INTERNATIONAL SYMPOSIUM ON SOCIAL PROTECTION AND SOLIDARITY IN DEVELOPING COUNTRIES

Turin, Italy, 23 - 25 April 2003

PROCEEDINGS

Manuscript dated 17/10/03
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ACRONYMS

AFD	French Development Agency
ARV	Antiretroviral drugs
BRAC	Bangladesh Rural Advancement Committee
CERMES	Research Centre on Medicine, Sciences, Health and Society
CIPRES	Interafrican Conference on Social Welfare
CNRS	National Centre for Scientific Research
DC	Developing countries
DDCT	Directorate for Development and Technical Cooperation
DGCID	Directorate-General for International Cooperation and Development
EHESS	School of Advanced Studies in Social Science
ESPH	Extension of Social Protection in Health
EU	European Union
FCFA	African Financial Community Francs
FEMCI	Medical Mutual Schemes Federation of Ivory Coast
GNP	Gross National Product
GSK	GlaxoSmithKline Foundation
GTZ	German Technical Cooperation
IGAS	General-Inspectorate for Social Affairs
ILO	International Labour Office/International Labour Organization
ILO-STEP	The Strategies and Tools against social Exclusion and Poverty global programme of the ILO
ITC ILO	International Training Center of the ILO
MFA	French Ministry of Foreign Affairs
NGO	Non-governmental Organization
OXFAM	Oxford Committee for Famine Relief
PAHO	Pan American Health Organization

PSZ	Priority Solidarity Zone
RAMUS	Support Network to Health Mutual Schemes
SEWA	Self-Employed Women's Association
UEMOA	West African Economic and Monetary Union
UN-ESCWA	United Nations Economic and Social Commission for Western Asia
WHO	World Health Organization

FOREWORD

Foreword by the Directorate-General for International Cooperation and Development (DGCID)

In April 2003, the Ministry of Foreign Affairs (MFA), in collaboration with the International Labour Office (ILO), organised an international symposium intended to promote the extension of social protection in developing countries (DCs). The symposium was held at the International Labour Organisation's training centre in Turin and involved about a hundred people from 25 countries. The symposium had a double aim: first of all, to gather together actors with different experiences based on varying geographical and political contexts. It provided the opportunity to look at the situations in countries in West Africa, the Maghreb, the Middle East, Southern Africa, the Indian Ocean, Asia and Latin America, but without making any judgemental assessments with respect to the paths they have followed as regards social protection. Also, the symposium was designed to start a debate on the principles likely to underlie social protection and on the mechanisms which can be used to assist its extension. In this respect, the presence of academics and representatives of governments, NGOs, trade unions and employers was of particular benefit in ensuring that initiatives of an analytic nature resulted in more practical approaches.

The symposium was introduced by Mireille Guigaz (Director of the DGCID) and François Trémeaud (Executive Director of the ILO, Director of the Turin Centre) with a welcome from representatives of the Piedmont Region and the city of Turin. Ms Guigaz described the main thrusts of the symposium to the participants: the link between development and social protection, the practical implementation of solidarity. She also said that the close partnership between France and the International Labour Office was based on common values with regard to social protection and the Ministry's keen desire to make use of the ILO's expertise.

The symposium was in three parts. The first, with four presentations followed by debates, was devoted to the approaches, values and actors in social protection. Michel Laroque (General Inspectorate for Social Affairs, IGAS) analysed the challenges to universal coverage in the context of globalisation, starting from the premise that entitlement to social protection is broadly acknowledged, but is in practice reliant on an approach which is often incomplete and changing in its objectives. Bruno Lautier (Paris I) used Latin American examples in an attempt to define the conditions for the effectiveness of social protection in the struggle against poverty. François Bourguignon (School of Advanced Studies in Social Sciences, EHESS) examined the link between redistribution of resources and economic growth, looking in particular at programmes of cash transfers for specific allocation to education and health, which have found some success in Latin America. Finally, Dr Jaime Galvez Tan (University of the Philippines) used experiences in his country to introduce the topic of role-sharing between state actors and civil society, emphasising both the importance of the political decision to establish universal coverage and the possibilities for entrusting practical management functions to joint bodies of the social partners.

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International Symposium on Solidarity and Social Protection in Developing Countries, Turin, Italy, 23-25 April 2003: Opening Speech by Mrs. Guigaz (Director of the DGCID) and François Trémeaud (Executive Director of the ILO, Director of the ITC-ILO).

The second part was devoted to the mechanisms and practices underlying the establishment and operation of social protection; this comprised four round tables.

The first was centred on the positions adopted within multilateral institutions to support social protection. Alexander Preker (Department of Health, Nutrition and Population, World Bank) demonstrated the vicious circle created by the constraints relating to the costs of disease, hindering economic growth and the development of health itself, and advocated the allocation of new resources to the sector. Azedine Ouerghi (Social Protection Programme at the World Bank Institute) presented the concept of social risk management, which lies behind the intervention of the Bank in the sphere of social protection as an instrument in the struggle against poverty. Emmanuel Reynaud (Social Security Policy and Development Branch, ILO) pointed to the content of the new international consensus on social security, which in particular rejects the idea of a single model and advocates a search for solutions adapted to the informal economy. He announced the upcoming launch of a global campaign on social security and coverage for all, which will provide an integrated framework for ILO activities in this field.

The second round table was devoted to the roles of workers' and employers' organisations in social protection, as presented by Barry Shipman (Employers' representative, South Africa) and Devanand Luchmun (Employees' representative, Mauritius). The third round table opened up the floor to several local actors, representing a variety of approaches. Mirai Chatterjee made a presentation on the life insurance and health insurance put in place by the SEWA organisation for women working in the informal sector in India; Carlos Galian described Oxfam's approach with regard to social protection, based in particular on support for working women and promotion of their rights at work; Dr Jean-Michel Lichtenberger described the solidarity fund project on HIV/AIDS set up by the research group Health-Cy for company mutual insurance funds in the Ivory Coast.

The last round table involved an assessment of the diversity of regional realities with case studies on the situation in the Maghreb countries (Miloud Kaddar, WHO), the situation and perspectives in the Middle East (Georges Kossaifi, United Nations expert), mutual health insurance funds in West Africa (Alain Letourmy, CNRS researcher), the joint PAHO/ILO initiative with respect to the extension of social protection in health in Latin America and the Caribbean (Dr Daniel López Acuña, PAHO) and the Concertation between actors in the development of mutual health insurance funds in Africa (Pascal N'Diaye, coordinator of the Concertation network).

The third part of the symposium took the form of a round-up. Attempts were made to identify convergences and to define strategies for cooperation. A discussion panel, lead by Ms Guigaz, involved four representatives of developing countries, in very diverse professional or institutional positions: Maria Ofelia Alcantara (manager at the Philippine Health Insurance Corporation, Philippines), Yero De (Minister for the Civil Service, Labour and Employment, Senegal), Ms Ngebou Toukam (University of Yaounde, Cameroun), Sheikh Aboud Daiyan (Grameen Kalyan, Bangladesh). The discussion started with four questions: what models might be envisaged for social protection? What strategy or strategies might be proposed to guide its development? What is really being done for women as regards social protection? What are the positive and negative features of the informal sector to be taken into account with a view to extending social protection ?

The last session of the symposium started with an overview of the work carried out, presented by two CNRS researchers (Blandine Destremau and Alain Letourmy). Finally, the symposium was summarised by Serge Tomasi (Deputy Director at the DGCID) and Assane Diop (Executive Director, Social Protection Sector, ILO). The continued involvement of the French cooperation agency in support of the extension of social protection and the strengthening of the partnership between France and the ILO were announced. In particular, there are plans to organise a regular working group involving representatives of the MFA and the ILO to schedule a series of operations of common interest in the field of social protection.

OVERVIEW

A few ideas emerging from the presentations and debates

The various contributions resulted in several observations on the current situation as regards social protection in the DCs and in an interest to promote its extension. At the same time, the symposium debates drew attention to the pitfalls to be avoided in following this route and some of the conditions required to achieve the desired objective. From the aspects discussed over the three days, the following ideas may be highlighted. They will be further developed in the symposium proceedings.

An initial statement relates to the diversity of the current situation in countries and regions with regard to social protection

A distinction may be drawn between three main groups of countries. The first comprises countries with systems of protection which aim at universalism, established very early (such as, for example, Latin America) and possibly involving hybrid forms, based on formal wage-earners and financed by the state budget. There has been, nonetheless, a blockage in the progression of extension of coverage, or even a regression, resulting in the exclusion of a significant proportion of the active population, denoted by the term "informal". In parallel with this, the benefits provided by the state tend to be degraded and to fall back into assistance to a rapidly increasing destitute population.

The second group is that of countries characterised by centralised socialist regimes where social protection was practically inseparable from citizenship and the status of worker. But the opening up of the market economy has given rise to a change in the solidarity approach to the management of risks. There is severe degradation of the social protection systems, a clear reduction in benefits and a drop in public services.

The third group comprises the majority of the poorest developing countries: sub-Saharan Africa, many of the countries in the Arab world and Asia. Here, we find the model for membership of social security systems put in place during the colonial era for wage-earners in the civil service and in enterprises belonging to the state. But this system does not aim to be universal and in fact gives rise to duality: only a small proportion of workers are covered, while workers in the informal economy and agriculture have no protection.

