 2008), adverse selection.[2]
All these initiatives show that no model on its own can effectively contribute to the extension of health coverage.

Health protection put on the international agenda

In recent years, more specific very local initiatives have been established in countries in transition (CITs) and developing countries – some of them very poor – and/or countries with a very weak State apparatus (for example the Democratic Republic of Congo). These national or foreign initiatives whereby organisations are under a contractual obligation to pay for the healthcare of their personnel, relate to a very general ILO recommendation dating from 2001 (Convention 102-130 and Recommendation 134).

More innovatively, at the initiative of small medical bodies (health centres) or even individual doctors, small-scale collective insurance systems are being set up in close consultation with users. Initiatives of this type, supported by health professionals (e.g. the *Association des médecins de campagne* (association of rural doctors) and community health centres in Mali) do not remove all the above obstacles with regard to community mutual societies but do deal with two of them: the issue of confidence and the issue of combining the ability to pay and access to proximity treatment (geographical and social proximity).

But it is mainly at a 'high' level, via a range of international initiatives intended to support the health systems of developing countries that pursuit of the objectives of collective healthcare cover and a trend towards universal systems are now asserting themselves in international public health agencies and the national policies of certain countries. It could be said that the international community ('global players' and also NGOs and civil society organisations (CSOs)) have become acutely aware of the health issue in developing countries and CITs. The reasoning behind this as follows: health depends on the performance and quality of health systems, and this is impossible to assess in the absence of broad access. This access is still

[1] Specifically due to premiums which are very low so that the effects are felt by as many people as possible.
[2] For an assessment of the determining factors regarding joining community systems based on voluntary contributions, see Failon & Defourny (2008), Waelkens & Criel (2004), Fonteneau (2003).

very limited, uneven and economically ineffective because it is not available to either the vast majority of or minorities of disadvantaged citizens. Therefore it is important to find means to socialise the costs involved in achieving this effectiveness and fairness by reducing the share of individual out-of-pocket payments and sharing the risk over a community that is large enough to contain the risk of adverse selection.

Between 2002 and 2008, international health aid doubled[3], but 1.3 billion people remain deprived of all access to healthcare. The extent of international aid confirms a growing consensus among 'global players' to put back on the agenda public coordination and regulation of basic services, with a clear priority being given to health. This renewed commitment to the objective of collective health cover brings together two major ideas – the expansion of risk pooling, and solidarity – and has arisen in the wake of the overhaul of various international paradigms:

- drafting of the Millennium Development Goals (MDGs) in 2000, revision of the Paris Declaration aid policies, monitoring of new budget support-related initiatives and experience with SWAps (Sector-Wide Approaches) in public health;

- new consensus on social security initiated by ILO in 2001 and the campaign to extend social protection implemented by STEP since 2003;

- Abuja Declaration of African health ministers in 2001, with the commitments to allocate 15% of government funds to health, to cancel countries' foreign debt and to achieve a contribution by OECD countries of 0.7% of their GDP for official development aid;

- repeated reports of a worsening health and medical situation for poor groups in the populations of CITs and developing countries and of the perverse effects of regulation of the demand for healthcare via out-of-pocket payments by users;

- proliferation of multilateral, plurinational and joint initiatives and forums aiming to support the development of sustainable financing systems for health and universal health protection systems, in particular via social sickness insurance systems in transitional and developing countries: WHO (2005), Providing for Health (P4H) (France, Germany, World Bank, ILO, WHO 2007), G8 (Saint Petersburg 2006, Heiligendamm 2007, Tokyo 2008).

- the Brussels conference on health system financing and the social protection of health (March 2009) which aimed to develop a European health protection policy for developing countries.

In accordance with his commitment at the Saint Petersburg meeting, on 15–16 March 2007 President Chirac held an international conference in Paris on *Health insurance coverage in developing countries: breaking the vicious circle of illness and poverty*.

One year later, France held a second conference on 7 May 2008 with a view to pursuing international mobilisation in this respect. This conference brought together high-level

[3] Unprecedented growth, due in part to mass vertical-fund initiatives and activities of foundations specifically focusing on certain afflictions and illnesses – activities whose stimulating effects on the weakest health systems are highly arguable.

representatives from more than 30 countries, international organisations and associations to discuss *Social health protection in developing countries: who will pay?* It achieved the following results

- increased mobilisation in terms of the dynamic between health, growth and combating poverty;
- an agreement from certain special funds (the Global Fund to fight Aids, Tuberculosis and Malaria (GFATM) and the Global Alliance for Vaccinations and Immunisation (GAVI)) to contribute to financing health systems in beneficiary countries;
- a recognition of the variety of approaches and initiatives that are possible in order to achieve innovative financing for social health protection;
- the declaration of Heads of State and Government of the G8 at Toyako in July 2008 again emphasised the need for partner countries to work towards sustainable, fair financing of health systems.

From the international agenda to establishment of universal health protection mechanisms tailored to individual countries

A number of developing countries have established social security mechanisms – in the form of social health insurance – for workers in the formal sector, and also support to a greater or lesser extent various types of voluntary insurance for individuals in the informal sector. Dozens of mutual initiatives for operators in the commercial informal sector have been supported by cooperation agencies in West Africa. This means that a minority are covered by a system of direct social security – in most cases, the individuals concerned are public sector employees or employees working in the formal private sector (ISSA, 2008b: 2). Strictly public systems may be complemented by professional insurance or mutualisation systems offered by non-profit organisations (mutual health organisations, cooperatives, trade unions, etc.). In many cases, these formal sector employees or, in any case, the 'easiest' members of this group are also targeted by offers from insurers.

Certain countries, of their accord, have gone further by launching a universal health protection system. They have made concrete commitments by substantially increasing their budget for health and making support for mechanisms providing health insurance and social protection for health a key component of their public health strategy (Rwanda: gradual extension of social security to cover the whole population by increasing the number of regional mutual societies and providing grants to enable the poorest members of the population to participate; Ghana: extension of the national social insurance system financed via the tax system to a growing proportion of the population).

Towards a combination of health financing mechanisms

Although there is still discussion about a number of theses in terms of new ways of developing collective systems for covering healthcare with a view to reducing the share of out-of-pocket payments by users (especially the viability of general social insurance systems and the appropriateness of abolishing user payments), a consensus appears to be emerging about the following bases for developing countries (GTZ, 2005; Carrin, 2004). The extension

of collective healthcare coverage via a standard (turnkey) model will not resolve the problem and the solution should combine and coordinate various existing systems for financing healthcare (taxes, health microinsurance, social insurance financed by taxation, individual payments, private insurance, international aid).

Such coordination – together with the demand for protection for the poorest members of society and vulnerable social groups and also the objective of reducing user payments or linking them to income (while not limiting cover), with a view to moving towards a system of universal cover – require public financing (supported in most cases by foreign aid). Above all it requires the definition of health policies and regulation, legitimately managed by a public authority. Now, in many countries international aid is provided, but it cannot meet this second requirement, and of course if reduced to the status of individual customers, users only have a limited participatory ability to exercise their rights. Add to that a widespread lack of confidence in public authorities in many countries and you can see what role could be played by profession-based mutual systems which could spread confidence beyond fixed categorial boundaries. This would enable them to take part in national health policy negotiations, not only with public institutions and community organisations but also with market operators. Professional education organisations are ideally placed to play this role which is typical of civil society organisations (CSOs), which involves managing confidence and acting as a partner in health system management.

Reonnecting public health systems with structuring issues (mutualisation) regarding care requests

Emphasis has been laid on how traditional development donors are showing renewed interest in community mechanisms for prepayment of healthcare, as revealed by a number of recent studies from public health organisations (e.g. WHO, 2008). Accordingly, the discussion on the organisation of health systems has rapidly come up against the issue of access.
"There is a substantial body of evidence on the comparative advantages, in terms of effectiveness and efficiency, of health care organized as people-centred primary care. ... Care that exhibits these features requires health services that are organized accordingly, with close-to-client multidisciplinary teams that are responsible for a defined population, collaborate with social services and other sectors, and coordinate the contributions of hospitals, specialists and community organizations." (*ibid*, p. xvii).

Unlike the microfinance institutions sector which developed out of novel strategies bringing together public authorities, private financial organisations, NGOs or CSOs and international organisations, the health insurance and social protection sector remains very isolated and very local (Poncelet & Pirotte, 2008: 9). In addition to the healthy practice of comparing notes on their experiences, the idea of coordination between community mechanisms and national institutionalised mechanisms in the formal employment sector could be put forward as a strategy for extending health coverage (Coheur, Jacquier, Schmitt-Diabaté & Schremmer, 2007: 2). In addition, the direct and indirect lessons learned by ILO-STEP can provide a database which reduces the gaps between these sectors which are too often kept separate from one another.

In this regard, in just addressing the request for treatment we must of course admit that we have left the other side of the issue in the dark, i.e. the supply or state of the health system (institution providing services in the strict sense) in emerging or developing countries. This

system depends on a wide range of national stipulations and also more or less stringent requirements of international public health organisations. And nowadays mention must also be made of a completely 'new' range of services provided by international foundations and vertical funds which in many countries mobilise more resources than the health ministries.
But of course there is no sense in a policy aiming at collective structuring of the request (prepayment, insurance, mutual society) if it makes no reference to the public health policy regulating care. However, note that the efforts made to establish collective mechanisms for participatory assessment of healthcare provision took too little account of the issue of mutualisation and the sustainability of user resources. This lack of coordination means that mutual organisations which continue to have a firm foothold in the public sector and their members' experience will be particularly useful.

Medium-term challenges

A consensus about working on universal healthcare cover is now growing among the various international authorities, many donors and the countries concerned. However, the new prospects which are opening up in the medium term with regard to cover of illness are posing direct challenges to mutual organisations.

1. Against a backdrop of a renewed demand for healthcare cover (Maccatory & Paul, 2008) and the recognition of affordable access to quality healthcare as a fundamental right, recent examples belie the apparent incapacity of many governments to define and implement a public health policy. Rather than going against appropriate action on the part of solidarity-based organisations, national health policy is essential to such action. However, in this context governments should take the initiative again without worrying about the lack of collective entrenchment of their policies and overestimate the actual participation of their citizens. For example, in many cases donors – consciously or not – foster highly inappropriate 'user anti-authority' systems. Ensuring a reliable link with the population and coordinating the protection mechanisms and the various types of stakeholder will mean that the universal health protection objective can be met in a gradual but sustainable way.

2. With a public initiative reinvigorated by the revival of international interest, private initiatives and the activities of 'global players' in public health, the fundamental guidelines for health services and financing principles are *ipso facto* not at all fair or based on solidarity nor do they match the needs of the majority of people. Therefore, mutual organisations have a role to play that goes well beyond technically organising the demand for healthcare – namely the role of a public policy partner. Original combinations of existing mechanisms and protection institutions must be launched and tested on a larger and larger scale to make progress towards universal health protection and extend cover to the entire population, especially in low- and middle-income countries.

3. If they are professionally managed with a view to their financial viability, if they inspire a climate of confidence in line with the contributions collected and if they become large enough, mutual health organisations should participate in partnership-based management (alongside public and also private organisations) of health systems. In this way they should also make a significant contribution to the extension of healthcare cover. Independent participation in central public hospitals (de Sardan & Jaffré, 2003) could greatly benefit these institutions.

4. Only collective identity and the condition community can deal with the issue that remains at the core of any pre-emptory system: confidence. This means that it has to be established how profession-based organisations can expand their catchment areas and their legitimacy beyond corporatist and categorical traditions. In this regard, it is important to integrate in another way into local societies with a view to ensuring the sustainable entrenchment of mutual health organisations.

5. Finally, in an international climate which is once again favourable to social cover of healthcare, professional education organisations should assert and recognise their key role in passing solidarity principles to the younger generations and their capacity to implement them in the quest for appropriate systems, the urgency of which is being proclaimed everywhere.

1.2. Changes in the education sector

Universalisation of publicly run schools

While the modern tradition of publicly run schools is of course more French than British or American, education-related issues and problems concerning education personnel have been at the centre of national development policies everywhere, regardless of the political regime. Private schools were much more common and respected in countries adopting the British or American educational model. Non-profit-based education (mostly of a religious nature) has played – and continues to play – a key role in countries with a Christian or Muslim tradition. However, processes of nationalisation of the public sphere have helped to put schools at the centre of the social and political agenda, leading to constant expansion of the public supervision over school systems, their content, methods, status and personnel. This has led to many 'school conflicts', and the balance found between direct management by an authority (national government, province, department, region, municipality) and more or less autonomous management by subsidised stakeholders is varied and complex. However, virtually everywhere the vast majority of schoolteachers were regarded until recently as being collective service employees (to avoid being considered 'public' service staff), and are described today as personnel in the charitable sector.

The 19th and 20th centuries saw the meteoric universalisation of schools and of the teaching profession, regardless of the regime. Teaching was at the heart of nascent public policies in all the new countries, and then in developing countries. The profession was comparatively stable and centred very much on a national public model, which provided a relatively homogeneous activity, career and social protection framework. Many teachers assumed comparatively strong union positions in the public services and were instigators of well-known social economic processes (MGEN, 2006), and representative organisations were established at international level (e.g. Education International (EI): www.ei-ie.org).

In 1966, at the initiative of UNESCO and ILO, an intergovernmental conference adopted a Recommendation concerning the Status of Teachers which defines teachers' rights and obligations for all levels of education in all establishments (public and private). Supporting teachers is generally considered a way of boosting the quality of teaching.

In 1997, teachers represented 1.6% of the world population in the age group 15-64 (Siniscalco, 2002: 7). "In 2004, there were more than 54 million primary and secondary teachers in the world. Seven countries account for more than one-half of the total number: China (11.1 million), India (6.0 million), the United States (3.3 million), Indonesia (2.6 million), Brazil (2.3 million), the Russian Federation (1.7 million) and Mexico (1.1 million)." (UIS, 2006: 21). Teachers probably represent one of the largest professional categories (in terms of staff numbers) among white-collar workers.