Along with the paucity of the coverage, it is also noted that the diversity of the social protection systems reflects that of the histories of the developing countries. This suggests an approach to extension adapted to each context, rather than reference to a single model, which is also difficult to identify on the basis of the situations in the developed countries, which exhibit so many special features.

There is a consensus in acknowledging that social protection is a tool in the struggle against vulnerability and poverty and it should be distinguished from assistance

Confirmation of the failure of the anti-poverty policies implemented in the 1990s made the international organisations and national governments think about poverty alleviation in terms of prevention, of a struggle against vulnerability and of social protection.

Social protection responds in particular to the temporary or permanent inability to produce an income. A distinction can be drawn between several ways of dealing with this: assistance, private or public; insurance, relying rather on individual precautionary mechanisms; solidarity mechanisms implemented by the family, the community or forms of social organisation of the mutual type.

Social insurance is distinguished from assistance by the automatic and incontestable right conferred by contributions. The western idea of social progress is associated with the decline of assistance in favour of insurance. The concept of right, moral and social, within the public sphere differentiates social protection from family or community solidarity and the forms of dependence for which they are often vehicles.

Social protection also differs from assistance in that it brings equity. This objective is difficult to achieve in DCs where the population described as destitute is sizable. It is then necessary to combine contributory and non-contributory mechanisms and, hence, the legitimacy of compulsory contributions is not necessarily achieved. The higher income categories accept the principle of solidarity more easily if they have the option of paying for broader coverage. Thus, social protection will constitute a tool in the struggle against poverty which is all the more equitable when it is universal in nature allowing, for example, certain groups the option of establishing mechanisms of the mutual type.

Aiming for universality sets a significant challenge in poor countries and the routes taken by the industrialised countries seem difficult to follow

In order to be an instrument of social cohesion and of the struggle against poverty, social protection should aim towards universality at the national level. But, in most developing countries, the expansion of the wage-earning population cannot constitute the motor for the development of universal systems. Deregulation of labour and the development of the informal sector, correlated with the search for economies in labour costs with a view to better competitiveness, are reflected in the non-payment of social contributions. Women are the most affected and the most vulnerable. There is then a vicious circle: the informal economy finds one of its sources in the exclusion of social protection, this is most often suffered by workers and cuts off schemes' revenues. Furthermore, the low level of wages and the significant inequalities within the wage-earning population make it difficult to establish and balance contributory schemes based solely on income from work. Finally, the paucity of resources is reflected in the poor quality of the services provided, particularly health care, which does not encourage payment of voluntary or compulsory contributions.

Decoupling the wage-earning population and social protection therefore seems to be the only possible way of extending coverage to workers known as informal, whether

wage-earners who are not covered or people engaged in other forms of work – self-employed, family, domestic, etc. This is the role that the states which have constructed social protection systems financed by the public budget wished to assume. But a favourable political climate is required for states to manage to set up systems of a universal nature – social services, and in particular health care, but also replacement income such as pensions, sickness and unemployment insurance - possibly accompanied by targeted transfers.

Collecting taxes and contributions, enforcing the rules of social law, operating and protecting compulsory and universal systems therefore requires both political ability and administrative skill, which are not available in many poor countries. It must be added that the processes of structural adjustment, applying pressure for budgetary reductions without deploying similar efforts to increase revenues, act against the establishment of systems managed by the public authorities.

A double challenge is set on the one hand by the limits on systems based on wage contributions for the inclusion of informal workers and, on the other hand, by the weak political, financial and institutional capabilities of the state in poor countries. This leads most donors, NGOs and governments wishing to extend social protection to unprotected and vulnerable groups to support the diversification of types of systems and actors, in particular through the development of parallel systems – private or "community-based". There are also those which attempt to take over from or substitute for public systems that are failing or in a phase of budgetary restrictions. In fact, on every continent, mutual insurance funds, micro-insurances, tontines, mutual guarantee groups and other mutual aid systems are supported or created from scratch

Promoting the diversification of systems and actors constitutes a risk of fragmentation and entrenchment of inequalities

Several presentations or contributions were devoted to the promotion and positioning of decentralised systems with a community base or target. In particular, micro-insurance and mutual health insurance funds were put forward, as efficient systems for the mobilisation of private health care financing and as a means of involving civil society in the management and governance of social protection in the face of an ineffective and poorly resourced public administration.

It is still the case that the durability and efficacy of "community-based" or alternative type systems have their limitations. The principle of voluntary contribution to insurance systems tends to close the systems for groups with similar standards of living (adverse selection), a phenomenon reinforced by their small size. Without employers' or state contributions, redistribution between categories or between income levels is low or zero. These systems are all the more financially limited when their contributors are poor; their members' contributions alone can only cover some of the risks and the paucity of the benefits discourages affiliation.

The diversity of statuses and the rights associated with the forms of protection produces or maintains inequalities and gives rise to fragmentation of the systems. Some would be insured by virtue of their status as employees of the state or large enterprises, while others would be affiliated to mutual insurance funds or to networks of informal solidarity owing to their community or local links. Households earning regular and sufficiently high

income would contribute to private insurance plans, while the destitute, the handicapped and other unemployable people should, in their condition, benefit from state or private assistance. According to the vision of "social risk management" proposed by the World Bank, universality could be achieved by juxtaposition of various targeted systems. The system produced would therefore guarantee neither equality of rights nor of benefits, but the competition between systems would in theory bring about effectiveness. Apart from its interventions on the macro-economic level, the state would only be required as a minimum to fulfil the function of last resort for people incapable of finding means for fighting against their vulnerability in the market.

For the ILO, the development of decentralised schemes based on local initiatives constitutes an intermediate phase in the achievement of universal ambitions and in the establishment of a culture of social protection. Recommending the establishment of links and partnerships between decentralised systems would make it possible to strengthen their ability to negotiate with the public authorities and the service providers, to have better sharing of knowledge and a guarantee of greater financial viability. Mutual insurance systems under the supervision of the state or the option of voluntary affiliation to statutory schemes would prepare for universal coverage under public control. But universality cannot follow from a simple juxtaposition of defined schemes, it necessarily depends on a political decision, determining a change in the nature of social protection.

The state is an indispensable player in universal and equitable systems of social protection: it is the guarantor of rights and solidarity

If social protection is not to constitute a privilege for the affluent or a favour for the most destitute, but a right for all citizens or residents, how can this right be guaranteed, its effectiveness monitored and the corresponding contributory duties established?

Social protection has a collective function: by preventing excessive inequalities from becoming embedded, by becoming a vector of national solidarity, it is a factor in social cohesion. Positioning social protection in this way necessarily calls upon the role of the state, which should not be limited to that of a financier: only the state can act as guarantor for this right as a social right, even if it is not necessarily in a position to guarantee the probity of the accounts, which may be entrusted to joint bodies of the social partners. Only the state is in a position to impose and legitimise the redistribution inherent in any universal system.

Social protection is not only a cost or a constraint: it is effective on the economic level and on the political level. The establishment of public coverage constitutes an affirmation of the power of the state and its desire for modernisation and development, when faced with the fragmentary approaches of corporate or community-based systems. Strengthened by the legitimacy drawn from its intervention in favour of a move from voluntary systems to compulsory affiliation, the state can then use social protection as an instrument of public policy: to support or restrain the birth rate, encourage women to work, promote training and abolish child labour, enhance public health and hygiene, etc.

It is still the case that the argument for the intervention and commitment of the state results from an analysis largely inspired by the history of the industrialised countries and

that it is sometimes difficult in the DCs to give the state such an important role. In many fields, the newness of the institutions means that public action has to be modest and pragmatic. The extension of social protection must be adapted to this reality.

It is also still the case that establishing universality of social protection at the national level only is not sufficient: not only is there the problem of frequent exclusion of migrants, clandestines, the stateless and refugees, but social protection also has to be affirmed as a universal principle at the international level. The role of international organisations is fundamental in this respect.

SUMMARY

Introduction

The general aim of the symposium was to open up a debate on social protection in developing countries and on the resources needed to encourage its extension. This involved provoking consideration of the configurations which social protection might take in these countries, without favouring any particular model, but attempting to assess their respective advantages and the conditions for their application in different national contexts. With this aim, the symposium attempted on the one hand to specify the concepts and approaches which might be used to extend social protection, in particular by questioning their relevance in terms of cooperation, and, on the other hand, to find common points in the support strategies of the various partners and to encourage coordination of local and external actors.

Woman entrepreneur with a disability: Petty trader, Tigray region, Ethiopia.

The presentations and debates provided for both an exchange of experiences and a search for practical solutions with a view to achieving as complete social coverage as possible. This document falls into three parts, the first two[1] attempting to report on the various aspects of the symposium. The first will look at the diversity of social protection situations in developing countries, as it appeared from the presentations and the responses of the participants. The second will attempt to identify the lessons drawn from the symposium in relation to the themes put forward by the organisers. The third part constitutes a contribution to the construction of cooperation with respect to promoting and developing social protection. It briefly explains the positions of the World Bank, the ILO and the DGCID, represented at the symposium in Turin.