Difficult end to the century

The effects of the collapse of statist regimes (socialist, communist, nationalist and 'development' regimes arising from decolonialisation and independence), all of which

favoured public administration of education and health, and the repercussions of the establishment of structural adjustment programmes and of the various conditionalities arising from 'governance' principles combined to force a redefinition of the approaches underlying the work of social, health and educational services. Finally the international fight against poverty deflected the attention and priorities of the middle classes (within which teachers in many cases are a core group and play an active role) towards very vulnerable groups, meaning that the signs of a general change in the education sector were there to be seen at the end of the 20th century.

In the 1990s, structural, political, economic and cultural changes (conventionally known as 'globalisation') took place, largely as a response to market liberalisation and internationalisation, covering a growing number of services relating to education and health. National governments, together with solidarity-based and self-help organisations (of both a mutual and cooperative nature) found themselves facing a new situation, forcing them in many cases to update their traditional systems.

Whereas certain countries have a functional education system with virtually universal primary school education and in which (albeit slightly ageing) teachers have the required skills, other (generally poorer) countries will have to deal with a spectacular rise in schoolgoers ("Expected growth rates in sub-Saharan Africa will translate into an additional 24 million primary pupils in 2015 than in 2005. The Arab States can expect another 5 million pupils over the same period." (UIS, 2006: 15)). Obviously the corresponding concrete projections regarding the education 'workforce' indicate a shortfall in terms of quantity and quality vis-à-vis these projections.
Countries where teachers are on the older side need to consider rejuvenating their workforce and the shortages they may face, although in certain regions which already have a very high rate of schooling such as East Asia, Europe and America the overall number of teachers should decrease in view of demographic trends.

"In most OECD and other countries of the European Union the majority of teachers are over 40, while in many middle-income or developing countries participating in the OECD/UNESCO WEI programme, the average age is much lower. The proportion of teachers under 30 years of age is very high in some of the least developed countries, where there tend to be very few experienced teachers." (Siniscalco, 2002: 1). In Indonesia, 51% of primary teachers are under 30 and have little experience.
For these countries there are two objectives: to keep (or bolster) the teachers currently employed and to attract young people to the profession, train them and 'retain' them in the face of the development of the services markets. These two objectives are all the more difficult because of the obvious decline in teaching conditions and in the social esteem for this profession. The question is how to attract and retain teachers in view of the following observations:

- Some classes are too big. The pupil-teacher ratio ranges from 9 to 72 pupils per teacher.
- The workload varies. Working hours and teaching hours differ greatly from one country to country, with working hours ranging between less than 20 hours and more than 40 hours per week.
- Salaries are unattractive. "Teachers' earning prospects affect the decision by individuals to enter or to remain in the teaching profession." (EI, 2006: 4). According to the study carried out by Union des banques suisses (UBS, 2003) in 70 countries

spanning five continents, only "in few cities are teachers better paid than cooks, almost nowhere they can compete with engineers, bank clerks, and even bus drivers and skilled industrial workers are better paid in the majority of places studied" (EI, 2006: 5). In many 'liberalised' countries, the development of services activities has offered young prospective teachers various immediate benefits which could turn them away from working as a schoolteacher.

Education at the start of the new millennium: between experimentation and liberalisation

The weight of financial institutions (IMF, WTO) or 'governance' (World Bank) in the new conditionality affecting the means available for fundamental reforms leading to 'adjustment' (in developing countries) and liberalisation (in Central and Eastern Europe, Asia and Latin America) has an undeniable impact on national school systems and especially on those school systems that have been established most recently and are the least comprehensive – in short, the most fragile systems. In the 1990s the teaching profession was at the heart of reforms for public sectors and monopolies. There is no doubt that these reforms were completely unjustified, but we suggest that schools paid an even higher price than other sectors which were more appealing for foreign investment or more 'attractive' to aid agencies or funds (e.g. health).

In addition to job cuts following the example of most public sectors and recruitment freezes of varying durations, many other trends deflated publicly run education systems even more (and indeed even compromised them). Not only did reductions in expenditure have a long-term impact (at least in Africa in the 1990s) on schools' operational resources, but key institutions in the profession such as teacher training schools (e.g. ENS in Benin), recruitment competitions and inspection services were neglected. Of course the education of children remained a declared priority for major donors and specialist international and national institutions but taking a close look at the promoted activities, it is easy to see that they did not really combat the crisis in schools or the decline in the status of local teaching staff.
Accordingly, for example the targeted activities of cooperation agencies or NGOs with regard to specific education programmes (gender, disabilities, early vocational training, specific groups of at-risk children, etc.) established temporary pedagogical and legal 'havens' whose effects on the school were insignificant or even negative, e.g. in cases where they contributed to 'laying off' teachers for project activities or increasing the number of additional activities they needed to perform. In this way, the number of local initiatives increased in the countries which were provided with the most aid, introducing new resources, new stakeholders and approaches that were ultimately not beneficial for most teachers.

As parents were approached using many different methods to ask them to finance schools whose results were scarcely certified previously, it seemed right to give an organisational structure to their participation and make them 'education partners'. There is nothing wrong in itself with this switch from the often passive rights of a user to the 'active rights of a customer' but it does presuppose strong public regulation, which was not in place in many countries. In many cases, the external support provided to the 'parental movement' in the public and private sectors helped to increase the powers of headteachers, to accentuate the inequalities between schools or sectors, and to give rise to new education stakeholders who very quickly took the co-management opportunities available to them: parents' committees, associations of committees, parent groups with a specific religious affiliation and national

federations[4]. Although many of these committees had a lot of trouble at local level in becoming more than a restricted co-management body in the hands of a large number of headteachers, their representations acquired national or international representativeness, which is regarded by teachers' unions as unjustified and union-busting.

The (re)deployment of new religious networks contributed to increasing the sense of unease with the national system, especially if this appeared to be a secular system. It will come as no surprise that the 1990s saw a number of cases where, faced with this impasse, children were taken out of school (West Africa) and that, in a few Sahel and East African countries, there was a boom in the popularity of traditional Muslim religious forms of education.

For the last ten years, the diverse reactions of teachers' unions have been very sectional and very polarised on remuneration and social benefits issues. To a certain extent, the convergence of unfavourable factors has led teachers themselves to maintain the informal market of individual supplementary teaching, and even the proliferation of private schools. Consequently, the situation of teachers today seems far removed from the image they had as the central pillar of national education which prevailed into the 1980s. A decline in prestige, the downgrading and diversification of teachers' status and fractures in the teaching profession were hot topics everywhere when the international community was putting together the consensus on the Millennium Development Goals (MDGs) and was starting its critical reflection on the details of public development aid (Paris Declaration 2005).

[4] In the case of Benin, the support for structuring of the parents' associations and establishment of national representation for them was due in very large part to USAID and subcontracting NGOs (GRAP-OSC, 2008).

The situation by 2015

Current teacher stock and teacher stock required to reach universal primary education (UPE) by 2015

Region	Current teacher stocks - 2004 (in 000s)	Projected teacher stocks required to meet goal by 2015 (in 000s)	Difference in teacher stocks to meet goal by 2015	No. of countries	Countries with need to expand (in 000s)	No. of countries
Arab States	1,752.3	2,202.2	449.9	20	479.0	15
Central and Eastern Europe and Central Asia	1,566.9	1,369.1	-197.7	29	33.6	2
East Asia and the Pacific	9,413.7	7,359.1	-2,054.6	23	32.2	7
Latin America and the Caribbean	2,898.9	2,538.0	-360.9	30	21.1	4
North America and Western Europe	3,605.0	3,506.3	-98.7	23	89.0	5
South and West Asia	4,421.7	4,747.1	325.4	9	413.7	6
Sub-Saharan Africa	2,395.5	4,028.9	1,633.4	44	1,643.9	37
WORLD	26,054.0	25,750.7		178	2,712.6	76

Source: UIS, 2006, Teachers and Educational Quality: Monitoring Global Needs for 2015, p. 42

These figures only cover primary education. Although it is hardly possible to distinguish rejuvenation of teacher stocks from new teaching jobs and although the background criteria may change (*x* children per class, per teacher), it is clear to see that the vast majority of the new jobs required need to be created in three regions (sub-Saharan Africa, Arab States, South and West Asia) and in a few specific countries experiencing a clear demographic decline.

The table below indicates that a growth at secondary level has taken over from a decrease at primary level and that this has been a clear trend already since the start of the new millennium in regions where primary teacher stocks had already increased substantially and also in regions where they should continue to grow until 2015. Note also that the Arab world, like Latin America, saw its secondary teacher stocks double in 13 years.

Change in the number of primary and secondary teachers between 1991 and 2004

Region	Primary teachers		Secondary teachers	
	In thousands		In thousands	
	1991	2004	1991	2004
Arab States	1,243	1,761	871	1,697
Central and Eastern Europe and Central Asia	1,736	1,539	3,127	4,058
East Asia and the Pacific	8,860	9,444	6,240	8,700
Latin America and the Caribbean	3,070	2,940	1,538	3,284
North America and Western Europe	3,153	3,589	4,451	4,913
South and West Asia	2,995	4,769	2,628	3,900
Sub-Saharan Africa	1,713	2,377	634	1,060
WORLD	22,771	26,420	19,490	27,613

Source: UIS, 2006, p. 22

The Arab States will see teacher numbers rise by 26% (450,000 extra teachers), while in South and West Asia 325,000 new teachers will be needed. Sub-Saharan Africa will have to recruit 1.6 million new teachers (i.e. an increase of 68%) between 2004 and 2015 to cope with the increase in its schoolgoing population (UIS, 2006: 41).

To meet the MDGs, which include universal primary education and gender equality, some four million teachers would need to be recruited by 2015 (Senou, 2008: 2).

As well as these trends, the priority which is given by donor organisations to the MDGs (of which two directly relate to basic education: universal primary education and gender equality in 2015) and which is related to demographic pressures, and deployable resources also provides an insight into the scale of the global challenge in terms of education and into the promised transformation of the work of a teacher.

Looking beyond the figures, it is worth stressing the structural factors which will continue to underpin the 'deconstruction' of the profession, specifically where the quantitative needs are most pressing and where the conditions required for earning an income and having access to minimal social protection are most precarious or unequal or are declining the most.

- We are witnessing the extension of market forces, and more generally cost recovery and the spectacular development of private education (especially in secondary education) or hybrid forms of education (known as community-based education). According to Vinokur (2004), the decline and also the calling into question of the public national model in many CITs reveal a highly heterogeneous sector in terms of its stakeholders and processes. This means that the customary criteria distinguishing private and public, profit-making and non-profit, and public

initiative and community initiative, etc. are now deceptive. The development of private education mainly targets, and will continue to target, secondary education. In a country such as Madagascar (UNESCO, 2006), half of all secondary school pupils attend private establishments vis-à-vis one-fifth at primary level.

- Although schools have never managed to rid themselves of reproducing social inequalities, school systems as a whole have also excelled at individual and collective social promotion. However, the qualitative differentiation factors have become very powerful in most emerging and developing countries where minority excellence exists alongside poor quality schools for large swathes of the population. The demand for teaching excellence often goes hand in hand with a form of privatisation and in certain cases benefits from international partnerships (Vinokur, 2004).

- Professional profiles: hundreds of thousands of contract teachers were recruited recently using assessment procedures more or less laid down by the public authorities, who are not always their employers. Very often, students without teacher training or professionals joined the classes in the subsidised or non-subsidised public education system, community education or in strictly private education. Only recently have cooperation organisations understood the importance of gradual integration into the civil service of contractual staff who have been hired by publicly run schools for over 10 years in some cases[5].

- Status: a lot of these new teachers are recruited on a temporary basis and remain outside their country's civil service. Significant minorities receive salaries negotiated with the management of establishments, or even in certain cases with parents' associations and 'representatives' coming from union organisations or proposed by teachers at the relevant school. In many countries, everything points to the prospect of increasing diversification of entrance and exit routes for the teaching profession and very flexible and very diverse career paths for teachers (including an increasing proportion of female teachers) even within a single country or indeed within a single establishment.

These contractual teachers, private-sector employees and 'volunteers' do not join the civil service. This new category of teachers also includes 'community' teachers for which the community, fairly recently established municipal institutions, NGOs or parents are responsible.
To cope with the demand for teachers, many countries – such as Benin or Senegal – call on the services of "new teachers" (Senou, 2008: 2).

[5] Thus in the Democratic Republic of Congo, under the leadership of the British Department for International Development, support is planned for the 'mechanisation' procedure, enabling the Congolese government to extend the privilege of a public salary to thousands of contractual teachers – in the civil service this salary only represents a very variabe fraction of teachers' income.

Distribution of primary teachers by status in Central and West Africa, 2003 (in %)

	Guinea	Chad (1)	Cameroon (1)	Togo (2)	Congo	Senegal
Civil servants	31	33	35	35	42	44
Contract teachers	39	68	20	31	4	42
Parents	30	0	45	35	54	15

	Niger	Madagascar	Benin(1)	Burkina Faso (1)	Mali (3)	Côte d'Ivoire (2)
Civil servants	46	46	55	64	71	87
Contract teachers	50	54	16	24	8	13
Parents	4	0	29	12	21	0

Source: UIS, 2006, p. 86
(1) Data refer to 2002
(2) Data refer to 2001
(3) Data refer to 2000

For a few years now, major public aid donors have tended to make education a key concern via programmes to combat poverty and their 'strategic documents'. In many cases, these policies have played a role in accentuating and institutionalising the individual statuses of new teachers. Note that while teachers' salaries often appear to be a core topic for negotiations in view of the imperatives of good management of establishments (*viz.* parents' committees), the overall status of teachers (continuing training, social security, pensions, healthcare, etc.) is not taken into account as such by these programmes.