Part 1: Diversity of social protection situations in developing countries

The symposium was an attempt to shed light on the diversity of social protection situations in developing countries, and made it possible to gain a better understanding of this diversity. This was clearly in line with the wishes of the organisers, who were aiming for quite a balanced representation of the world's regions. Thus, the presentations or responses dealt with the very diverse contexts of the countries of Latin America, North Africa, sub-Saharan Africa, Southern Africa, the Middle East and Asia. The regional

1 *The first two parts include extracts or quotes from the texts presented at the symposium in Turin in April 2003. Selected texts, in the original language, are given in Annex 3.*

diversity of social protection corresponds to the different levels of development, but also with historical evolution and varied forms of economic and social regulation exerted by the political system. It is also the result of the variability in the design of the systems, in terms of the definition of protected persons, the risks covered and the management organisation.

1. Diversity of methods of access to social protection

Definition of the protected population questions the bases underlying people's entitlement to benefit from social protection. In developing countries, it is noted that such entitlements can be traced back to two traditional methods which have acted as a base for the systems in developed countries and very often to a combination of both. There are systems inspired by Bismarck, based on wage-earners, or more generally people's employment status, and backed by the collection of social contributions. There are also systems inspired by Beveridge, based on residence in the country and with guaranteed benefits at a minimum level financed through taxation. Finally, many countries use hybrid forms whereby certain groups, in particular employees in the private sector of the formal economy, are covered by specific social insurance, while others are covered by a public system financed by the state budget, for example, civil servants or the more disadvantaged people. Another hybrid form consists in providing the same person, or the same household, with benefits associated with employment and allowances financed by the state.

In the industrialised countries, two approaches dominate as regards basic social security systems, with a tendency to converge to a greater or lesser extent:

- the Bismarckian approach to social insurance for workers, providing maintenance of the standard of living and financial coverage of health care under the auspices of social protection funds, the management of which involves the social partners and to which workers and employers contribute,
- the Beveridge approach of universal protection against poverty and illness, financed essentially by taxation and managed by the state.

The convergence is illustrated by, among others, the French approach. In the Bismarckian context, this involves a decentralised autonomous system, financed by social contributions. It also adds, in a Beveridgian way, aspects of social minima, in particular a guaranteed minimum income and financial coverage of health insurance for the most disadvantaged, with financing from taxation[2].

2 *Source: contribution by Michel Laroque, Inspector General for Social Affairs, former Deputy Director of Social Security at the Ministry of Social Affairs and Health and consultant Professor at the University of Paris I Pantheon-Sorbonne, rapporteur for the Social Security Committee at 89th sitting of the International Labour Conference (June 2001).*

This diversity should not, however, conceal the dominant feature of social protection in developing countries: the fact that the great majority of the populations is excluded from it.

As indicated by the work of the ILO, more than half of the world's population has no social protection. In sub-Saharan Africa and Southern Asia, only 5% to 10% of the population is covered by a statutory social security system. In the rest of Asia and in Latin America, the rates of social protection vary from 10% to 90%. In most of the industrialised countries, there are just certain sectors or categories of the population which are not covered. In the countries in transition, in particular the countries of Central and Eastern Europe, the rate of social protection has been tending to decline[3].

2. Diversity of social risks covered

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International Symposium on Social Protection and Solidarity in Developing Countries. Turin, Italy, 23 - 25 April 2003.

Nor do the risks covered by social protection constitute an identical set from one country to another. Generally speaking, countries do not achieve the objective defined by the International Labour Organisation (ILO) in 1952 with Convention 102. The Convention in a way defines the minimum scope of intervention to be achieved. It proposes that all states should extend the system currently in existence in their countries to cover 9 major social risks: unemployment, illness, work accidents, occupational disease, old age, invalidity, death, maternity and family. This involves in general providing a substitute income when the various types of risk come into play.

Generally speaking, the developing countries fall below this standard. They usually favour the distribution of emergency monetary benefits for the poorest, plan to cover the costs of maternity and health for as broad a population as possible and reserve to employees in the formal sector of the economy benefits relating to occupational diseases and work accidents, and a system of pensions to this same sector and civil servants (for example in West Africa). But this frequent restriction of the scope for social protection, which does not mean that the benefits provided are of good quality or the payments are at a meaningful level, does not prevent some countries and organisations from developing a far more extensive concept, including primary education in social protection or integrating the coverage of certain risks (health, maternity) in local development (in particular in Bangladesh).

3 *Source: contribution by Michel Laroque.*

The strategies for social protection aimed at eliminating exclusion in health are public interventions designed to guarantee citizens access to decent and effective care and to reduce the negative economic and social impact of adverse personal situations (for example, illness or unemployment) or general events (for example, natural disasters) on the population or the most vulnerable groups in society. In this context, social protection in health can be defined as a guarantee offered by society through the public authorities that individuals or groups of individuals can meet their health needs and demands through adequate access to the health services of the system or sub-systems in existence at a national level whatever their economic means.

Social groups which cannot take advantage of this guarantee constitute "the excluded" from access to care.

ESPH[4] involves a group of mechanisms designed to guarantee the population access to protection and health care through the allocation of resources of diverse origin, and not only the measures taken directly by the state to guarantee access to health care through the provision of public services. Consequently, social protection is considered do be the state's guarantee of a right which citizens can exercise and not a type of social benefit which can be granted at the discretion of the authorities.

In practice, three conditions have to be met for ESPH to act effectively as a guarantee: access to services(…); financial security of the family (…) and dignity in care (…).

These three conditions must be met and the absence of one or more of them gives rise to some form of exclusion in health.

Poverty is one of the most important determinants of exclusion in health[5].

3. Heterogeneous management methods

The organisation of the management of social protection in developing countries calls upon quite disparate models. The systems traditionally associated with the welfare state in the developed countries are present where the establishment of systems of social protection has been inspired by such configurations. There are then social security funds managed either equally by representatives of employers and employees, or by public administrations, or by mixed authorities. But there is also a whole series of decentralised systems with more or less participative management, which correspond to a coverage put in place as a reaction to states' failings. Some of these systems, such as the mutual insurance funds in West Africa, recall the organisation underlying social security in the northern countries and advocate the heavy involvement of communities in management. Others are effectively based on

4 *ESPH - Extension of Social Protection in Health, a joint initiative of the Pan American Health Organisation and the International Labour Organisation.*

5 *Source: Contribution by Mr López Acuña, PAHO - Refer to site http://www.paho.org/.*

communities, while attempting to reproduce, by formalising them, joint entities and mechanisms specific to the countries or to graft onto them (tontines, micro-credit institutions). Finally, others use NGOs, trade unions or development organisations to offer products which are accessible to groups in the informal economy (BRAC, Grameen Kalyan, SEWA).

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Dakar, Le Dantec hospital: Nurse in the intensive care unit.

SEWA is an association of 680,000 women working in the informal economy in India. Founded in 1972 by a labour organiser and lawyer, Ela Bhatt, in Ahmedabad, Gujarat, this association has 535,000 members in that state. SEWA members include manual labourers and service providers (construction workers, agricultural workers, headloaders, etc.), street vendors, home-based workers in clothing and embroidery and small manufacturers (…).

"After witnessing at first hand the impact of frequent crises on women's lives, we understood that insurance can provide essential protection against the many risks which threaten working women every day. SEWA has therefore developed an insurance programme with the support of the SEWA Bank. Initially, SEWA was linked with government insurance companies. Now, we insure our members with both government and private insurances. We ourselves insure women for maternity".

Today, SEWA has 101 926 people insured – women, men and children. The women hold membership cards also covering their families for life, accident, sickness, loss of earnings. Our experience of covering women for ten years has taught us that insurance for the poor can be viable and may contribute, thanks to the participation of the state, employers and workers, to the establishment of a joint solidarity fund. Insurance coverage should cover the greatest possible number of risks. Furthermore, if the services are managed by women in an efficient way, the demand will increase. Also, workers must be made aware of the advantages of insurance and the reduction of risks. Risk prevention strategies, like health care programmes putting the emphasis on education on the subject, reduce the vulnerability of women and strengthen the viability of insurance; above all, an organisation attracting numerous members, encourages the development of micro-insurance.

Although the extension of insurance to the poor is possible and desirable, it must face up to considerable challenges. The importance of strong and increasing membership, and the retention of existing members, cannot be overestimated; for this reason, care must be taken to provide appropriate, rapid services at a reasonable cost. Strengthening the skills of workers and the team managing the

insurance is also important. Finally, it is essential that a legal framework should be established, providing for the creation and development of the workers' insurance organisation, i.e. a people's solution with regard to social security in partnership with the state and the private sector, so that the poor can administer their own security themselves[6].

4. Social protection as a product of the history of the developing countries

Finally, it seems that the most comprehensive way of describing the diversity of social protection in developing countries is to consider that it reflects that of the histories of the developing countries. These histories give a good illustration of the varied processes of construction of these systems: processes of sedimentation with the superimposition of Bismarckian or Beveridgian models and more recent systems, assembled in a more pragmatic perspective; processes of differentiation, establishing distinctions between groups based on gender, habitat (rural and urban) or on the sector of activities (formal economy and informal economy). A distinction may thus be drawn between three main groups.

The first comprises countries with systems of protection originating from a desire for universalism. Latin America is distinguished by the fact that such systems were established there very early, sometimes even before western Europe, straight away setting up hybrid forms, based on formal wage-earners and financed by the state budget. There has been, nonetheless, a blockage in the progression of extension of coverage, or even a regression, resulting in the exclusion of a significant proportion of the active population, denoted by the term "informal".