Health and social protection in a destabilised and fragmented professional environment

The few elements which were mentioned above give an indication of the background against which recent mutual initiatives for teachers in the health and social protection domain must be analysed and evaluated. The new conditions (fragmentation or diversification of the public education model) and the new composition of the teaching sector which are emerging en masse in the South and East call into question the 'achievements' of professional social protection and make innovation essential since this means planning healthcare[6], an area where the private sector is developing but at very variable rates. The teaching sector will probably retain an important role for the middle classes in most countries, but internal differences in terms of status, career and training will increase. The relationship with national governments will become less direct or exclusive and, for certain priority categories, the offers on the

[6] Certain negative trends described above with regard to education systems over the past twenty years were also seen in the health sector.

market will become more 'attractive', particularly in terms of insurance (also complementary health and retirement insurance).

Although the solidarity approach, and in particular solidarity vis-à-vis personal and family risks, seems to be asserting itself, we think that the foundations and specifics of such an approach cannot avert the need for more in-depth discussion about the changes in the contemporary situation of teachers. Our general hypothesis is that the new diverse, less secure or even 'boundary-breaking' professional and social statuses of the new cohorts of teachers and the fractures in the public/national model present new prospects for mutual solidarity, as long as careful assessments are made of the changes in progress.

- As a literate group covering virtually the whole spectrum of the middle class, the teaching profession – in spite of its increasing fragmentation – remains a driving force behind the collective call for a right to health. A number of reasons combine here: teachers' schooling prepares them for this, and indeed their role of passing on knowledge and providing citizen education requires it, but it must not be forgotten that their own concern for intergenerational transmission to their own descendants is centred not on material property but on the precious assets of health and education.

An original case is that of Senegal, which launched the Education Volunteers Project in July 1995. This project called on the services of volunteers to make good the shortage of teachers, especially in rural communities. The goals were to increase the schooling rate and to reduce the disparity between boys and girls and also between rural and urban communities. This project was initially for a fixed period, and then a more stable status was created for these volunteers: the status of 'contractual teacher'. After a four-year period, a volunteer obtains the status of 'contractual teacher'.
To provide these volunteers with healthcare coverage, the MHO (mutual health organisation) for Education Volunteers (MVE, which subsequently became MVCE after the creation of 'contractual teacher' status) was established in 1995.
While more than 80% of the volunteers gained their school-leaving certificate, only 25% have a teaching qualification.[7]

- Access to healthcare via a solidarity-based system of social protection could represent an even more appealing social benefit favouring teaching as long as salaries remain low and financial and other advantages diminish as the share of 'state employees' decreases. In certain cases, health-related social benefits (access to quality medicine) and security of existence in the face of uncertainty can bring satisfaction and indeed ensure that individuals remain in the profession.

- A solidarity-based 'mutualist' process could help to give back some semblance of unity and identity to a profession which in some cases has been destabilised by the contraction of public employee status and threatened by the market – two dangers which are often pointed out to the global players.

[7] See www.volontaires.sn to learn what criteria need to be met for an individual to be hired as a volunteer.

- In view of the great heterogeneity of social security traditions and the growing diversification of the conditions covering teachers and their careers in most countries, a 'turnkey' model is a pipe dream. Every solidarity-based social protection model should be designed in a specific manner, in terms of the organisational model, membership and the products on offer (Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), 2005).

- Against the background of the legitimate defence of the profession by traditional organisations and the subcategorial trends of today, systems could develop within the education context around reconstructed or emerging representative organisations (probably on varying bases). While many representative organisations make strenuous efforts to maintain categorial or even subcategorial positions and also suffer very much from the effects of international teaching rules, education professionals can renew their 'contract' with local societies by means of their commitment to original solutions from the social economy which are open to other professional groups.

2. Study of the involvement of teachers in solidarity-based social protection systems

2.1. Brief methodological note

This first pilot study, which has been carried out via internet, has provided an impressive amount of information in a record time and at very low cost. It starts a process of research and also of communication and networking. The parallel research carried out by CIRIEC and Pôle-Sud (University of Liège) in cooperation with the network partners also provides them with a solid framework for interpreting the results. However, an overly 'statistical' interpretation of the results should be avoided.

There is no list defining the population constituted by all the mutual solidarity-based initiatives launched by or for teaching staff or education professionals. Therefore we could not use any systematic random or nested sampling method, nor did we have reliable information on any (possibly weighted) classification of these initiatives on the basis of a determining factor (status, type of members, financial position, ideology, etc.) which would have allowed us to construct a quota-based sample which we could use to identify the relevant units and sample them. Indeed none of these initiatives are currently delimited or classified, nor have they been subjected to legal, organisational or financial systematisation. The spectrum is extremely broad (from microinitiatives through to organisations with hundreds of thousands of members; and little-known associations through to organisations that have been fully integrated (up to the point where they lose their image as a social economy organisation) into some of the most robust social security systems in the world).

The considerations above and those which follow should indicate to us that the list of mutual societies we draw up in this study is not exhaustive. It is quite possible that some members of the target group were not contacted regarding their initiatives. Other members of the target group were contacted but did not reply or did not provide comprehensive answers. Given the large differences in the knowledge and positions of the intended respondents, 'yes' and 'no' answers are not necessarily reliable in all cases and no response does not necessarily mean there is no national organisation.

The people contacted are members of trade unions, of mutual society federations, of mutual societies, academics and individuals who have no direct link with the world of solidarity-based health protection systems but who are experts who are the first point of reference when seeking information either about the health sector in these countries or about social economy organisations active in the insurance, welfare and healthcare domains. This means a very wide range of levels of involvement in the organisations.

Accordingly, the information is incomplete (due to the many non-responses) and the information which is available should be systematically verified later. But these difficulties also tell us about the heart of the matter: solidarity-based organisations from the education sector and the actual situations they face are much more diverse than expected, as are their institutional 'settings'.

Follow-ups to this study could use the following resources:

- an in-depth literature review covering international and local documents;
- interviews from a distance or in the field with recognised national social security experts;
- field studies covering typical organisations and organisations with a special significance.

Presentation of the results of the surveys

Foreword

This study aims to provide a global inventory of solidarity-based mutual social protection initiatives initiated by or for teachers.
In the autumn, a first questionnaire was compiled in three languages (French, English and Spanish) and sent to the partner networks (MGEN, AIM, EI) and distributed within the CIRIEC network. This questionnaire comprised eight questions, with the first question indicating whether the respondent knows a mutual initiative that is being researched. If they did, the rest of the questionnaire was completed.
Of some 650 questionnaires that were sent out, 90 completed questionnaires were collected by the research team. The response rate of approximately 13.8% is due to language and lexical problems and also problems with properly understanding the field of investigation (see also section 2.1). Therefore the research team warns readers against using these data. Comments are made on the following tables but they cannot be considered to be representative in any way. The tables present mutual initiatives from across the world. Of the 90 questionnaires received, only 49 featured a 'yes' answer to the first question. Given that a respondent can complete the questionnaire for a number of mutual initiatives, these 49 questionnaires cover a total of 42 mutual initiatives in 34 countries.
Following this questionnaire, we had to acknowledge that it was impossible to draw up an exhaustive inventory. As this is a pilot study, another method had to be developed to deal with this subject in more depth and to cover more countries.
Then a second questionnaire was drafted in December 2008 and sent to the 42 mutual initiatives which had been identified in the first questionnaire. The second questionnaire was also subsequently sent to mutual initiatives that were found by other means (internet research, bibliographical research, CIRIEC contacts).
Note that some mutual initiative contacts responded to both questionnaires, while others only filled in the first questionnaire or the second questionnaire. Consequently the figures and tables that are presented for the first and second questionnaires must not be compared with each other at all, meaning that they must be analysed and commented on separately.

In all, the two questionnaires sent out provided a total of 92 mutual initiatives in 36 countries for the purposes of this study (see list in annex).

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Worldwide study of the mutualist experiences of solidarity-based social protection systems initiated by or for teachers

QUESTIONNAIRE No. 1

QUESTIONNAIRE No. 1

Data were gathered in a number of stages. After this first questionnaire was drafted, it was sent out by the networks of partners. In total, some 650 copies of questionnaire 1 were dispatched; 90 responses were received (response rate of 13.8%). Of these 90 responses, 49 answered 'yes' to the first question and therefore could be used. Another notable feature is that 38% of the responses indicate the absence of the type of initiative being researched.
Most of the mutual health organisations initiated by or for teachers are located in three geographical areas: North America and Western Europe; Africa; and Latin America. Note also the complete lack of positive responses in South and West Asia and Central Asia.

- **Number of responses to questionnaire no. 1 by <u>geographical region</u>**

Geographical region	Number of responses	Positive responses	Negative responses	Don't know
North America and Western Europe	23	10	12	1
Central and Eastern Europe	5	2	3	0
North Africa	4	3	1	0
Sub-Saharan Africa	21	14	6	1
Latin America and the Caribbean	22	12	7	3
Central Asia	2	0	2	0
South and West Asia	3	0	2	1
East Asia and the Pacific	10	8	2	0
Total	**90**	**49**	**35**	**6**

❖ **Details of the number of responses to questionnaire no. 1 by <u>country</u>**

North America and Western Europe

Country/response	*Total*	*Yes*	*No*	*Don't know*
Germany	3		3	
Austria	3		2	1
Republic of Cyprus	2	2		
Denmark	2	2		
France	2	2		
Finland	1	1		
Greece	1		1	
Republic of Ireland	2		2	
Netherlands	2		2	
Portugal	2	2		
United Kingdom	2	1	1	
USA	1		1	
Total	**23**	**10**	**12**	**1**

North Africa

Country/response	*Total*	*Yes*	*No*	*Don't know*
Algeria	1	1		
Morocco	2	2		
Mauritania	1		1	
Total	**4**	**3**	**1**	

Central and Eastern Europe

Country/response	*Total*	*Yes*	*No*	*Don't know*
Poland	1	1		
Czech Republic	1		1	
Russia	1	1		
Slovakia	1		1	
Turkey	1		1	
Total	**5**	**2**	**3**	**0**

Sub-Saharan Africa

Country/response	*Total*	*Yes*	*No*	*Don't know*
Benin	1		1	
Burkina Faso	3		3	
Burundi	1	1		
Cameroon	1	1		
Congo	1	1		
Côte d'Ivoire	1	1		
Gabon	1		1	
Ghana	1	1		
Madagascar	1		1	
Mali	1	1		
Niger	1			1
DRC	3	3		
Senegal	4	4		
Togo	1	1		
Total	**21**	**14**	**6**	**1**

Latin America and the Caribbean

Country/response	*Total*	*Yes*	*No*	*Don't know*
Argentina	4	2		2
Bahamas	1	1		
Brazil	4	1	3	
Chile	2	2		
Colombia	2	1	1	
Commonwealth of Dominica	1	1		
Costa Rica	1		1	
Mexico	1		1	
Peru	1	1		
Puerto Rico	1	1		
Dominican Republic	2	2		
Uruguay	1		1	
Venezuela	1		1	
Total	**22**	**12**	**8**	**2**

Central Asia

Country/response	*Total*	*Yes*	*No*	*Don't know*
Azerbaijan	1		1	
Mongolia	1		1	
Total	**2**		**2**	

South and West Asia

Country/response	*Total*	*Yes*	*No*	*Don't know*
Bangladesh	1		1	
India	1			1
Pakistan	1		1	
Total	**3**		**2**	**1**

East Asia and the Pacific

Country/response	*Total*	*Yes*	*No*	*Don't know*
Australia	3	2	1	
South Korea	2	2		
Japan	1	1		
Malaysia	1	1		
New Zealand	1	1		
Samoa	1		1	
Taiwan	1	1		
Total	**10**	**8**	**2**	

ANALYSIS OF RESPONSES TO QUESTIONNAIRE No. 1

The following tables list the number of responses received for each question.

Question no. 1 – Are you aware in your country of one or more health mutuals intended (in particular) for teachers or alternatively initiated by teachers?

Geographical region	One	Several	No	Don't know	Total
North America and Western Europe	6	4	12	1	23
Central and Eastern Europe	0	2	3	0	5
North Africa	0	3	1	0	4
Sub-Saharan Africa	8	6	6	1	21
Latin America and the Caribbean	7	5	8	2	22
Central Asia	0	0	2	0	2
South and West Asia	0	0	2	1	3
East Asia and the Pacific	4	4	2	0	10

The first problem arising from how the questionnaire was disseminated (i.e. being sent to a few contacts in each country) was that it was difficult to know for a whole country whether the relevant country had any mutual initiatives that had been launched by or for teachers, since such initiatives are managed locally or regionally. For example, in North America and Western Europe 12 negative responses and 10 positive responses were given for the same 'region'. A similar situation is found in Africa, where we notice that identified initiatives may be local and cover small organisations. It is difficult to track down all microinitiatives worldwide.

Question no. 2 – Do these mutualist experiences take the form of:

Geographical region	Mutual	Insurance	Mutual & insurance	'Health and welfare' microinsurance	'Health and welfare' cooperative	Agreement between union(s) and insurance companies or mutuals	Other	No response
North America and Western Europe	5	3	1	0	0	3	1	1
Central and Eastern Europe	1	1	1	0	1	1	1	1
North Africa	1	0	2	0	0	0	0	0
Sub-Saharan Africa	10	1	6	3	1	1	1	1
Latin America and the Caribbean	2	3	3	3	5	3	2	0
Central Asia	0	0	0	0	0	0	0	0
South and West Asia	0	0	0	0	0	0	0	0
East Asia and the Pacific	3	3	2	2	0	1	0	0

The identified initiatives take various forms, but most are 'mutuals' (i.e. mutual societies). (Note that in Latin America the term 'cooperatives' is used.) Another initiative that is found is an agreement signed between a trade union and an insurance company or mutual society. This may appear simple at first sight, but there are two major underlying problems: vocabulary – the term 'mutual' has different meanings depending on the country – and language: the questionnaire was sent out in three languages (French, English and Spanish) and it emerged that the term 'mutual' is not understood or known in certain countries and that the French term 'mutuelle' is not translated in the same way in Spain and Latin America.