As regards the causes of the non-implementation and disappearance of the principle of mutualism in social protection in Latin America, the classic argument whereby this non-implementation is essentially due to the development of "informality" (self-employment or employment in micro-enterprises) is refuted. This argument has two aspects; the first is "technical": lack of administrative staff, difficulty in tracing and pursuing non-payers; but the technical problems have always found technical solutions when there has been political will. The second aspect is political and ideological: it is very difficult to impose upon the self-employed and small employers with low incomes the payment of taxes and contributions for which they do not see any resultant advantage. But this was not an a priori outright rejection of social protection, but rejection of a system perceived by the "informals" as counter-redistributive.

6 *Source: contribution by Mirai Chatterjee, SEWA.*

The main causes of the lack of extension of mutualism are the following three aspects:

1) The large and increasing income disparity of employees. The consequence of this disparity (apart from its effects on internal demand) is to make the ability of employees close to the minimum wage to contribute almost zero and, above all, to push the upper layers of employees towards protection systems of "restricted mutualism", generally private, since the redistributive effects of generalised mutualism appear to be unfavourable to them. (…)

2) The very unequal redistribution of gains in productivity. The allocation of gains in productivity to financing social protection has always been purely residual in Latin America, unlike in Europe. When these gains are large, they are everywhere definitely allocated to social protection, but in a very fragile and reversible way, owing to the non-separation of the state budget from the social budget. Also, numerous benefits and contributions are not proportionate to the entire salary, but to the minimum salary. The consequence of using monetary manipulation to reduce the minimum salary, which is very imperfectly indexed to inflation, is often a reduction in contributions and basic social benefits.(…)

3) The fact that the number of wage-earners expands without a proportional expansion in the contribution base. More than the increase in the "informal sector", in the traditional sense, the 1990s were marked by "informalisation of wage-earners". This was accompanied (unlike in Europe) by "disconnection" between the increase in wage-earners and the increase in social contributions, which is the major phenomenon in the recent phase of insecurity/flexibility. The informalisation of wage-earners is not only a "technical" reaction to cyclical shocks or brutal phases of adjustment, but a long and significant trend. The most immediate of the consequences of this "informalisation of the formal" is a financial consequence. This financial consequence should a priori be slight: "informalised" wage-earners of course do not contribute (or rather, their employers do not contribute, do not pay the contributions on the salary), nor do they receive benefits. But this financial neutrality is in part illusory: despite the low quality of care in basic health systems, despite the low level of basic pensions, "informalised" wage-earners have access to them. The informalisation of the formal then produces a transfer (even at less cost) of the mutual protection system towards the state's general budget and contributes to its financial crisis[7].

The failure of enterprises or states to honour their financial responsibilities with respect to social protection (non-payment of contributions, irregular payment of pensions, etc.) weakens the characteristics of the formal economy. Informality, which is defined in particular as not contributing and being excluded from social protection, most frequently affects workers and reduces the systems' receipts. In parallel with this, the benefits provided by the state tend to be degraded and to fall back into assistance to a rapidly increasing destitute population. This group also includes countries which have more

7 *Source: contribution by Bruno Lautier, Professor of Sociology at Paris I University.*

Woman entrepreneur with a disability: Trader, who is affected by leprosy, with her children, Addis Ababa, Ethiopia .

recently established social protection systems with universalist aims, but restricted to the wage-earning sector.

The second group is formed by countries characterised by a high degree of state centralisation[8]. This is the case with socialist regimes or regimes emerging from socialism. Social protection there was practically inseparable from citizenship and the status of worker. But the switch to the market economy has generated economic inequalities and given rise to a change in the solidarity approach to risk management. There is severe degradation of the social protection systems, a clear reduction in benefits and a drop in public services. With certain reservations, this category could also include the oil countries in the Gulf, where state protection covers everyone recognised as citizens, but generally excludes wage-earners who are not citizens, just like the sometimes large numbers of people with no defined status (stateless, refugees…).

The third group comprises the poorest developing countries: sub-Saharan Africa, many of the countries in the Arab world and Asia. The model for membership of social security systems put in place during the colonial era often continues in effect, but it is generally restricted to wage-earners in the civil service and in enterprises belonging to the state. This system does not aim to be universal in nature and in fact gives rise to some duality: only a small proportion of workers are covered, 10% in India, for example, while workers in the informal economy and agriculture have no protection. This is the situation in many cases in this colloquium: social protection is out of range for most of the population.

8 *The symposium did not involve any countries in this category, but it is nonetheless important to mention it.*

For George Kossaifi, with regard to the countries of western Asia, "It is believed that those who benefit from a full coverage of different SP schemes are public sector employees and military personnel followed by employees in the formal private sector, especially in establishments that employ five or ten employees and more. The percentage of the total public sector employees and military personnel varies from a minimum of 15 percent of the total labour force in Lebanon to 29 percent in Egypt.

One should distinguish, within the private sector employees, between those employed in the formal and modern sector who are covered by different SP schemes, and those employed in the informal sector, who are excluded. "It is estimated that the size of the informal sector is between 30 and 35 per cent of the urban labour force in Egypt, 35 and 45 per cent in Yemen, 44 per cent in the Syrian Arab Republic and 33 per cent in Jordan" (ESCWA 2001, p 28).[9]

With the breakdown presented above, the observable differences in regime are not only expressed by disparate coverage or by exclusions. They are also associated with particular attitudes with regard to the law and rights, with labour representations, with expectations towards the state and with institutional cultures.

Part 2: Principles and actors in social protection

Four major themes had been suggested to the participants and they resulted in presentations intended to provoke debate: social protection, a tool for the alleviation of poverty, moving towards universality, using social protection to promote economic efficiency and equity and diversified provision of services in developing countries.

After three days of work together, it appeared necessary to reformulate some of these themes, which constitute the framework for this section: the rights underlying social protection; social protection in the struggle against poverty; redistribution and social inequalities; actors in social protection. These themes are clearly interdependent and should rather be considered as specific approaches to the problems of social protection.

1. Rights underlying social protection

When states wish to implement an extension of social protection, the question of rights brings with it many points of tension. An initial aspect of this question is that the recognition of the rights of people faced with social risks, when a remedy is available, marks the fundamental difference between social protection and assistance. It results in a recommendation for universality and thus equivalent rights for everyone living in the country. Unfortunately, it has to be said that it is impossible in the short term for developing countries to base these rights on the work undertaken by people. They then have to institute other approaches.

9 *Source: contribution by George Kossaifi, consultant.*

Effective social policies in the struggle against poverty cannot be restricted to what is at present known as "policies for the struggle against poverty". These may in fact be defined as policies of partial compensation for the failure of social policies; rather than combating the social causes of poverty, they persistently reproduce the conditions in which it emerges. The "focussed struggle against poverty" is frequently an alibi to justify the dismantling of social policies (both for reasons of the limited available resources and for political reasons, namely that the aid is not going to the poorest people). But, in doing this, the dismantling rapidly increases the vulnerability not only of those who are not the "targets" of the aid policies, but also of those who are. Furthermore, the broadly procyclic nature of these "focussed" policies and their weak financial weighting tends to stress the instability of the internal demand. And, owing to this (this is not a perverse effect, but a logical consequence), the struggle against poverty increases vulnerability and poverty. Finally, "focussed" policies fail in their attempts to establish social rights and thus the conditions for the citizenry to exercise them. These conditions can only emerge as part of social protection based on the "principle of mutualism"; i.e. social rights are balanced by contributions (even very small ones) by all insured persons, which make it possible to provide a political basis for the financial independence of social protection, its institutional unification and the mechanisms for redistributive transfers which they allow[10].

1.1 Social protection and assistance

In a society dominated by economics, the first social risk is the temporary or permanent inability to work to produce an income. A distinction can be drawn between several ways of dealing with this: assistance, private or public; insurance, relying rather on individual precautionary mechanisms; solidarity mechanisms implemented by the family, the community or forms of social organisation of the mutual type; mechanisms based on broad solidarity guaranteed by the state.

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Young illegal street sellers in the city centre, Bangalore.

Social insurance is distinguished from assistance by the automatic and incontestable right conferred by contributions, while aid to the poor, always and everywhere, is subject to humiliating proof of the destitution of the beneficiaries, who are also often suspected of fraud. As is well illustrated by the Mexican Progresa/Oportunidades programme, one is an absolute right, the other is conditional.

10 *Source: contribution by Bruno Lautier, Professor of Sociology at Paris I University.*

(…)The Progresa programme launched a few years ago in Mexico has had a quite considerable international impact. In fact, it demonstrated that an ambitious and effective programme of means-tested cash transfers was possible in countries where redistribution in favour of the poorest was initially rather limited or essentially the effect of political clientelism. It is well known that the innovative aspect of these programmes is that they redistribute in cash rather than in kind through public goods, while imposing innovative conditions (children's attendance at school and health monitoring)[11].

Insurance also makes a contribution to limiting the hold exerted by clientelism. The western idea of social progress is associated with the decline of assistance in favour of insurance; the extension of insurance systems should leave only a residual share to assistance. Furthermore, the concept of right, moral and social, within the public sphere differentiates between social protection and family or community solidarity and the forms of dependence for which they are often vehicles.

1.2 Moving towards universality and its limitations

In order to be an instrument of social cohesion and the fight against poverty, social protection should aim towards universality at the national level. This can be achieved in different ways, but none seems to be within the scope of the majority of developing countries. States which attempt to build systems of social protection financed on the public budget have had to give up universality and limit their ambitions, the benefits which they have put in place for their civil servants (pensions, partial coverage of hospital costs) or for the poorest people (free health care) still often being provided irregularly or even being completely theoretical. Reproduction of the Bismarckian models of the northern countries has come up against the difficulty of expansion of the wage-earning population. The result is that, although sometimes very similar to those in place in the west, the systems in place in developing countries are often partial: when there is an insurance component, the payment of replacement income is rarer and the mechanisms for redistribution between income or population groups are weak. They generally only concern a minority formal wage-earning group and are often weakened both by poor management and by the economic crises of past decades.

11 *Source: contribution by François Bourguignon, economist at the World Bank*

Social protection policies in the Maghreb have been in crisis for at least 10 years. For almost three decades, the Maghreb states have been expressing a wish to expand the system inherited from the colonial period and to draw inspiration from the western model based on paid employment and redistribution of income. The results today are not very convincing despite some remarkable advances during the 1970s and 1980s. In Morocco, the social protection system is still very limited as regards both the population covered and the benefits provided (only 18 % of the population benefits from health insurance). In Algeria and Tunisia, the social protection systems, after being greatly extended (more than 60 % of the population is covered) and diversified (insurance for sickness, old age, maternity, occupational accidents and even unemployment), are experiencing some decline and increasing difficulties with financing and regulation. In all three countries, reforms are in progress or planned, new ways of covering risks are being sought. In Tunisia, harmonisation of the existing systems and contract-based solutions for relationships between the actors concerned are being sought. In Morocco, extension of health insurance and assistance to the destitute along with regulation of retirement systems have been on the agenda for years. In Algeria, the partial collapse of the pension funds, the explosion of health expenditure covered by health insurance and the increasing rise in unemployment are giving rise to debates aimed at a profound reconfiguration of the social protection system. In parallel with these partial changes in the institutions and policies of the old, formal social protection system, new forms of intervention are being developed with a view to generating income, supporting micro-projects and providing access to certain basic benefits. These actions are being conducted under new structures, such as the Social Development Agency in Morocco or on the initiative of local authorities, as in Tunisia or Algeria[12].

In most developing countries, the expansion of the wage-earning population, which was the basis for the development of social protection systems of the Bismarckian type, is finding it difficult to continue as the motor for the development of universal systems. There are several reasons for this. The first is the weakness of the rate of creation of new enterprises, which is reflected in stagnation of the wage-earning population. It is then held back, if not reversed, by the deregulation of labour and the development of the informal sector, correlated with the search by some enterprises for economies in labour costs with a view to better competitiveness on international markets and reflected in the non-payment of social contributions.

In increasingly competitive globalised trade, many governments perceive that "cheap labour" is their only competitive advantage. Creating badly needed jobs and export income through promoting investment in manufacturing in trade zones, plantations and processing plants is perceived to be a successful economic development

12 *Source: paper by Miloud Kaddar, WHO.*

strategy. In an attempt to remain competitive and attract foreign investment, governments often weaken or fail to enforce labour rights in these zones, in particular with flexible workers and home workers. This trend poses a threat to social protection since national labour codes usually do not protect these workers and they cannot organise to demand their rights either.

Weakening national labour codes or exemptions on the enforcement of existing labour regulations may also be due to the pressure from international institutions. International financial institutions may advise national governments on labour market liberalisation or include conditionality on labour legislation as part of loan agreements. National governments may also be limited by bilateral or regional trade agreements in terms of what labour protections can be required from employers[13].

The current trends in the world of work in India suggest informalisation as the formal workforce shrinks for several reasons, including closures, lay-offs, and new, contract-based production systems.

Perhaps one of the biggest examples of this shift from formal to informal work systems comes from our own home city of Ahmedabad. In the late seventies and eighties, more than 60 textile mills shut down, rendering more than 80,000 workers jobless. Most of these workers obtained re-employment in the city's informal economy – as street vendors, construction workers, loaders and unloaders in the market place and rag-pickers.

The trend toward informalisation preceded globalisation and liberalisation in India, but certainly has been expedited by these economic changes. (…)

Of course, the changes are more in the nature of a continuum with formal systems giving way to contractual ones and often one worker moving in and out of formal and informal work.

All of the rapid changes in employment and work systems have a direct bearing on how social protection can be organised for informal workers. In any case, these workers barely had any social security. But in the new context, with the struggle for work and work security more acute, with the increasing of multiple economic activities undertaken by one worker and migration in search of employment, social protection poses both a challenge and an opportunity (…) to organise workers[14].

13 *Source: paper by Carlos Galian, OXFAM.*

14 *Source: paper by Mirai Chatterjee, SEWA.*

Furthermore, it is hard to contest that the low level of wages and the extent of the inequalities within the wage-earning population make it difficult to establish and balance a contributory system based on earnings from work alone.

Decoupling the wage-earning population and social protection therefore seems to be the only possible way of extending coverage to workers known as informal, whether it concerns wage-earners who are not covered or people engaged in other forms of work – self-employed, family, domestic, etc.

1.3 Towards community-based forms of social protection?

The double challenge set by the clear limits on systems based on wage contributions for the inclusion of informal workers, on the one hand, and by the weak political, financial and institutional capabilities of the state sectors in poor countries, on the other, leads most donors, NGOs and governments wishing to extend social protection to unprotected and vulnerable groups to support the diversification of types of systems and actors. In environments where there are severe political, financial and material constraints, the development of parallel systems is noted – private or "community-based". There are also those which attempt to take over from or substitute for public systems which are failing or in a phase of budgetary restrictions. In fact, on every continent, mutual insurance funds, micro-insurance schemes, tontines, mutual guarantee groups and other mutual aid systems are supported or created from scratch (Rahman, Munir, Hal, N'Diaye, Letourmy).

Construction: Reconstructing the facade of St.Joseph's Cathedral - Dar Es Salaam, Tanzania.

(…) There are at present two views of the contribution of mutual insurance funds to universal coverage in the plans of governments of low-income countries or in the recommendations of experts. The first is a pragmatic view based on the experience of the developed countries and the failures in the organisation of social security systems in the developing countries. This consists in considering the mutual insurance funds to be a stage in the establishment of social insurance. Mutual schemes would make it possible to popularise insurance and to train a set of people qualified to manage it before moving on to the generalisation of the system by making it compulsory. This view of mutual insurance funds has a corollary in the interest of the state in encouraging such bodies and establishing a follow-up, the results which would be used when appropriate to set up universal coverage. This clearly has a disadvantage with respect to the time

needed for the mutual insurance funds to be developed and the national system to be designed. Thus, universal coverage is delayed and a fair proportion of the population is at risk of being without coverage for a long time. The second view of the contribution of mutual insurance funds to universal coverage is that of complementary coverage, either in terms of people, or of benefits. This is designed as part of a national architecture which may possibly be segmented by categories or which may just provide for basic coverage. The juxtaposition of compulsory insurance for the formal sector, voluntary insurance for the relatively favoured informal sector and assistance for the destitute constitutes an apparently quite attractive model, in which the position of the mutual insurance funds is confirmed. It has a serious disadvantage with respect to equity and it is probable that it would not result in universal coverage, since only part of the informal sector is insured. The alternative model is that of compulsory coverage for all, mixing contributory and non-contributory systems, but only offering minimal benefits. It would then be for the mutual insurance funds (or other bodies) to offer complementary benefits in a voluntary and contributory framework[15].

Thus, the assumption is made that universality could be achieved by the juxtaposition of different target systems, but this is only a partial resolution of the question of rights. In fact, through insurance schemes with voluntary membership, the contractual source of rights is predominant: there are, for example, provisions integrated into the articles of association of micro-insurance bodies which define people's rights in return for the regular payment of contributions. However, the participation of members in the decision-making process changes their relationship to the rights: they construct the rights as a function of their needs when the organization is set up and they subsequently shape them in line with its development. Another source of rights is expressed, for

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Workshop on the Strategies for the Extension of Social Security: Introduction to Health Micro-Insurance, Khartoum, Sudan.

15 *Source: paper by Alain Letourmy, CNRS/CERMES.*


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A man with a mobility impairment with his children in Tigray region, Ethiopia.

example, in terms of belonging to a community, which is fully revealed when the social protection system is itself organised within groups which have built up their own identity through a common settlement (village micro-insurance) or the shared management of economic activities (SEWA, Grameen Kalyan).

2. Social protection and poverty

The debates at the symposium confirmed the anticipated role of social protection in the struggle against poverty. Confirmation of the quasi-failure of the anti-poverty policies implemented in the 1990s made the international organisations and national governments think about the question of poverty alleviation in terms of prevention, a struggle against vulnerability and of social protection. But the promotion of social protection in the struggle against poverty also results from its preventative dimension: less social protection is generally reflected in more poverty.