Question no. 3 – Risk cover:

Geographical region	Sickness/disability	Retirement	Hospitalisation	Death	Other	No response
North America and Western Europe	6	3	6	5	1	1
Central and Eastern Europe	2	2	2	1	0	0
North Africa	3	1	3	1	2	0
Sub-Saharan Africa	11	4	12	6	3	0
Latin America and the Caribbean	8	5	7	6	0	1
Central Asia	0	0	0	0	0	0
South and West Asia	0	0	0	0	0	0
East Asia and the Pacific	6	5	7	5	4	0

The identified mutual health organisations mainly cover sickness/disability and hospitalisation. The least commonly covered risk is death.

Question no. 4 – Are these 'mutualist' experiences intended:

Geographical region	Exclusively for teachers	Exclusively for professionals in an education sector (private or public)	For civil servants in general	For all people in an employed position	For varying categories depending on the organisations	No response
North America and Western Europe	3	3	1	2	1	0
Central and Eastern Europe	0	1	0	1	0	0
North Africa	1	1	2	1	0	0
Sub-Saharan Africa	8	2	6	4	4	0
Latin America and the Caribbean	6	3	2	0	0	2
Central Asia	0	0	0	0	0	0
South and West Asia	0	0	0	0	0	0
East Asia and the Pacific	4	4	1	2	1	0

Of the 42 listed mutual initiatives, 22 involve teachers only and 14 exclusively involve education professionals. Only 10 are open to anyone in employment. These figures show that organisations which are intended for or initiated by teachers do actually exist, which was of course the objective of the survey. It also means that teachers are asking for this type of initiative and that these mutual societies are a way of bringing teachers together.

Question no. 5 – Are these 'mutualist experiences' initiated for or by teachers generally:

Geographical region	Voluntary	Compulsory	Variable depending on the organisations	No response
North America and Western Europe	8	3	1	0
Central and Eastern Europe	2	1	0	0
North Africa	1	2	0	0
Sub-Saharan Africa	10	2	3	0
Latin America and the Caribbean	9	2	2	0
Central Asia	0	0	0	0
South and West Asia	0	0	0	0
East Asia and the Pacific	5	1	2	0

Voluntary initiatives are by far the most common among those launched for or by teachers generally. In 64.8% of cases, membership of the mutual societies is voluntary. The research team deduces from these figures that teachers appear to be asking for the services provided by mutual societies and that mutual health organisations have real potential. Consequently, the idea that teachers can be a real vector for developing solidarity-based social protection appears to be a valid basis for forming the Education and Solidarity Network.

Question no. 6 – Are these 'mutualist experiences' initiated for or by teachers:

Geographical region	Integrated in the State social security or health system	Simply recognised by the public authorities	Supported by an international partnership	Autonomous or community based	Variable depending on the organisations	No response
North America and Western Europe	1	6	0	1	2	1
Central and Eastern Europe	1	1	1	1	0	0
North Africa	3	0	0	0	0	0
Sub-Saharan Africa	1	14	4	6	2	0
Latin America and the Caribbean	2	4	0	1	5	1
Central Asia	0	0	0	0	0	0
South and West Asia	0	0	0	0	0	0
East Asia and the Pacific	5	0	0	1	4	0

In general, these mutual initiatives are recognised by the public authorities. However, few of them are integrated into the social security system of the relevant country. The recognition of the public authorities confirms the idea of the social utility of these initiatives. This is significant in Africa. The initiatives may even be backed by international, autonomous or community-based partnerships.

Question no. 7 – What is the geographical coverage of these 'mutualist experiences' initiated for or by teachers?

	Local	Regional	National	Variable depending on the organisations	No response
North America and Western Europe	1	0	10	0	0
Central and Eastern Europe	1	0	0	1	0
North Africa	0	0	3	0	1
Sub-Saharan Africa	4	4	11	1	0
Latin America and the Caribbean	2	4	7	1	0
Central Asia	0	0	0	0	0
South and West Asia	0	0	0	0	0
East Asia and the Pacific	0	1	5	2	0

This table shows that most of the mutual initiatives provide national cover, even in the countries of sub-Saharan Africa and in Latin America and the Caribbean. All the same, note that cover is provided on a national basis in theory, but that while institutions offer cover to members nationwide, in practice most of the members come from the same region.

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Worldwide study of the mutualist experiences of solidarity-based social protection systems initiated by or for teachers

QUESTIONNAIRE No. 2

QUESTIONNAIRE No. 2

The positive responses to the first questionnaire can be subdivided into two types:

- responses concerning one or more mutual initiatives that are clearly identified by the respondent (organisation name and name of an individual to contact in this organisation);
- responses indicating one or more mutual initiatives in some country, with no further details being provided. We will use the term 'organisations' for these responses.

The first questionnaire clearly identified a number of mutual initiatives. However, there were also other initiatives which were not identified – i.e. 'organisations' in various countries. Finally, the organisations which were identified in this way had to be supplemented by those organisations found in this first phase through other information sources than the questionnaire. This meant that at the end of the first phase we had a list of mutual initiatives for which we had indicative but certainly not representative data.

Given the various categories of responses to questionnaire 1 that were mentioned above, we compiled three versions of questionnaire 2, with each version tailored to one of the three main response categories.
This second questionnaire had two objectives:
1) to verify with our contacts the accuracy of the information we had on the mutual initiatives or 'organisations' thrown up by the first questionnaire and on mutual initiatives found through other information sources;
2) to obtain more information on how these mutual initiatives or these 'organisations' work and how they are financed.

Therefore this second questionnaire was disseminated to the 42 mutual initiatives (spread over 34 countries) which had been identified by the first questionnaire. However, the second questionnaire was also sent to other institutions whose existence and details had been found via additional research.
In all, some 100 copies of the second questionnaire were distributed. This questionnaire featured nine questions. In this context the responses obtained to the first and questionnaires cannot be compared since not all of the 42 mutual societies from the first questionnaire responded to the second questionnaire and other mutual societies which had not completed the first questionnaire did fill in the second questionnaire. In other words, certain mutual societies only responded to the first questionnaire whereas others only responded to the second questionnaire and some mutual societies responded to both questionnaires. Hence we drew up a list of all mutual initiatives identified during this study (see the list by country in annex). Moreover, for each question we noted the responses obtained for each mutual society that was identified. The two letters between brackets after the abbreviation indicating the mutual society are the ISO country code.

Number of responses by <u>geographical region</u> to questionnaire no. 2

Western Europe	4
North Africa	7
Sub-Saharan Africa	14
Latin America and the Caribbean	12
East Asia and the Pacific	5
Total	**42**

NB: In these 42 received responses, some of the information comes from the 42 mutual initiatives identified by the first questionnaire, while other information comes from the mutual initiatives discovered in another way.

- **Details of the number of responses by <u>country</u> to questionnaire no. 2**

North America and Western Europe

Germany	1
Cyprus	2
Canada (British Columbia)	1

North Africa

Morocco	4
Tunisia	2
Algeria	1

East Asia and the Pacific

Australia	2
Japan	1
New Zealand	1
Philippines	1

Sub-Saharan Africa

Congo-Brazzaville	1
Côte d'Ivoire	1
Mali	1
DRC	3
Senegal	7
Togo	1

Latin America and the Caribbean

Argentina	8
Chile	1
Commonwealth of Dominica	1
Peru	1
Puerto Rico	1

We were able to extract 40 mutual initiatives from the 42 responses listed above.

ANALYSIS OF RESPONSES TO QUESTIONNAIRE No. 2

The following tables list the number of responses to each question.

GENERAL INFORMATION:

Establishment date

	North Africa	Sub-Saharan Africa	Latin America and the Caribbean	South Asia and the Pacific	North America and Europe
1915 – 1950	3		1		
1951 – 1975	4	1	3	3	1
1976 – 1999		6	4	1	3
2000 or later		6	1		

	North Africa	Sub-Saharan Africa	Latin America and the Caribbean	South Asia and the Pacific	Europe
1915 – 1950	-MGPAP (MA)(1946) -OMFAM (MA) (1929) -MNET (TN) (1950)		-AMD Cordoba (AR) (1919)		
1951 – 1975	-MGEN (MA) (1963) (2x) -*Mutuelle STT – SNTRI* (TN)(1967) -MUNATEC (DZ) (1965)	-MUGEF (CI) (1973)	-*Derrama Magisterial* (PE) (1965) -*Colegio de profesores* (CL) (1974) -*Asociación Hospital de Maestros* (PR) (1950)	-Teachers Federation Health Fund (AU) (1954) -Teachers Union Health (AU) (1972) -Private School Mutual Aid (JP) (1954)	-OELMEK (CY)(1953)

1976 – 1999		-MUTEC (ML) (1987) -*Mutuelle du Sud Kivu* (CD) (1997) -MVCE (SN)(1995) -*Multi Assistance de l'Education* (SN) (1988) -MUGEF (1988) (CG) -MUSA CSTT (TG) (1997)	-AMPF (AR) (1994) -*A.M de Docentes de la Prov. Del Chaco* (AR) (1982) -AMSAFE (AR) (1991) -AMDEC (AR) (1979)	- Alliance of Concerned Teachers (PH) (1982)	-*Hannoversche Kassen* (DE) (1985) -OLTEK (CY) (1983)
2000 or later		-MUSECKIN (CD) (2000) -*Mutuelle du SUDES* (SN) (2000) (x2) -MSEPFA (SN) (2005) -MSE (CD)(2003) -MUSU (CD)(2007)	-AMUDOSAL (AR) (2005)		

Note that we received no responses regarding the following mutual societies: *Asociación Mutual de Capacitadores y Emprendedores Cordobeses* (AR), *Mutual Maestra del Magisterio de la Provincia de Santa Fe* (AR), Dominica Association of Teachers (DM), *Mutuelle de l'Education de l'UDEN* (SN), NZ Post Primary Teachers' Association (NZ), British Columbia Teachers' Federation (BCTF) (CA).

Most of the mutual initiatives for which we received responses for the second questionnaire were established in the second half of the 20th century.

This table shows that mutual initiatives have existed for decades. Four were established between 1915 and 1950, including AMD Cordoba in Latin America (established in 1919) and OMFAM in Morocco, which has existed since 1929. The number of mutual initiatives has increased over time, with this trend continuing today, as witnessed by the six initiatives which have been launched since 2000.

Number of members

	North Africa	Sub-Saharan Africa	Latin America and the Caribbean	East Asia and the Pacific	North America and Europe
50-250			1		1
250-1000		4	1		
1,000-5,000		3	2		1
5,000-9,999		1			
10,000-50,000	2	2	3	2	1
50,000-100,000			1	1	
100,000-250,000	1	2	1		
>250,000	3			1	

No trends in terms of geographical regions were established on the basis of the received responses regarding the size of mutual initiatives covered by the second questionnaire.

	North Africa	Sub-Saharan Africa	Latin America and the Caribbean	East Asia and the Pacific	North America and Europe
50-250			-AMDEC (AR) (198)		-OLTEK (CY) (98)
250-1000		-MUSU (CD) ((279) -MUSECKIN (CD)(700) -MSE (CD) (950) -MUSA-CSTT (TG) (406)	-Dominican Association Teachers (DM) (610)		
1,000-5,000		-*Mutuelle du SUDES* (SN) (1,331) -*Multi Assistance de l'Education* (SN) (1,500)	-*AM Capacitadores et Emprendedores Cordobeses* (AR) (1,000-5,000)		-OELMEK (CY) (3,010)

		-MSPFA (SN) (1,200 beneficiaries)	-*Mutual Maestra del Magisterio de Santa Fe* (AR) (>5,000)		
5,000-9,999		-MUTEC (ML)(7,650)			
10,000-50,000	-*Mutuelle STT-SNTRI* (TN) (12,000) -MNET (TN) (10,000)	-MUGEF (18,730) (CG) -*Mutuelle du Sud Kivu* (CD)(38,243)	-*AM del Chaco* (AR) (over 10,000) -AMSAFE (AR) (12,000) -AMD Cordoba (AR) (21,000)	- Alliance of Concerned Teachers (PH) (14,000) -Teachers Union Health (AU) (21,000)	- BCTF (CA)
50,000-100,000			-AMPF (AR) (73,000)	-Teachers Federation Health Fund (AU) (92,000)	
100,000-250,000	-OMFAM (MA) (210,800)	-MVCE (SN) (135,000) -MUGEF (CI) (221,229)	-*Derrama Magisterial* (PE) (approx. 280,000)		
>250000	-MUNATEC (DZ) (277,453) -MGPAP (MA) (386,467) -MGEN (MA) (351,334)			-Private School Mutual Aid (JP) (478,856)	

Note that we obtained no data regarding the following mutual societies: *Mutuelle de l'Education de l'UDEN* (SN), *Colegio de profesores de Chile* (CL), *Asociación Hospital de Maestros* (PE), *Hannoversche Kassen* (DE), AMUDOSAL (AR) and NZ Post Primary Teachers' Association (NZ).

The mutual societies vary greatly in size (based on number of members). Most of them have between 10,000 and 50,000 members. There are also small organisations (250-1,000 members) and very large organisations (>250,000 members), such as MGEN and Morocco's MGPAP.

Target audience

	North Africa	Sub-Saharan Africa	Latin America and the Caribbean	East Asia and the Pacific	North America and Europe
Teachers	1	7	6	3	3
Professionals of one educational sector (private or public)	3		3	1	
Civil servants	2	2			
Any person in employment		5	2		1

In view of the slant of the questionnaire, it is only natural in our opinion that most of the received responses involve initiatives whose target audience is teachers or education professionals.
Note that we have no data for NZ Post Primary Teachers' Association (NZ) or for AMUDOSAL (AR).
Half of the mutual initiatives which are presented in this table are strictly for teachers only. The nature of the teaching profession, which is fundamentally federative, means that mutual initiatives for teachers can be developed in every geographical region of the world.

Question no. 1 – Who set up this 'health and welfare' initiative?

	North Africa	**Sub-Saharan Africa**	**Latin America and the Caribbean**	**East Asia and the Pacific**	**North America and Europe**
Teachers only	-MNET (TN)	-*Mutuelle de l'Education de l'UDEN* (SN) -MVCE (SN) -*Mutuelle du SUDES* (SN) (trade union members) -*Multi Assistance de l'Education* (SN) -MSEPFA (SN) -MSE (CD) -MUGEF (CG)	-*Mutual Maestra del Magisterio de Santa Fe* (AR) -AM Docentes del Chaco (AR) -*Colegio de profesores de Chile* (CL) -AMSAFE (AR) -AMD Cordoba (AR) -AMDEC (AR)	-Alliance of Concerned Teachers (PH) -Teachers Federation Health Fund (AU) (for trade union members) -Teachers Union Health (AU) (as above)	-OELMEK (CY) -OLTEK (CY) -BCTF (CA)
Professionals of one educational sector (private or public) only	-MGEN (MA) -*Mutuelle STT-SNTRI* (TN) -MUNATEC (DZ)		-*A.M. de Capacitadores y Emprendedores Cordobeses* (AR) -*Derrama Magisterial* (PE) -Dominican Association Teachers (DM)	-Private School Mutual Aid (JP)	
Civil servants in general	-MGPAP (MA) -OMFAM (MA)	-MUGEF (CI) -MUGEF (CG)			
Any person in employment		-MUTEC (ML) -MUSECKIN (CD) -*Mutuelle santé du Sud Kivu* (CD) -MUSA-CSTT (TG) -MUSU (CD)	-AMPF (AR) -*Asociación Hospital de Maestros* (PR)		-*Hannoversche Kassen* (DE)

	North Africa	Sub-Saharan Africa	Latin America and the Caribbean	East Asia and the Pacific	North America and Europe
A group of teachers	2	4	9	1	1
A trade union	1	7		3	3
A religious organisation		1			
An international partnership					
The public authorities		2		1	
Other	3		1		

In the same way as the previous question, the slant of the questionnaire as a questionnaire targeting teachers as initiators of mutual initiatives meant that most responses were received from teachers. Trade unions play an important role in establishing organisations which aim to provide a solidarity-based social protection system.

	North Africa	Sub-Saharan Africa	Latin America and the Caribbean	East Asia and the Pacific	North America and Europe
Initiative set up by a group of teachers	-MNET (TN) -MUNATEC (DZ)	-MUSECKIN (CD) -*Multi Assistance de l'Education* (SN) -MSEPFA SN) -MUSA – CSTT (TG)	-*Asociación Mutual de Protección Familiar* (AMPF) (AR) -*Mutual Maestra del Magisterio de la Provincia de Santa Fe* (AR) -*Asociación Mutual Docentes de la Provincia del Chaco* (AR) -*Derrama magisterial* (PE) -*Colegio de profesores de Chile* (CL) -*Asociación Hospital de Maestros*(PR) -AMSAFE (AR) -AMD Cordoba (AR) -AMEDEC (AR)	-Teachers Federation Health Fund (AU)	-*Hannoversche Kassen* (DE)
Initiative set up by a trade union	-MGEN (MA)	-MUTEC (ML) -*Mutuelle du Sudes* (SN) (2x) -*Mutuelle de l'Education de l'UDEN* (SN) -MSE (CD) -MUSU (CD) -MUGEF (CG)		-Alliance of Concerned Teachers (PH) -Teachers Union Health (AU) -NZ Post Primary Teachers' Association (NZ)	-OELMEK (CY) -OLTEK (CY) -BCTF (CA)

Initiative set up by a religious organisation		-*Mutuelle santé du Sud Kivu* (under the aegis of the Church in Bukavu) (CD)			
Initiative set up by an international partnership					
Initiative set up by the public authorities		-MVCE (SN) -MUGEF(CI)		-Private School Mutual Aid (JP)	
Other	-*Mutuelle STT-SNTRI* (TN) -MGPAP (MA) -OMFAM (MA)		-AMPF (AR)		

Note that we have no data for AMUDOSAL (AR).

Some 43.6% of 'health and welfare' initiatives were set up by a group of teachers, while 35.9% of them were established by a trade union. These figures support the hypothesis that teachers want and are able to develop such initiatives.

Question no. 2 – What is the organisational form of this initiative?

	Mutual society	Insurance company	Mutual society and insurance company	'Health and welfare' micro-insurance company	'Health and welfare' cooperative	Agreement between one or more trade unions and insurance companies or mutual societies	Other	No response
North America and Western Europe	1	1	1	0	0	0	1	0
North Africa	6	0	0	0	0	0	1	0
Sub-Saharan Africa	8	0	0	0	0	0	6	0
Latin America and the Caribbean	7	1	2	0	0	0	1	0
East Asia and the Pacific	3	0	2	0	0	0	0	0

Other: OELMEK (CY): solidarity-based initiative;
Derrama magisterial (PE): non-profit association;
MGEN (MA): private-law body;
MUSECKIN (CD), MUSU (CD), MSE (CD), MUSA-CSTT (TG): association;
trade union (*Mutuelle du SUDES*) (SN);
Church (*Mutuelle de santé du Sud Kivu*) (CD).

Note that we have no data for AMUDOSAL (AR)

Most of the initiatives that were identified here are mutual societies. As mentioned above, our study was not able to be exhaustive, and therefore any additional information for this table would be welcome.

With its solidarity basis, the mutual model therefore appears to fit into the health and welfare system for teachers, meaning that they can be a vector for solidarity in the solidarity-based social protection system.

Question no. 3 – Cover provided by this 'health and welfare' organisation (multiple-choice question)

We want to remind the reader at this point that the trends that are revealed below can in no way be presented as representative of the overall global situation. Our knowledge is limited by the number of collected responses and the quality of the information acquired which we cannot verify.

It is worth pointing out that we received to this question for the following organisations: OELMEK (CY), AMD Cordoba (AR), AMUDOSAL (AR), *Mutual Maestra del Magisterio de Santa Fé* (AR) and Private School Mutual Aid System (JP).

Cover for illness/invalidity

	North Africa	**Sub-Saharan Africa**	**Latin America and the Caribbean**	**East Asia and the Pacific**	**North America and Europe**
Basic illness/invalidity cover	2	9	4	1	1
Additional illness/invalidity cover	1	1			1
Basic and additional illness/invalidity cover	4	2	1	1	
No cover provided for illness/invalidity		2	4	2	1

Most of the cases where only basic cover is provided occur in sub-Saharan Africa.

	North Africa	Sub-Saharan Africa	Latin America and the Caribbean	East Asia and the Pacific	North America and Europe
Basic illness/invalidity cover	*-Mutuelle STT-SNTRI* (TN) -MGEN (MA)*	*-Mutuelle de santé Sud Kivu* (CD) *-Mutuelle du SUDES* (SN) (2X) *-Mutuelle de l'Education de l'UDEN* (SN) -MVCE (SN) *-Multi Assistance de l'Education* (SN) -MSEPFA (SN) -MUSA-CSTT (TG) -MUGEF (CG)	- Dominican Association Teachers (DM) *-Derrama Magisterial* (PE) *-Asociación Hospital de Maestros* (PR) -AMSAFE (AR)	-NZ Post Primary Teachers' Association (NZ)	-BCTF (CA)
Additional illness/invalidity cover	MUNATEC (DZ)	MUGEF-CI (CI)			*-Hannoversche Kassen* (DE)
Basic and additional illness/invalidity cover	-MGPAP (MA) -OMFAM (MA) -MNET (TN) -MGEN (MA)*	-MUTEC (ML) -MUSU (CD)	-AMPF (AR)	-Teachers Federation Health Fund (AU)	
No cover provided for illness/invalidity		-MUSECKIN (CD) -MSE (CD)	*-AM de Capacitadores y Emprendedores Cordobeses* (AR) *-AM Docentes de la Provincia del Chaco* (AR) *-Colegio de profesores de Chile* (CL) -AMDEC (AR)	-Teachers Union Health (AU) -Alliance of Concerned Teachers (PH)	-OLTEK (CY)

* We received two questionnaires. They provided different responses for the same initiative.

Cover for hospital care

	North Africa	Sub-Saharan Africa	Latin America and the Caribbean	East Asia and the Pacific	North America and Europe
Basic cover for hospital care	3	9	4		
Additional cover for hospital care	1	1		1	
Basic and additional cover for hospital care	3	2		2	
No cover for hospital care		1	5	1	2

As was the case for illness/invalidity, most of the cases where only basic cover for hospital care is provided occur in sub-Saharan Africa.

	North Africa	Sub-Saharan Africa	Latin America and the Caribbean	East Asia and the Pacific	North America and Europe
Basic cover for hospital care	-STT-SNTRI (TN) -MNET (TN) -MGEN (MA)*	-MUSECKIN (CD) *-Mutuelle de santé Sud Kivu* (CD) *-Mutuelle du SUDES* (SN) (x2) *-Mutuelle de l'Education de l'UDEN* (SN) -MVCE (SN) *-Multi Assistance de l'Education* (SN) -MSEPFA (SN) -MSE (CD)	*-Colegio de profesores de Chile* (CL) -Dominican Association Teachers (DM) *-Asociación Hospital de Maestros* (Puerto Rico) -AMSAFE (AR)		
Additional cover for hospital care	MUNATEC (DZ)	MUGEF-CI (CI)		-NZ Post Primary Teachers' Association	

				(NZ)	
Basic and additional cover for hospital care	-MGPAP (MA) -OMFAM (MA) -MGEN (MA) *	-MUTEC (ML) -MUSU (CD)		-Teachers Federation Health Fund (AU) -Teachers Union Health (AU)	
No cover for hospital care		-MUSA-CSTT (TG)	-AMPF (AR) *-AM Capacitadores y Emprendedores Cordobeses* (AR) *-AM Docentes de la Provincia del Chaco* (AR) *-Derrama Magisterial* (PE) -AMDEC (AR)	-ACT (PH)	-OLTEK (CY) *-Hannoversche Kassen* (DE) -BCTF (CA)

* We received two questionnaires. They provided different responses for the same initiative.

Cover for retirement

	North Africa	Sub-Saharan Africa	Latin America and the Caribbean	East Asia and the Pacific	North America and Europe
Basic retirement cover	1	1	1		
Additional retirement cover	5				
Basic and additional retirement cover		1	1		1
No retirement cover	1	12	7	4	2

Unlike cover for illness/invalidity and hospital care, retirement cover is rare among the initiatives and mutual societies which responded to our second questionnaire.

	North Africa	Sub-Saharan Africa	Latin America and the Caribbean	East Asia and the Pacific	North America and Europe
Basic retirement cover	-*Mutuelle STT-SNTRI* (TN)	-MUGEF (CG)	-*AM Docentes de la Provincia del Chaco* (AR)		
Additional retirement cover	-MGPAP (MA) -MGEN (MA) (2X) -OMFAM (MA) -MUNATEC (DZ)				
Basic and additional retirement cover		-MUTEC (ML)	- Dominican Association Teachers (DM)		-*Hannoversche Kassen* (DE)
No retirement cover	-MNET (TN)	-MUSECKIN (CD) -*Mutuelle de santé Sud Kivu* (CD) -*Mutuelle du SUDES* (SN) (x2) -*Mutuelle de l'Education de l'UDEN* (SN) -MVCE (SN) -*Multi Assistance de l'Education* (SN) -MSEPFA (SN) -MSE (CD) -MUSA-CSTT (TG) -MUGEF-CI (CI) -MUSU (CD)	-AMPF (AR) -*AM de Capacitadores y Emprendedores Cordobeses* (AR) -*Mutual Maestra del Magisterio de la Provincia de Santa Fe* (AR) -*Colegio de profesores de Chile* (CL) -*Derrama Magisterial* (PE) -AMDEC (AR) -*Hospital de Maestros* (PR)	-Teachers Federation Health Fund (AU) -Teachers Union Health (AU) -NZ Post Primary Teachers' Association (NZ) -Alliance of Concerned Teachers (PH)	- OLTEK (CY) -BCTF (CA)

Cover for death

	North Africa	Sub-Saharan Africa	Latin America and the Caribbean	East Asia and the Pacific	North America and Europe
Basic death cover	2	5	5	2	1
Additional death cover	5	1			1
Basic and additional death cover		1			
No death cover		7	4	2	1

In most cases where death cover is provided, this cover is only basic cover, which is provided in all geographical regions.

	North Africa	Sub-Saharan Africa	Latin America and the Caribbean	East Asia and the Pacific	North America and Europe
Basic death cover	-*Mutuelle STT-SNTRI* (TN) -MNET (TN)	-*Mutuelle du SUDES* (SN) (x2) -MVCE (SN) -MUGEF (CG) -*Mutuelle de l'éducation* (SN)	-*AM Docentes de la Provincia del Chaco* (AR) - Dominican Association Teachers (DM) -*Derrama magisterial* (PE) -AMSAFE (AR) -AMDEC (AR)	-NZ Post Primary Teachers' Association (NZ) -Alliance of Concerned Teachers (PH)	-OLTEK (CY)
Additional death cover	-MGPAP (MA) -MGEN (MA) (x2) -OMFAM (MA)	-MUGEF-CI (CI)			-*Hannoversche Kassen* (DE)

	-MUNATEC (DZ)				
Basic and additional death cover		-MUTEC (ML)			
No death cover		-MUSECKIN (CD) *-Mutuelle de santé Sud Kivu* (CD) *- Mutuelle de l'Education de l'UDEN* (SN) *-Multi Assistance de l'Education* (SN) -MSEPFA (SN) -MSE (CD) -MUSA – CSTT (TG)	-AMPF (AR) *-AM de Capacitadores y Emprendedores Cordobeses* (AR) *-Colegio de profesores de Chile* (CL) *-Hospital de Maestros* (PR)	-Teachers Union Health (AU) -Teachers Federation Health (AU)	-BCTF (CA)

In general terms, most 'health and welfare' organisations provide basic risk cover and cover for illness/invalidity and for hospitalisation. Retirement and death are less commonly covered among the listed initiatives.