> From the very beginning at SEWA, we saw that our members faced frequent risks and even major disasters. They not only caused immense suffering but also eroded their carefully accumulated assets, resulting in indebtedness and their sinking deeper into poverty. Hardly had a woman saved to buy her house or re-claim mortgaged lands through a loan from a SEWA Bank, when she had to sell it or mortgage it again to cover the costs of a new crisis[16].

Poverty also determines the forms which social protection can take. By limiting the level of contributions, which must match the ability of certain groups to contribute, social protection only provides for modest benefits and poor quality services, especially health.

> Wealth improves health, and health improves wealth. But for people on low incomes, there is not enough money to go around. As a result, health services (preventive and curative) and health-enhancing extrasectorial policies (education, nutrition, reproductive health, infrastructure, hygiene, and sanitation systems) are often underfunded. This leads to high morbidity and mortality from conditions that are preventable or curable even in low income countries. The resulting reduction in labour productivity curtails economic growth and development. In many low income countries, health gaps lead to development traps. Improvements are needed in health status to continue economic growth, but increased spending on health is often

16 *Source: paper by Mirai Chatterjee, SEWA.*

impossible due to lack of a capacity or the political will to shift public expenditure towards the health sector. [17]

The contributions of the poor alone can in fact only cover the risks to a very limited extent: often primary health care, but less frequently the reimbursement of medicines, laboratory tests or surgery; even less frequently the replacement of earnings in cases of sickness, invalidity, maternity or unemployment. Moreover, the paucity of the benefits tends to discourage membership and constitutes a disincentive to the payment of voluntary or compulsory contributions.

The question of the contribution of mutual health insurance funds to the fight against poverty produces a subtle, or even paradoxical reply. On the one hand, a priority target of the mutual insurance funds is, as stated earlier, the informal economy and the rural sector, where the prevalence of poverty is high. But, on the other hand, there is no true insurance or mutual protection without financial contributions from the members, which immediately excludes the poorest. The consequence of this requirement is that the mutual insurance funds constitute a tool in the preventive fight against poverty for categories which are now capable of mobilising sufficient resources to pay the mutual contributions regularly. If such households are affected by illness, they will have access to care, will be able to re-establish themselves and will avoid the chain of events leading to poverty.

Having said this, the restricted solidarity (limited to contributors) which characterises mutual insurance funds does not prevent this target from encompassing some of the households considered poor. (…)

However, it is still the case that the permanently destitute are in principle excluded from membership of mutual insurance funds unless their contributions are paid externally. In this respect, the countries which consider that mutual insurance funds are intended to provide sickness coverage for the poor are not always very explicit with regard to the methods of payment. It is assumed that the state or local communities will pay the contributions on behalf of the destitute but, to our knowledge, such substitute payments have never been noted in practice in West Africa. On the other hand, there are examples of mutual insurance funds which take action in favour of the destitute, giving them access to benefits payable without contributions. These examples are characteristic of very limited groups, which cannot envisage excluding a member of the community. This is the case in rural environments (Mali, Benin) and it may be stated in this respect that mutual solidarity is continuing the traditional solidarity in these areas[18].

17 *Source: summary of the paper presented by Mr A. Preker, Chief Health Systems Development, Health, Nutrition and Population, World Bank, Washington D.C.*

18 *Source: paper by Alain Letourmy, CNRS/CERMES.*


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Child shoe-repairmen in the streets of Bali.

In this process, women are the most affected and the most vulnerable. They are generally less well represented than men in the formal wage-earning population and single-parent families headed by women are over-represented among the poor population. They are also often less well equipped to assert their rights and claims. This specific vulnerability justifies, among other things, the fact that women are a priority target of programmes aimed at building social coverage where the informal economy is most extensive.

Policy makers too easily ignore the costs of export employment for women, their families and their communities. Promoters of export zones reinforce the myth that "these women have work for the first time in their lives", erasing consideration of the compromise between housework and women's former (unpaid) contributions agricultural production and informal services.

Working women are at the forefront of export-oriented growth. For example, in the developing countries, women represent more than a third of the manufacturing workforce (almost 50% in some Asian countries). They represent 70% of the workforce in the Export Processing Zones and 80-90% of homeworkers in the clothing sector. Working women are fighting for their rights to be recognised. They are often regarded as expendable, secondary workers, not the "real" providers for their families. In addition, since export workers tend to be young, unmarried women, expected to be replaced within a few years, it is only too easy to ignore their rights to social insurance, health, pensions or statutory leave. When employers and governments fail to provide these, working women are impoverished.

Working women, as well as companies, also face a problematic mix of benefits and costs. Many women value the economic independence and the social status gained through their jobs. When working in these export industries, women often enjoy higher than average wages. But, for these short-term gains, they often trade away sickness benefits and long-term social welfare for themselves, their children and their families. On returning home to rural areas, these working women are often stigmatised. As women become "wage-earners", male relatives may reduce their traditional support to households, leaving women more vulnerable in times of crisis.

On the one hand, governments are subjected to enormous pressures from different actors to relax labour codes and reduce social expenditure. On the other hand, faced with a growing presence of women on the labour market, their role in providing social protection to their families and communities diminishes. Consequently, neither the state nor the communities can provide the required social protection at a time when it is most needed[19].

The limits induced by situations of insecurity and poverty explain the attraction of models of integration of social protection, whereby the systems are grafted on to local economic development (SEWA, Bangladesh), which provides financing for them and offers greater possibilities for pooling of resources.

3. Redistribution and inequalities

Social protection also differs from assistance in that it brings equity. For this purpose, it has to include mechanisms for redistribution, making it inevitable that states will decide to establish forms of obligation (affiliation, contribution). Thus, aiming for universality has consequences in terms of financing. When all citizens are to be included in a single system of social protection, including people with a low or zero ability to contribute, a compulsory contribution system becomes essential, since it may be assumed that the strata with most income will be reluctant to contribute voluntarily in a proportionally greater share than the poorest.

The objective of equity is all the more difficult to achieve as the population described as destitute is sizable in developing countries. It is then necessary to combine contributory and non-contributory mechanisms and, hence, the legitimacy of compulsory contributions is not necessarily achieved. The higher-income categories must then be allowed the option of paying for broader coverage, if they are to accept the principle of solidarity. Thus, social protection will constitute a tool in the struggle against poverty which is all the more equitable when it is universal in nature, allowing certain groups the option of establishing mechanisms of a complementary nature, in particular of the mutual type.

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Old man selling newspapers in the streets of Havana.

19 *Source: paper by Carlos Galian, OXFAM.*

The first criterion for assessing the potential effectiveness of a measure in social policy with regard to the struggle against poverty is knowing whether it constitutes an advance in the implementation of the principle of mutualisation or not. It quickly seems that most "targeted" policies for aid to the poor are regressive policies from this point of view. In fact, "targeted" policies are mainly, if not solely, aimed at inactive people (more or less "unemployable"); also, the extent and volume of aid generally decreases in periods of recession. Conversely, the number of insured people decreases continually. There is then a "no man's land", neither insured, nor assisted, dominated not by inactive people, but by the "working poor"[20].

In this respect, the durability and efficacy of "community-based" or alternative type systems in fighting against inequalities are threatened by various limitations. The principle of voluntary contribution to insurance or mutual fund systems tends to fence off the systems for groups with similar standards of living (adverse selection), a phenomenon reinforced by their small size. There is then segmentation of the risk-sharing systems among affiliated members identifying with a group which has its "own" system. On the one hand, without employers' contributions and without injections from the public budget, providing no compensation policy is envisaged, redistribution between categories or between income levels is low or zero.

Whether Bismarckian or Beveridgian, social protection systems are based on the redistribution of revenues, either of the more horizontal type, towards families caring for children, benefits going towards the victims of social risks, thus covering poverty or periods of parental responsibility, or of the more vertical type between rich and poor. If the models recommended by the international financial institutions prevail, would this solidarity and redistribution not risk being limited by individual capital accumulation and private management, generalising economic liberalism to a sector which has up to now been social? [21]

On the other hand, the diversity of statuses and the rights consequent upon the types of protection produce or maintain considerable inequalities in the levels of social protection provided to one group or another. Some would be insured by virtue of their status as formal wage-earners employed by the state or large enterprises, while others would be affiliated to mutual insurance funds or to networks of informal solidarity owing to their community or local links. Households earning regular and sufficiently high income would subscribe to private or funded insurance plans, while the destitute, the handicapped and other unemployable people should, in their condition, benefit from state or private assistance. The system produced would therefore guarantee neither equality of rights nor of benefits, since the market remains the main principle for the allocation of resources and the competition between systems has to bring about effectiveness. Apart from its interventions on the macro-economic level, the state would only be required as a

20 *Source: paper by Bruno Lautier, Professor of Sociology at Paris I University.*

21 *Source: contribution by Michel Laroque.*

minimum to fulfil the function of last resort for people incapable of finding means for fighting against their vulnerability in the market. The exclusion and great inequalities produced by such fragmentation would, however, be likely to give rise to social conflicts.

Past transitions and the current context of crisis are making the conventional model of social protection totally inoperative. This assumes steady growth in paid employment, an ability to make deductions from all income, active and targeted mechanisms for the redistribution of resources and finally a regulatory state and legitimate social partners.