Question no. 4 – This 'health and welfare' organisation is: (multiple-choice question)

	A part of the social security system or national public health system	Merely recognised by the public authorities	Backed by an international partnership	Autonomous or community-based	Variable depending on the organisations	No response
North America and Western Europe	0	3	0	1	0	0
North Africa	4	2	0	2	0	0
Sub-Saharan Africa	2	13	2	7	0	0
Latin America and the Caribbean	0	6	1	6	0	1
East Asia and the Pacific	1	3	0	2	0	0

In general, these mutual initiatives are recognised by the public authorities. However, few of them are integrated into the social security system of the relevant country. The recognition provided by the public authorities confirms the idea of the social utility of these mutual societies. This is significant in Africa. Other initiatives are backed by international, autonomous or community-based partnerships.

Question no. 5 – To benefit from basic cover in your country, membership of an organisation of this type is:

	Voluntary	Compulsory	No response
North America and Western Europe	3	1	0
North Africa	3	4	0
Sub-Saharan Africa	14	0	0
Latin America and the Caribbean	11	0	1
East Asia and the Pacific	4	1	0

Voluntary membership is by far the most common type of membership needed to benefit from basic cover. The research team deduces from these figures that teachers appear to be asking for these services and that mutual health organisations have real potential. On the basis of the received responses, this desire and need indicate that teachers can be a real vector in developing solidarity-based social protection, especially in sub-Saharan Africa and in Latin America and the Caribbean.

Question no. 6 – The rate of contributions for basic cover is:

	Fixed (same rate for everyone)	Proportionate with salary	Proportionate with salary but capped	Variable based on other criteria (e.g. number of members in the group)	No response
North America and Western Europe	2	1	0	0	1
North Africa	0	3	4	0	0
Sub-Saharan Africa	10	0	1	5	0
Latin America and the Caribbean	7	2	0	3	1
East Asia and the Pacific	2	2	0	1	0

In most cases in sub-Saharan Africa and in Latin America and the Caribbean, the contribution is fixed, but it may vary depending on the number of members in a family.
In other regions the responses are too varied to enable trends to be established.

Question no. 7 – For basic cover, contributions are:

	Deducted at source from pay	Paid by the member in cash	Paid by the member in kind (e.g. agricultural produce)	No response
North America and Western Europe	3	1	0	0
North Africa	7	2	0	0
Sub-Saharan Africa	11	10	0	0
Latin America and the Caribbean	9	4	0	1
East Asia and the Pacific	4	1	0	1

In most cases, contributions for basic cover are deducted at source (from pay), but in sub-Saharan Africa they also be paid in cash.
Our survey found no mutual society or initiative where payment was made in kind.

Question no. 8 – Under basic cover, the services provided to the insured party include (you can tick more than one box):

	Free care (without providing the money upfront) from a designated service provider	Free care (without providing the money upfront) from a service provider of his/her choice included on a list of approved/ contracted service providers	Partial reimbursement of fees charged by a designated service provider	Partial reimbursement of fees charged by a service provider of his/her choice included on a list of approved/ contracted service providers	Total reimbursement of fees charged by a designated service provider	Total reimbursement of fees charged by a service provider of his/her choice included on a list of approved/ contracted service providers	A specified number of free services paid for at a flat rate	No response
North America and Western Europe	0	0	1	1	0	0	0	2
North Africa	0	0	0	6	0	4	0	1
Sub-Saharan Africa	1	0	0	11	0	0	3	0
Latin America and the Caribbean	2	2	4	8	2	0	1	2
East Asia and the Pacific	0	1	1	3	0	1	0	1

In most cases, the insured party receives a partial reimbursement of the fees charged by an approved service provider of his/her choice. We also encountered a few cases in Latin America in which care was provided entirely free of charge.

Question no. 9 – Cover is provided for:

	The insured party alone	The insured party and his/her family	The insured party and a specified number of his/her family members	No response
North America and Western Europe	1	3	0	0
North Africa	0	6	1	0
Sub-Saharan Africa	2	9	4	0*
Latin America and the Caribbean	4	6	1	1
East Asia and the Pacific	0	2	2	1

* According to one respondent, unlimited cover was provided.

In most cases, the cover provided is for the insured party and his/her family, which can be interpreted as reinforcing the solidarity-based nature of these mutual initiatives.
In 33% of cases in Latin America and the Caribbean, cover only applies to the insured party.

Conclusion

The key characteristic that emerges from the responses is the wide range of situations which are encountered. Since our survey is not representative, no clear trends can be established – however, in every region of the world, mutual societies and mutual initiatives have been set up, and are still being established today. Teachers have played an important role in their creation and their subsequent development. It is clear that education professionals can play a key role in pursuing and expanding such initiatives. In many cases, there is still substantial potential for development, in terms of increasing the number of members and expanding geographical coverage and of expanding the range of risks/needs which are covered.
Moreover, we think it would be beneficial to complete the study which has been launched so as to improve our knowledge and more accurately reflect the reality and the diversity of the initiatives worldwide.
Please send any data that would complement or enhance the data base to the coordinator of the Education and Solidarity Network: sgrasso@educationsolidarity.org.

2.3. – Presentation of a few case studies showing the involvement of education professionals in solidarity-based social protection systems

The pilot study that was carried out to provide an indication of the situation in the field and obtain an initial overview provides insufficient information to produce a global typology of existing initiatives.
Moreover, the institutional and socioeconomic characteristics of those countries in which such initiatives are found are so different that no comparison is possible. Indeed the realities of and recent changes in the education sector across the world are as wide-ranging as the initiatives that teachers, educators and education professionals in the broad sense of the term can take to respond (more effectively) to protection requirements.

However, starting out from a few case studies based on telephone interviews, data collected from the website of an organisation and/or from e-mail correspondence with local contacts, we shall present a range of mutual initiatives encountered in our investigations, based on their origin or how they were set up.

The establishment dates of the listed organisations that are still in existence span about a century. However, in the course of our research we discovered mutual societies of education professionals which were established in the mid-19th century: for example, in Germany a mutual health insurance fund was set up in 1840 for teachers in Saxony and another was established in 1842 for education professionals and their instructors – both of these funds existed until 1940. Also in Latin America, at Valparaiso in Chile, a mutual aid society was established for primary school teachers in Valparaiso.

The mutual initiatives that were encountered involved a group with a certain structure (e.g. a union-based structure) comprising education staff, a religious organisation or even an organisation that was created at the instigation of the public authorities. In many instances, these organisations which were established at the initiative of authorities are located in countries which have a scarcely developed statist structure with an existing social security system and the possibility to organise a collective prepayment system and/or apply a deduction from salaries at source to collect funds which are intended for the mutual initiative.

The stimulus or event that led to the establishment, by or for education staff, of a mutual initiative meeting the demand for solidarity-based social protection apparently plays a key role in the further development of the initiative. The will and rationale to mobilise a group of people or stakeholders to establish the organisation and also ensure its development and continuation once the founders have left the scene appear to have a considerable impact on the chances of survival of the type of initiative covered by this study (mutual initiatives).
But the level of economic development of a country or region and of its social security system (from both an institutional point of view and in terms of the care and services available to meet the needs encountered) also appears to have a strong influence on the scale of an initiative and above all on its continuation.
Therefore, a range of prerequisites seem to have to be in place to ensure the long-term survival of a mutual initiative:

- a more or less institutional social security system or such a system that is at least recognised (and promoted) by the public authorities;
- an organised body bringing together a group of individuals around a solidarity-based mutual social protection initiative;
- the ability to deduct from pay at source to provide for payments into a mutual fund;
- a structure on a certain scale (break-even point) which is financially stable (need for regular contributions to be received and maintenance or growth in the number of members);
- sufficient human resources to organise, manage and develop the operations of the mutual initiative.

There are very few initiatives for which we were able to gather sufficient data to present these activities as illustrative cases. They do not reflect the wide range of possible legal statuses, socioeconomic and institutional contexts, establishment dates, reasons for establishment, etc. Moreover, in certain cases the initial data that were collected are incomplete and requests for additional information led to nothing, meaning that a considerable number of cases remain where data need to be unearthed.
Therefore, in terms of dealing with the difficulties encountered[8] in data collection, the Education and Solidarity Network is definitely a useful tool to identify and list other organisations and initiatives. However, if we want to develop the study and improve our analytical perspective, we must carry out a proper field study with the assistance of a specially designated contact person who has a good knowledge not only of the mutual initiative, but also of the social, economic and institutional context surrounding an initiative covered by the present study.
The initiatives which are presented below as example boxes could be the topic of a further more in-depth investigation, depending on the objectives of the Education and Solidarity Network, because they have features which would be worth analysing in greater detail. But that would require time and resources which were not available for the present study.

The illustrative case studies which are presented below have various aims:

- to start from scratch a system of social coverage or a mutual initiative (as was the case for the group of former pupils in India;
- to extend to other beneficiaries (including beneficiaries without coverage) the care or services available (see the mutual society that was established in Japan for private-sector teachers and community initiatives and mutual societies developed in Africa);
- to provide improved coverage of healthcare (complementary or supplementary coverage) (e.g. in Canada, at the initiative of the British Columbia Teachers' Federation, in Argentina the *Asociación Mutual de Docentes de la Provincia del Chaco* (Chaco Province Mutual Teachers' Association), etc.);
- to re-establish a system following a period of crisis, to respond to new societal problems or even to supplement the services of public authorities that are failing or in decline, but also dealing with the need to establish, alongside care and services, a contributory system to fund the system (mainly in Africa);
- to coordinate and extend to as many people as possible the services offered by various local or professional organisations (e.g. the development of MGEN in France).

[8] See section on methodological issues.

Finally, these cases also illustrate the wide range of partnerships and cooperation initiatives between stakeholders that are encountered in the context of establishing a solidarity-based social protection initiative.

Initiatives based around a group of education professionals

INDIA – St. Stanislaus Ex-Students Association

When, in February 2007, news spread amongst the ex-students of St. Stanislaus High School that Joe Maumkel, a man who had served their school for 60 years, was dying in hospital, a solidarity drive was launched among this group, gathering a substantial sum to support their former teacher.
Following on from this, the former pupils, who were based more or less all over the world, set up the St. Stanislaus Healthcare Initiative. This initiative provided 100 current and former teachers of the school with health insurance, giving them free hospitalisation and pre-existing illness cover. Comprehensive insurance cover was also agreed on for non-teaching staff in the event of an accident. On the school grounds ex-pupils who have become doctors also organise health camps for teachers, giving them a comprehensive annual check-up free of charge.
A document clearly sets out the procedure to follow for former pupils wishing to join this initiative and make their own contribution.
The services provided by this initiative were made possible via an agreement with the Bajaj Allianz Gururaksha insurance company and certain care organisations (Tata Aig Hospital Care and Tata Aig Maharaksha).

St. Stanislaus High School in Bandra (Mumbai) has existed for 143 years. Many famous figures attended the school.
The former pupils primarily used the internet to set up this project.

ARGENTINA – *Asociación Mutual de Docentes de la Provincia del Chaco* (MUDOC – Chaco Province Mutual Teachers' Association)

MUDOC is a mutual society that was established in 1982 by a group of teachers and now has more than 12,000 members (*socios*), most of them women due to the composition of the teaching profession in Chaco Province. Members are covered together with their spouse and children.

In Argentina, social security is organised by the government on a compulsory basis for the formal sector of the labour market (both private and public) based on a deduction from pay at source and in the case of the private formal sector a contribution by employers. In this way teachers are entitled to this public system which covers basic services and to complementary services from MUDOC upon payment of a fixed contribution.

The members are public sector teachers, headteachers and inspectors in Chaco Province, where MUDOC has no competitors in this professional segment.

Socios receive a partial reimbursement of medical expenses for illness. 40% of these expenses are paid by *socios*. This means that 60% of most healthcare costs are paid by the mutual society and the government. Hospitalisation, medicines, medical examinations and individual treatments are covered on the basis of a comparative key.

The mutual society provides compensation for income to cover the retirement of the insured party.
In the event of the death of the insured party or an immediate member of his/her family (spouse or child under 21 years old), the insured person or his/her immediate family receives a payment towards funeral or cremation expenses.

Joining this autonomous community-based professional scheme is on a voluntary basis. The contributions involve a fixed sum which is deducted from pay at source.

The major crisis in 2001, especially hyperinflation and loss of income, led MUDOC to reduce its staff and services but it overcame this "due to solidarity and without losing members". However, mutual associations specifically for administrative staff and teachers disappeared in that period.

MUDOC is recognised at provincial level by the government and, via a federation, also at national level. It receives no subsidies or technical support. Since the start of the crisis, it has even extended its cover to orthopaedic care and retirement-related services. It is not involved in any international partnerships.

Initiatives of a group of education professionals in cooperation with a religious organisation

DEMOCRATIC REPUBLIC OF CONGO -

***Mutuelle des Enseignants des Ecoles Catholiques de Kinshasa* (MUSECKIN – Mutual Society of Teachers in Catholic Schools in Kinshasa)[9]**

MUSECKIN is a mutual health organisation for teachers in Catholic schools in Kinshasa in the Democratic Republic of Congo (DRC). The organisation was established in 1998 and restructured in 2000 and numbers some 600 members and 2,000 beneficiaries.

Background

Teachers, like all civil servants, saw their salaries affected by the Structural Adjustment Plans and the socioeconomic degradation of the country in the 1980s and 1990s. The decrease in their pay was such that in 1994 the Congo National Episcopal Conference asked the parents of pupils in the subsidised Catholic network to pay an incentive bonus to teachers to top up the salary paid by the government. Since 1994, this bonus has steadily increased and now constitutes most of teachers' pay. The government's bankruptcy also damaged the claimant card system which gave civil servants access to medical treatment.

At the same time, the economic decline also affected health services. There was a 500% devaluation in the value of the local currency, and runaway inflation and increases in the price of healthcare services became commonplace. As a result, the population visited health centres less often. While basic care has remained relatively affordable, hospitalisations are no longer affordable for most of the population.

Against this background, a group of teachers from Collège St-Joseph in Gombé (Kinshasa) decided to join together to form a mutual society to help each other and facilitate access to healthcare for their families. Subsequently, the Catholic coordinating body for Kinshasa decided to extend the initiative to all Catholic schools in the city.