(…) Overall, state social protection in the Maghreb, while still centred on the urban formal sector, assists in reproducing inequalities of income. The inability to conceive and above all to implement a proper fiscal and income redistribution policy in the new economic and social context described above reveals the extent of the reforms to be undertaken. The measures and initiatives brought about by structural adjustment measures and by the action of community-based associations have been found to be too weak to achieve a balance in the distribution of resources and better coverage of the risks associated with, among other things, unemployment, sickness and old age. This impasse has now been widely recognised. It is a condition favourable to proper debate on the reconstruction of social protection[22].

4. Actors in social protection

The conditions under which social protection is able to expand in developing countries mean that the coordination of public and private actors represents a success factor, if not an imperative. In other words, the simultaneous mobilisation of the communities and groups making up civil society, on the one hand, and the various levels of the state and the administration on the other hand, are inevitable. Furthermore, in the particular case of sickness coverage, the involvement of professionals in the construction of compulsory or voluntary systems is a necessity. The coordination and organisation of debates between actors does not mean that their roles are interchangeable. Clearly, the role of the state is specific and it must be asked whether its ability to intervene and the qualifications represented within its administration are really up to the requirements for the development of social protection.

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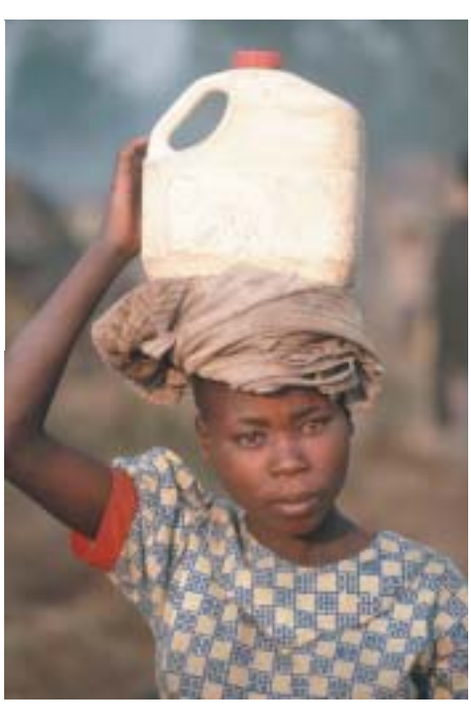
Sawing lumber in a sawmill, Gabon.

22 *Source: paper by Miloud Kaddar, WHO.*

4.1 Role of the state

Collecting taxes and contributions, enforcing the rules of social law, operating and protecting compulsory and universal systems therefore requires both political ability and administrative skill, which is not the case in many poor countries.

The Latin American governments of the 1940s and 1950s relied on a theoretical system extremely close to that which had guided the European governments. This system may be summarised very simply: a) the resources providing for mutual coverage of social risks form part of salaries; the financial problem of social protection is therefore first of all a problem of political decision-making, namely imposing this partial pooling of salaries; b) three variables determine the level of these resources and the changes in them: changes in the number of employees, changes in the level of salaries and the proportion of salaries which is pooled; c) the most likely relative changes in the three variables are as follows: the number of employees increases quickly first of all and then less rapidly; the increase in salaries is regular and self-supporting; the pooled proportion of the salaries is regularly increasing. Contrary to the leitmotiv of neo-liberal analyses, this concept of social protection was no more "unrealistic" in Argentina or Mexico than in France or Sweden. Any establishment of a social protection system is based on a political "wager" and thus on a high capacity for independence of the political system. Historically, social protection produces a political consensus, but it is never based on a prior consensus, and this was true on both sides of the Atlantic[23].



Goma, water duty in a refugees camp.

A weak state finds it difficult to impose a concept of solidarity when faced with the deregulatory trends present within the private production system, which has been said to be capable of paralyzing systems' resources and giving rise to the development of the informal economy. On the other hand, fighting against this development from this angle (fraud, failure to observe social law, insecurity) is reflected in an increase in the resources of social protection systems. There is thus a correlation between the state's capacity for control and the resources of social protection. It may therefore be added that the processes of structural adjustment, by exerting pressure for budgetary reductions without deploying similar efforts to increase revenue, act against the establishment of systems managed by government.

23 *Source: paper by Bruno Lautier, Professor of Sociology at Paris I University.*

Social protection has a collective function. By preventing excessive inequalities from becoming embedded, by becoming a vector of national solidarity, both in its purpose and through the means which it implements to achieve it, it is thus a factor in social cohesion. Positioning social protection in this way necessarily calls upon the role of the state, which should not be limited to that of a financier: only the state can act as guarantor for this law as social law, even if it is not necessarily in a position to guarantee the probity of the accounts, which may be entrusted to joint bodies of social partners. And only the state is in a position to impose and legitimise the redistribution inherent in any universal system; otherwise, how would the middle and upper strata accept financing social protection for the lowest contributors? How could compulsory contributions be imposed and paid?

Social protection is not only a cost or a constraint. It is effective on the economic level and also on the political level.

Is social protection or is it not a threat to states' growth and competitiveness? It is certainly a cost at the micro-economic level for the enterprise which, on top of direct wages, pays deferred wages in the form of social contributions and for the worker, who sees his or her immediate income limited in order to provide for future risks. But it is also a possible growth factor at the macro-economic level through its anti-cyclical effects and through the development of a health and social sector which constitutes an aspect of economic development. Finally, if it is well designed, it is not a handicap in international competition, in so far as it does not represent a cost at the macro-economic level but is mainly a method of redistribution of the product of labour within the national population[24].

Recent studies on development economics have put forward a number of reasons why too unequal a distribution of resources may give rise to inefficiency in economic mechanisms and a low capacity for development. These studies consequently suggest a kind of virtuous circle whereby redistribution of the initial resources would result in increased economic efficiency and more rapid growth, these two factors possibly contributing to a further extension of redistribution. Having said this, not every redistribution programme necessarily leads to this type of result and further consideration is required with respect to the instruments to be implemented in order to achieve the above result[25].

The establishment of public coverage constitutes one of the mechanisms affirming the power of the state and its desire for

24 *Source: contribution by Michel Laroque.*

25 *Source: contribution by François Bourguignon, economist at the World Bank.*

modernisation and development, when faced with the fragmentary approaches of corporate or community systems. It is at this point that the switch from free and voluntary systems to compulsory affiliation can be made, on mainly political bases. The state, strengthened by the legitimacy drawn from its intervention in this dimension, can then use social protection as an instrument of public policy: support for or restraint on the birth rate, encouragement of women to work, promotion of training and abolishment of child labour, enhancement of public health and hygiene, etc.

It is still the case that the fulfilment of its role by the state is dependent on its capacity for intervention when it has not yet established supervisory mechanisms. In this respect, the capacity of states for action is one of the obstacles to progression towards universality. If social protection is not to constitute a privilege for the affluent or a favour for the most destitute, but a right for all citizens or residents, how can this right be guaranteed, its effectiveness monitored and the corresponding contributory duties established, when going outside the spheres covered by state regulation (formal work, declared income) in order to integrate these areas?

4.2 Civil society and the groups within it

One of the roles more or less explicitly allocated to civil society or to communities with respect to social protection is the establishment of mechanisms for supervision and regulation where the public authorities are incapable of intervening. In fact, these roles form part of an even wider system, since these groups also have to fulfil a function of initiative, when the state cannot stimulate sufficient dynamic for the population to organise itself.

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Woman entrepreneur with a disability: Tearoom keeper serving customers in Tigray region, Ethiopia.

Observation of the situations of the developing countries indicates that there are various methods of collective mobilisation within civil societies and that this results in quite different coverage and management configurations of systems.

The world of work constitutes an initial type of operational provider of social protection, but the emergence of bodies originating from employers or employees does not necessarily result in systems which are analogous to those present in the developed countries. On the one hand, enterprises in the formal sector are likely to set up systems covering the risks of interest to both employers and employees, but ignoring the others. For example, the common interest which both parties have in responding to cases of sickness is sufficient for in-house systems to have been organised and managed, in principle within a mutual framework, which limits the drawbacks of a cessation of activities. In such systems, the objective of effectiveness is essential and the outward appearance of mutuality will often give way to private management sub-contracted to specialised bodies (South Africa, Ivory Coast). Although the cost of such formulae puts them beyond the range of all of the population, they still have a capacity for innovation which may produce models with a view to broader protection systems, as in the case of HIV/AIDS insurance products.

The aim of the project (AIDS Solidarity!) is to enable company mutual health funds to take responsibility for financing the prevention of HIV/AIDS transmission, as well as the ARV treatment of infected people, through the creation of a Solidarity Fund.

The contracting authority for this is the FEMCI, the Ivory Coast Federation of Mutual Medical Associations. This non-governmental association is an independent grouping of company mutual health funds, covering about 38 000 people, employees, spouses and children.

This population covered by the project is well known since it is being monitored as part of a medical mutual fund management programme, assigned to a private service provider specialising in the field, MCI – Managed Care International. Thus, the project has access to data concerning this population. It also has access to analysis facilities for detailed monitoring.

The programme is coordinated with the supervising ministries. It forms part of the national policies for combating HIV/AIDS.

The GSK Foundation has allocated a grant with the aim of establishing, measuring and demonstrating the effectiveness, realism and acceptability of a system of solidarity for the benefit of the members of the FEMCI.

It is interesting to note that a foundation of a pharmaceutical company, a pioneer in the field, has been able to provide resources in an attempt to respond to the vital question of financing.