In 1999, the mutual society was contacted by the International Labour Office as part of the pilot Mutual Health Organisation project in DRC (feasibility study of mutual health organisations by UNDP) and was restructured to cover healthcare only (the initial project envisaged a fixed sum towards death-related expenses), with individual (non-family) cover and agreement being signed by the service provider and the mutual society.

[9] The details of this case which are given here are taken from a study conducted by Gael Comhaire (of GRAP-OSC, a University of Liège research group providing support for cooperation policies involving civil society organisations in the South), under the coordination of Prof. Marc Poncelet.
This particular mutual organisation, MUSECKIN in the Democratic Republic of Congo, was the subject of an in-depth field study, enabling more concrete information to be gathered and the difficulties that may be encountered in the operations of the mutual society to be identified more effectively.

The partner: BDOM

The mutual society signed an agreement with Kinshasa's BDOM network regarding healthcare for its beneficiaries. BDOM (the Diocese Bureau of Medical Activities) is a non-profit association of the Catholic Church in Kinshasa which also cooperates with the care network of the Salvationist Church. It provides health cover for 1,100,000 residents and is active in 24 of the 35 health districts in the city of Kinshasa, covering 20% to 25% of the primary healthcare requirements of the Congolese capital. BDOM has 48 health centres, eight hospital centres, 22 maternity units and a general reference hospital. BDOM with its reputation as one of the best providers in terms of value for money and territorial cover was chosen by MUSECKIN to sign the healthcare cover agreement.

How the organisation works and problems with managing and financing it

Membership of the mutual society is on a voluntary basis and all members can register as many individuals to be covered as they want. All services provided for MUSECKIN beneficiaries are managed and paid for by the central administration of BDOM.
New affiliates have a three-month trial period before they are entitled to healthcare cover, which means that a financial reserve can be built up with the contributions. All beneficiaries must have paid the entire amount of their monthly contribution to be entitled to healthcare cover in the month following the payment.
Each month the mutual society draws up a list of all beneficiaries (with the order being determined by their contribution) and sends this information to BDOM with the amount corresponding to the number of individuals registered as claimants for the month in progress.

The initial management of the mutual society was not effective because the organisation was run directly by teachers who had insufficient relevant training, and the lack of a system to monitor and assess the services had major repercussions.
The mutual society has received technical support from the International Labour Office's STEP programme since 2004. In early 2006, this programme contributed to creating monitoring tools, including care summaries.

Organising cover for hospital care is particularly difficult because of the general insolvency of the individuals concerned. But at the same time the costs that the population are charged for primary care are mostly affordable for individuals or are less likely to have catastrophic financial consequences for household budgets.
But in contrast with the mutualisation of risks are the costs of care.
Apart from coverage of hospital care, families pay for an individual and take care of two or more individuals on this person's account, and thus find themselves in debt to the mutual society and the care provider.

MUSECKIN has noted a sharp decrease in the number of beneficiaries/contributors (from several thousand at the start to only 1,300 in October 2007) due to the high level of new contributions requested to cover the costs involved in healthcare. An increase in members is the major challenge currently facing MUSECKIN with a view to extending its cover among the 45,000 intended beneficiaries (i.e. all the public education networks, in other words 10,000 teachers and approximately 4 individuals per family).
This lack of financing means that the basic operating costs of the mutual society can no longer be covered.

Initiatives launched by trade unions

CANADA (British Columbia) – British Columbia Teachers' Federation (BCTF)

This case study covering a teachers' federation is just one example of 15 mutual associations of teachers in Canada that provide solidarity-based social protection services. BCTF stands out from the other associations because of the close involvement of its members in the Canadian labour and trade union movement and also its radicalisation after years of crisis and tensions, resulting in very fraught relations with the provincial government of British Columbia which sets not only salaries, but also class sizes and so has a considerable influence on the conditions in which teachers work.

BTCF was established in 1917 by a group of teachers from Vancouver and Victoria. Very quickly this federation came to deal with individual issues in this region of Canada, especially those of teachers in rural communities, and invested in improving salaries and working conditions. It currently has some 41,000 members (mainly nursery, primary and secondary school teachers) and directly employs 150 staff.

It stepped up its efforts to secure social benefits and care and social protection services from the early 1980s, when the union federation found itself in a position to negotiate with the provincial government about retirement indemnities and compensation for dismissal. Then BCTF gradually developed a structure which is a hybrid of a mutual initiative and an insurance company to provide healthcare and social protection services for its members, by means of mainly basic coverage for illness and invalidity. This initiative is recognised by the public authorities.

From then on, it also laid a clear emphasis on its leading role as a driving force behind improving the living and working conditions of teachers, by means of the teachers sharing common experiences, common values and often common goals about the type of society they collectively hoped to achieve[10].

As regards healthcare provision, the members of BCTF and their dependants can choose from a list of care providers approved or directly under contract with BCTF. The contributions due for this healthcare cover are deducted from teachers' salary at source and the services supplied by care providers are partially reimbursed.

There is also a Salary Indemnity Plan, a specific programme which provides indemnities in the event of illness, accident or short- or long-term invalidity.
This means that of the 41,000 members, 1,700 teachers are currently entitled to these short- or long-term indemnities.
The contributions to this plan are set each year by the BCTF Annual General Meeting. For example, in the school year 2008-2009 every teacher is contributing 1.5% of his/her salary. 0.5% of the teacher's salary finances indemnities for periods of illness/short-term invalidity[11]

[10] See http://www.bctf.ca/AboutUs.aspx?id=3016
[11] Indemnity payments for short-term invalidity commence on the first day of the invalidity.

and 1% for periods of long-term invalidity[12] and the specific rehabilitation programme put in place to combat the stress that is specific to the profession and to enable individuals suffering from stress to return to their job, at least on a part-time basis. If it is impossible to return, retraining solutions are sought to help the teacher.

The mutual insurance organisation set up in the early 1980s has now reached a state of maturity according to its promoters.

PHILIPPINES – Quezon City Public School Teachers Association (QCPSTA)

This association is the official recognised organisation for teachers at publicly run schools and non-teaching staff at schools in Quezon City. The organisation, which brings together 9,500 teachers and 1,000 non-teaching staff members, is affiliated to the Alliance of Concerned Teachers (which in turn is affiliated to EI).

In January 2007, QCPSTA launched the Death Aid Contribution System (DACS) programme. Currently if someone belonging to this system dies, his or her family receives aid amounting to 68,000 Philippine pesos.
DACS is a mutual benefit system. Whenever a member dies, all the other members pay 10,000 pesos. This sum is directly deducted from pay. In addition to this death aid contribution, a monthly contribution of 5 pesos is automatically deducted from pay.
Death aid is paid a few days after the sum was collected.

QCPSTA organises annual check-ups. Female teachers are entitled to a free check-up (breast and gynaecological examinations) in Women's Week.
QCPSTA has also managed to raise funds to finance a medical assistance programme for retired teachers requiring immediate medical attention.

There is a social insurance system in the Philippines, and a special system covers government employees and military personnel.
The social insurance system covers private sector employees of under 60 who are earning at least 1,000 pesos per month, domestic staff and all self-employed individuals of under 60 who are earning at least 1,000 pesos.
Under the management and supervision of the Social Security Commission, the social security system[13] collects contributions and issues payments.
In the Philippines, access to healthcare appears to be related to an assessment of the individual's resources.
The national health insurance programme covers 79% of the population, for the most part workers in the formal sector. Yet 15.5 million individuals work in the informal sector. In 2003, a pilot project was launched targeting workers in the informal economy by developing microcredit cooperatives (ILO-PhilHealth).

[12] In the event of long-term invalidity, indemnities are paid for a year. Subsequently a disability or physical or mental invalidity has to be demonstrated to be able to continue to enjoy these indemnities.
[13] See www.sss.gov.ph

FRANCE – *Mutuelle générale de l'Education Nationale* (MGEN – General Mutual Society for National Education)

From the mid-19th century, teachers – especially primary school teachers – put together a vast network of mutual aid societies to cope with the vagaries of life.

The first mutual aid societies for primary school teachers, most of which were set up from the Second Empire onwards, were generally local companies whose activities cover a department of France. Between 1886 and 1944, some 110 such organisations developed in France.

In addition to these departmental mutual aid societies, at the start of the 20th century national organisations were set up specialising in taking on specific risks, e.g. the *Union nationale des sociétés de secours mutuels d'instituteurs et d'institutrices de France et des colonies* (National Union of Mutual Aid Societies for Primary School Teachers in France and the Colonies, also known as *Union des sanas* (the Sanatorium Union)), established in 1901 to build and manage sanatoria for teachers only. Another example is the *Orphelinat de l'enseignement primaire* ((Primary Education Orphanage, 1885) and *Soutien mutual* (Mutual Support), set up in 1921 to take action in the event of long-term illness.

In the 1930s, primary school teachers who were involved in mutual initiatives attempted to bring the various initiatives together in a federation, and in 1933 the *Fédération des oeuvres mutualistes de l'Enseignement public* (Federation for Public Education Mutualist Activities) was born. This organisation was renamed *Fédération nationale de l'Enseignement public* (National Public Education Federation) in 1938. Certain regions also saw organisations joining together, e.g. in Bouches-du-Rhône in 1936, in Eure and in Morocco where the *Union marocaine des oeuvres de mutualité des fonctionnaires de l'Enseignement public et laïque* (Moroccan Union for the Mutual Society Activities of Public and Civil Servants involved in Public and Secular Education) started up in 1938.

Following interruption by the Second World War and the Occupation, the Liberation saw the resumption – at the initiative of teachers belonging to mutual societies and trade unions – of the discussions about bringing together the mutual societies for teachers, in parallel with the implementation of social security.

The first French mutual health organisation, MGEN, provides protection for more than 3.3 million professionals involved in national education, research, culture, youth and sport.

Having been delegated public service and/or complementary service duties, MGEN manages social security on their behalf.
In return for a single contribution, the additional health services offered by MGEN bring together many no-options guarantees. Additional services go well beyond just health with specific services to assist affiliates in their daily life: one-off financial assistance, home help, additional income in the event of a lengthy absence from work, assistance with settling down and accommodation, etc.

In its role as a public health stakeholder, MGEN manages 33 health and medical/social establishments and, via its corporate foundation and its active partnership with INSERM (the

National Institute of Health and Medical Research) actively supports public health research. It also implements many prevention and health education programmes.

Initiatives launched by a trade union and backed by the public authorities

TOGO – *Mutuelle Générale des Enseignants du Togo* (MUGET – General Mutual Society for Teachers in Togo)

In Togo, less than 20% of the population is covered by a social security system and in many cases the social security provided is not comprehensive.[14]

The social security system for employees has two components: the prevention of occupational risks, and reimbursable healthcare expenses.
For this second component any company or institution must ensure that a medical service is provided to workers and their families. The self-employed and informal sector workers are not covered by social security.

In early 2006, social dialogue meetings were held. At these meetings the social partners and the Togolese government agreed on the need for a national policy on universal healthcare. To achieve this, a decision was taken to promote mutual associations and build a national social security system covering the whole population. This change in direction led to the establishment of mutual health organisations. Some ten of these were set up, and financing was provided through monthly contributions from members (ranging from 125 F CFA to 1,500 F CFA).

MUGET, which was set up already in 1973, targets professionals in the education sector and is recognised by the public authorities. Public education sector professionals from throughout the country can freely join the organisation.
It provides retirement and death cover but no cover for sickness or hospital care.
This mutual society is linked to the *Fédération des Syndicats de l'Education Nationale* (FESEN – Federation of National Education Trade Unions).
FESEN provides national coverage.

[14] Regional Experts Group Meeting on Social Protection entitled *Investing in Social Protection in Africa*, document presented by Ms Assoumatine Kounon, Mr Dogoumangue Danangue and Mr Denyo Komi – 9-11 June 2008 in Dakar.

CÔTE D'IVOIRE – *Mutuelle Générale des Fonctionnaires et Agents de l'Etat* (MUGEF-CI – General Mutual Society for Civil Servant and Government Workers)

The reason behind setting up MUGEF-CI was sociopolitical: in 1973, the Côte d'Ivoire government, at the request of the public sector employees' unions, established this mutual society to compensate the withdrawal of their right to free medical services.
In 1989, the management of the mutual society was transferred from the government to the trade unions and the organisation is currently in the process of stabilising its technical and financial management, all the more because the number of affiliates is above the break-even point.

The mutual society offers nationwide basic and complementary coverage for illness/invalidity and additional cover for hospital care and for death.
It provides a robust solidarity-based system based on voluntary membership, making use of contributions that vary depending on the members' income, and the support of one generation for another. The contributions (which are limited to a maximum amount) are deducted from pay.
It is a non-profit organisation which is administered democratically by its members.
The organisation has just over 220,000 members and employs 229 staff.

Up to now, MUGEF-CI signed agreements with medical partners to ensure the provision of medical services. The benefits provided to the insured party (and his or her family) are a partial reimbursement of the expenses billed by the provider whom the insured party can choose from a list of approved/agreed providers. But soon the organisation will have its first centre providing care.

This mutual society currently has international partnerships with *Association internationale de la Mutualité* (AIM – the International Association of Mutual Benefit Societies), *Union Africaine de la Mutualité* (UAM – African Union of the Mutuals) and the International Social Security Association (ISSA).

One of the challenges will be to integrate this organisation into a broader government social security system, which does not exist yet in Côte d'Ivoire.

Initiatives launched by public authorities

JAPAN – Private School Personnel (Teachers and Employees) Mutual Aid Association

Japan has two health insurance systems:
- A national health insurance system for everyone living in Japan who is not covered by the health insurance programme for employees. This insurance is managed at regional level.
- A profession-based health insurance system which covers employees and their dependants. Employees of companies of a certain size and their employers form a health

insurance association. For individuals working in smaller companies, the government arranges collective health insurance financed by contributions from both employees and employers. For other professions and for civil servants, national associations were set up. Finally, the government also provides a collective health insurance system for seasonal workers, temporary workers, etc.

As regards education personnel, Japan has mutual aid systems for teachers at private schools, government-run schools and local publicly run schools. The services offered by these systems are the same.
The following associations provide these services:
- the Local Public School Mutual Aid Association: all teachers of local publicly run schools are members of this association. It provides pension, invalidity and widow(er)'s benefit and benefits for sick and injured people and victims of natural disasters;
- the National Public Service Mutual Aid Association and the Japan Mutual Aid Association of Public School Teachers which offer the same services and benefits to national (government-run) schools and their teachers;
- the Private School Personnel (Teachers and Employees) Mutual Aid Association.

The Private School Personnel (Teachers and Employees) Mutual Aid Association is a mutual society which was established in 1954 by the public authorities. It has some 480,000 members and employs 1,500 people.
This mutual society is part of the Japanese social security system, but only covers private sector education professionals; all teachers from a private school must join, but a number of private universities (e.g. Keio University) are exempt from this obligation.
The contributions are deducted from pay and vary depending on that pay. They entitle members and their family to receive a partial reimbursement from an agreed provider.

These three systems were established by the public authorities and are integrated into the national public health system. Membership is compulsory.
Some of the fees for health services are reimbursed to the user.
Japanese patients can be treated in either a private or public hospital without any restrictions (including geographical restrictions).

Community initiatives

There are also many community initiatives, e.g. in the form of health microinsurance. These initiatives have been analysed in depth in other studies, especially in sub-Saharan Africa. Microinsurance activities of this type were supported by the STEP programme (Strategies and Tools against social Exclusion and Poverty) of the International Labour Organisation (ILO) Social Security Department. We will now cite a few conclusions from a summary of a study coordinated by Prof. Marc Poncelet[15], as these initiatives may be very instructive.

[15] "Mutuelles communautaires de santé en Afrique subsaharienne : synthèse", Julie Failon of the PôLE SuD research and teaching centre at the University of Liège and the same university's GRAP-OSC research group providing support for cooperation policies involving civil society organisations in the South.

Following the withdrawal of the public sector from health financing, health microinsurance systems have been set up in the past 15-20 years in sub-Saharan Africa to improve the access of destitute groups to primary healthcare. Not all of these health microinsurance systems are viable – some of the initiatives remain in the experimental phase – or functional (success rate of approximately 50%), but the number of these systems is increasing, especially in West Africa.[16]

As a result, the realisation and consensus today among major international organisations that large-scale social protection systems need to be developed will enable some of the above-mentioned difficulties to be overcome and will play a role in establishing a link between these community initiatives and more solid organisations which are developed on a larger scale and which provide cover for more people.

There are not only important needs that must be covered, but also opportunities for all partners in the Education and Solidarity Network to set up new initiatives in countries where we note an actual expectation of and demand for aid and cooperation with a view to implementing sustainable structures which aim to implement a solidarity-based social protection system for education professionals.

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Notwithstanding these examples of the global involvement of education professionals in solidarity-based social protection systems, the picture remains blurred and above all incomplete – but this study is only the start.

However, the study, which was conducted with limited resources, yielded a number of findings:

- the substantial interest of the subject of analysis, since very little information is available about this area;
- the conceptual problems involved in the term 'mutualism';
- the structural prerequisites that need to be in place to implement mutual systems, both in institutional terms and in terms of mobilisation of stakeholders;
- the assets of the network partners (mutual society members, education personnel trade unions, representatives of the umbrella international organisation for mutual benefit societies and of the worldwide STEP programme which works on extending social security in the health domain) vis-à-vis the ambitious nature of the project because they can support each other's actions;
- the need to pursue the investigation so as both to enhance the data base of mutual initiatives and to describe more experiences of initiatives with a view to determining all their aspects and their respective assets and contributions.

Of course the financial challenges in terms of healthcare and social security systems are huge. However, in the various cases encountered, there is real and substantial potential for projects by members of the Education and Solidarity Network.
Due to their profession, their experience and their own networks, all network members have all the assets they need to help to set up and develop mutual initiatives which establish sustainable solidarity-based social protection systems.

[16] See the summary in section 1.1.

The network partners also clearly have a major role to play, with their ability to mobilise stakeholders and resources, their contribution of expertise in the field to develop a project and their medium- or long-term presence alongside local stakeholders.
Not only may the partners be the initiators of new mutual initiatives for solidarity-based social protection – they may also strengthen and perpetuate existing initiatives (some of which may be in decline). They may work on institutional levers to boost the level of institutional development of social security or the mobilisation of teachers as vectors for and stakeholders in solidarity-based social development, or the promotion of mutual society concepts and ideals.
Finally, they may effectively coordinate international partners around concrete projects and encourage the development of mutual society ideas worldwide.

3. Conclusion – Education professionals: vectors for mutual solidarity

3.1. Origins and values of mutualist involvement

The origins of mutual benefit societies go back to Antiquity. For example, in Egypt in 1400 BC there were already societies of artisans, with stonemasons contributing to a fund intended to provide them with assistance in the event of an accident; and in Ancient Rome, Roman 'funeral colleges' developed to give their members a form of funeral insurance. Similarly, in the Middle Ages, brotherhoods, guilds and societies of artisans provided their members with financial cover for illness, invalidity, old age, loss of work and fire; these members were bound by an oath and paid a contribution into the mutual aid fund which served to provide each of them with assistance from their peers (Bennet, 1981: 19, 27-28, 42, 67-68).

In Western Europe, industrialisation and bad working and living conditions for the working class led to the establishment of mutual aid societies in the first half of the 19th century. These were the forerunners of many mutual benefit societies. The companies organised welfare in 'socio-vocational' groups clearly defined by membership of a company, a job, a sector of activities, a region, a national origin, etc. Most of these first mutual benefit societies, like many mutual organisations today, shared two complementary philosophies: efficiency of service to members and collective action (which for many equates to militant activism or even contesting the established order).

Thus, a number of these first modern mutual societies organised solidarity-based initiatives and collective action instead of banned trade unions. They developed in parallel and in many cases in synergy with other cooperative initiatives involving collective action. These close links in terms of actions and values between mutual benefit societies, trade unions and cooperatives remained intact in many countries despite the historical tumult of social, economic and political events. And what could be a clearer sign of this similarity in their actions and values than the establishment of the new Education and Solidarity Network at the initiative of the mutual benefit societies and trade unions for education personnel?

In many cases, the emergence of 'mutualist' involvement in the 19th century seems to signal the establishment of an alternative form of organisation which, having arisen from among the populace, opposes dominant political, social and economic forces. Indeed, in some cases they would be banned or put under public supervision. In addition to welfare, education – which enables the gaps between social classes to be reduced – is often a major preoccupation, as was the case explicitly for the first Chilean mutual societies (Grez Toso, 1992: 158) and for many other mutual benefit societies from other parts of the world.

The modern mutual organisation model that European immigrants introduced in many Latin American and African countries in particular was launched in the absence of government social protection. To guard against the uncertainties thrown up by life (unemployment, illness, infirmity, old age, death) and to combat poverty, in many cases individuals had to seek help from private charity and philanthropy, in dependency relationships via-à-vis the 'comfortable'

classes of society or religious institutions. In certain countries, the public authorities, the local authorities in particular, offered basic protection in the form of public assistance.

The 'mutualist' involvement of the past and present is based on values which stand in contrast to the excesses of charity and of philanthropy (as Jean François Draperi (2007: 33) wrote, "philanthropy only booms in the presence of striking inequalities") and to dependence to a basic government safety net. This involvement combines the assumption of responsibility by individuals, freedom of involvement (i.e. volunteering), democracy and solidarity with a view to providing protection and welfare and, more generally, improving the physical, economic and social well-being of individuals.

'Mutualist' solidarity mingles altruism and personal interest, reciprocity and the common interest. As J. D. Reynaud (1999) wrote, "solidarity cannot be taken out of the equation". Obviously, that is particularly true in the main field of operations of mutual benefit societies. The insurance interest of solidarity-based protection via mutualisation of risks meets the precepts of a rational economic equation. Obviously the non-profit nature and non-selection of risks represent additional advantages of the 'mutualist' solution to health problems. Léon Walras himself advocated the economic (and moral) legitimacy of the mutual benefit society (Lacan, 2006). In other words, mutual organisations combine altruist or even militant and anti-authority involvement with economic and social effectiveness for the members.

Mutual benefit societies are a source of innovation. They preceded government social security where that exists. They contribute to it and complement it. In certain cases, they manage it or co-manage it. How many times has a service initially offered by mutual benefit societies subsequently become a service of general interest that is integrated into social security by the government? With a view to prevention and the requirements of its members, mutual organisations are a catalyst for innovation and as such act as a fundamental complement to the administrative management of government social security.

We must stress the ambiguity and abundance of relations between mutual benefit societies and public authorities. In certain countries, the government has shown utter contempt for this source of democracy – an intermediate body which provides an alternative way of representing and defending the interests of citizens vis-à-vis the established systems of political representation. Totalitarian governments have generally banned or instrumentalised mutual organisations. In contrast, other, more democratic governments, more open to civil society organisations, have aided, promoted and subsidised mutual benefit societies so as to utilise as effectively as possible the complementary nature of government actions and the actions of mutual organisations.

The place of mutual benefit societies between civil society and the market is clearly dependent on a relationship of confidence between that civil society and the government and, following on from this, the quality and capacity of public action. It is impossible here to avoid a parallel between the situation of mutual aid societies in Western Europe in the 19th century against the background of an asocial government and the mutual initiatives in certain African countries where governments have no means any more to finance any social initiatives. When the government no longer has the means to provide social protection, collective and community initiatives reappear on the scene as the only responses to the basic requirements of the population. This contempt vis-à-vis an 'instrumentalising' government only goes to boost this trend towards 'mutualist' self-help.

3.2. Education professionals in the context of mutual solidarity

In many cases one individual or a small group of people who have an education and an above-average ability to take action, to communicate and to hold convictions is responsible for initiating and ensuring the success of a 'mutualist' project. Often the project itself involves a group which has a high level of internal coherence linked to the job it carries out. Therefore it is no coincidence that education personnel have often invested in mutual initiatives targeted at the teaching professions, at civil servants more generally (when teachers are civil servants, which is not always the case), and even at a wider range of categories in the population. It is no accident that from the 19th century onwards mutual benefit societies were established for teachers or at the initiative of teachers. Take for example the establishment in Chile of a mutual aid society for Valparaiso primary school teachers in 1873 (Grez Toso, 1992: 163). We would also like to draw particular attention to the mutualist beliefs of republican staff, especially primary school teachers, in France during the 3rd Republic (Gueslin, 1998: 228), with the school and nursery school mutual organisations in the late 19th and early 20th centuries (Gueslin, 1998).

Today we face a severe problem in terms of coverage of health requirements and of social protection in general. Many countries have no universal social protection, while other countries have universal protection which is insufficient and/or flawed. Social protection systems must be reformed, consolidated, built up or reconstructed. The current economic situation is destabilising the protection systems even more but it is also a potential opportunity to be seized. Today there is global awareness and a consensus on large-scale implementation of sustainable social protection systems. The major donors of global funds and the multilateral organisations have realised that support for multiple small-scale local initiatives did not enable satisfactory results to be achieved and that there was no geographical expansion of these initiatives. The development of health insurance systems (and of social protection systems more generally) is clearly an objective for the fight against poverty. We need to go beyond the stage of small insolvent organisations which are too small to survive and participate in the extension of social protection to become as universal as possible. In this context, mutual benefit societies obviously have a role to play to develop sustainable solidarity-based social security systems. This is particular true in Africa and in many countries with delayed development.

'Mutualism' may not be the panacea for all problems – the government, insurance companies and market mechanisms are other tools which can each contribute to a sustainable solution – but leaders must become more aware of the benefits of the social economy and of mutual societies. In this context, teachers (especially academics) must be more effective at explaining and promoting the advantages of solidarity-based and 'mutualist' action, particularly in the health domain.

Teachers are a 'homogeneous' socioprofessional category, which is organised and open to involvement and the promotion of a shared interest. They are an essential component of civil society on the edge or at the heart of the public sector. Whether or not they are integrated into the public sector, they share values: promotion of individuals, the emancipation and elevation of individuals, and social well-being. All of these elements are aspects which make teachers naturally open to mutual solidarity. They can fully assess the advantage of the mutual organisation as a complementary element to government social action or as a substitute for failing public authorities. They can 'incarnate' solidarity and reconstruct social links.

The teaching profession has certainly lost its prestige in many countries today. Subjected to criticism from parents and students, victims of underinvestment in education and concerned by their working conditions (pay and stress), they are maybe less ready to get involved in a solidarity campaign project.

However, the values of 'mutualism' (responsibility, voluntary participation, solidarity, equality, democracy) are shared by many teachers, and the promotion of mutual benefit societies can be a mobilising project which restores esteem to a profession which is key to the future of our civilisation and to the transmission of values to subsequent generations. For them and also for others, we can rely on their involvement to bring these values into the domains of social protection and welfare and to implement them there. Whether these involve organisations which are actually mutual societies or more capitalistic organisations based on similar values and whether these involve a solidarity drive with the government, against the government or in the absence of the government, education personnel can play a key role. In these uncertain times, against the background of a global financial, economic and social crisis, the launch of this Education and Solidarity Network, which will make use of individual and collective efforts, provides real hope.

Education staff are a vector for mutual solidarity

Recognition of the objective of universal health protection for low- and middle-income countries has been put on the international agenda and is shared by many of these countries, as a means of fighting poverty and advancing socioeconomic development. Affordable access to quality healthcare is a fundamental human right.

With a view to achieving this objective, health protection can only be extended by combining and coordinating mechanisms for providing health cover.

Mutual organisations are important stakeholders in this challenge. Their participation in the actual extension of health protection involves more general coverage of the population and professional management. Implementation is a major challenge for solidarity, one of the founding values of the social economy.

In this context, education personnel have a key role to play in promoting and developing mutual benefit societies and participating in the extension of health cover. This is clearly a major vector for mutual solidarity.

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