The AIDS Solidarity ! project is based on the creation of a Solidarity Fund, which will be formed from contributions made by employers and employees. This project broadly aims to determine the acceptability by all, and the technical and financial feasibility of the establishment of such a fund. This will be created after a six-month period of observation, everything have been explained from the very start for those concerned.

A contribution corresponding to what is deemed necessary to sustain the system will be determined. The amount is estimated today at 3 000 FCFA per contributor per month.

(…) Acceptability has been the initial concern. This concerns members, company managers and occupational doctors. The initial findings are excellent: there is astonishing motivation. However, the development of the project needs time and teaching. Far more than we anticipated.

The pitfalls encountered have been:

- The time required to overcome apprehension.
- The distrust on the part of the members, in particular fearing that their revealed status will be used against them by their employers.
- The fears of employers that a Pandora's box has been opened whose consequences they will not be able to control, especially financial ones.
- The difficulties of doctors, fearing the loss of their prerogatives by passing their HIV positive patients to the outside.

However, everyone carried on regardless, despite the rather unfavourable Ivory Coast context[26].

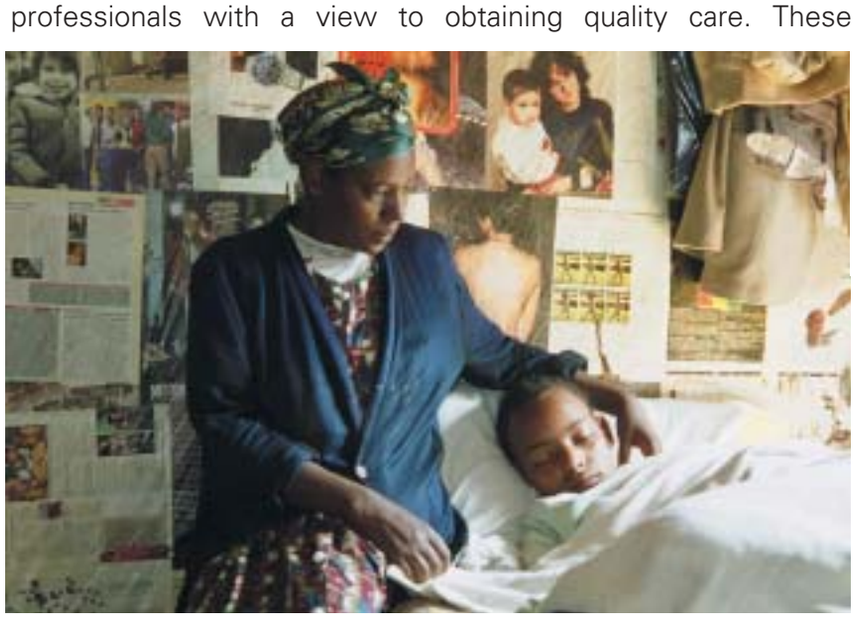
In the informal sector, production activities may also be the origin for insurance systems and groups of producers are inclined to develop schemes of voluntary or compulsory insurance based on the existing production organisation. Women's groups are particularly favourable for the emergence of such schemes, which appear to be effective overall and likely to spread rapidly (SEWA). The risks of sickness/maternity and death are apparently most frequently covered, in direct relation to the impact they have on production activities.

Independently of production activities, even though they are also likely to develop from the world of work, mutual insurance funds represent highly developed formulae in some zones such as West Africa, as a function of various initiatives.

26 Source: paper by Jean-Michel Lichtenberger, GSK Foundation.

The limits and drawbacks of recovering costs provide an understanding of the importance attached to alternative systems likely to lower the financial barrier to access to health care and make the demand manageable. In fact, quite diverse responses have been made to the question: what financing mechanisms to promote in order to increase the demand? Many formulae for the arrangement of payment conditions (prepayment/subscription, health savings) have been the subject of experiments and it may be observed today that the term "community financing" covers a whole series of systems with the same objective. But it is mainly sickness insurance which has attracted attention. The concept of micro-insurance, as a system putting this method of financing within the range of small groups or populations with few resources, has given rise to large-scale awareness in West and Central Africa. Health establishments (mainly hospitals) have also proposed methods of payment based on insurance. Finally, the promotion of insurance in a mutualist framework has been implemented, in West Africa in particular[27].

The risk of sickness is the most frequently covered, but the mutualist schemes apply to the coverage of other risks (old age in particular) and to the development of social insurance. The mutual insurance funds are based in principle on management methods controlled by the members and are intended to form a social movement which has the ability to exercise internal control over its different components. These characteristics explain the success of the mutual insurance funds where the state is weak or where it wishes to relinquish the practical organisation of social protection. It is still the case that mutual insurance funds cannot be promoted without the support of the public authorities and that they cannot alone resolve problems such as the conclusion of contracts with professionals with a view to obtaining quality care. These



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A self-employed enjera baker taking care of her child with mental disabilities, Addis Ababa, Ethiopia.

27 *Source: paper by Alain Letourmy, CNRS/CERMES.*

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Paraplegic teacher in a training centre, Harare, Zimbabwe.

difficulties explain the relatively slow development of mutual insurance funds and the search for alternative approaches for the establishment or management of these schemes towards the same objective of setting up of micro-insurance. In any case, these schemes are the only ones which seem suitable for the informal economy and their promotion brings together the development partners.

The development of micro-insurance should not be left entirely to communities, in the sense that professional bodies are also capable of structuring the emergence of social protection within civil society. On the one hand, in the particular case of health, providers sometimes propose schemes for mutual insurance. On the other hand, the NGOs involved in economic and social development are effective actors in the promotion and implementation of schemes for social coverage. With a presence in large populations (Grameen Bank, BRAC), legitimised by their success in their economic field (agricultural development, micro-finance), they can propose methods of coverage which quickly achieve the support of their members. They represent successful pilot experiments, the implementation of which should be generalised. But, at this level, cooperation between the state and the NGOs does not operate automatically, since there are still heterogeneous systems present without external control.

4.3 Coordination of actors

Consultation between and coordination of actors in social protection appear to be necessary conditions for its development.

Various international partners decided in June 1998 to hold a meeting to define the strategies to support the budding mutual insurance movement in Africa. A workshop held in Abidjan (Côte d'Ivoire) brought together various organisations: mutual insurance federations from Africa and other regions in the world, international organisations, states, cooperation agencies, care providers, local and international NGOs, universities, research centres and trade union confederations. Representatives of nine states and about fifty bodies took part in the activities. It was during this workshop that a reference document was produced: The Abidjan Platform. This is the product of the experience of the main architects of the development of mutual health insurance funds in West and Central Africa.

The participants in the workshop expressed the need to create a more structured mechanism for cooperation between the actors in the development of mutual insurance funds. This idea was put into practice through the establishment of a "Concertation among actors in the development of mutual health insurance funds in Africa", known as "The Concertation" based in Dakar in Senegal. "The Concertation" is an innovative and strategic mechanism. It can be used to create strategic and technical links and cooperation and to establish a dialogue between African mutual health insurance funds, the social partners, the actors in development and communities through specific activities, such as training, workshops with thematic discussions and exchanges. Since its establishment, through ten newsletters and the "Concertations" internet site, numerous actors have been able to share their points of view, their knowledge and their experience. Every month, new users are joining the "Concertation", of whom there were more than five hundred in 2002. The "Concertation" is active in eleven countries in Francophone Africa: Senegal, Mali, Burkina Faso, Niger, Ivory Coast, Benin, Mauritania, Cameroon, Guinée forestière, Chad and Togo.

The "Concertation" is based on a partnership between the actors in the development of mutual health insurance funds in Africa. Four entities are actually involved in this: promoters (…), coordination cell (…), members (…), and focal points (…).This structure has implemented an operational information system around four priority activities: an internet site (..), a newsletter (…), a system for monitoring the development of mutual insurance funds (…) and the organisation of forums[28].

The driving role of the state is incontestable, but this should go beyond the rigidities and compartments of its administration to mobilise private actors en masse. Debate seems inevitable, just like reciprocal compromise. It may be asked what are the facilitating factors in this process of coordination (geography, level of economic development, degree of democracy), since the obstacles are often great and success relatively rare (Mauritius).

28 *Source: paper by Pascal Ndiaye, Concertation des acteurs du developpement des mutuelles de sante en Afrique.*

Information regarding the lack of a coherent poverty eradication policy in most of the Arab countries, may be generalized to other domains, including the lack of an integrated social vision and an integrated approach to SP. This is the most important challenge to be faced. With the exception of Tunisia, all the remaining Arab countries have not formulated an integrated social vision, which would be connected to an integrated economic vision on one hand, and reflected in the different sectoral social policies on the other.

Even though one can find an interesting sectoral social policy (employment, education, health, social protection, etc), it is usually not linked to other social policies and coordination is lacking among the different actors, whether among the different ministries or between the leading ministry and concerned NGOs.(…)

In Jordan, Coordination is one of the main issues raised by nearly all officials. There is an obvious absence of formal coordination between the many different government and non-governmental agencies working in the field of poverty reduction. This applies to intra-ministerial coordination, inter-ministerial coordination, coordination between the different NGOs. Lack of coordination among the providers of assistance to the poor results in the duplication of efforts or conflicting initiatives.(..)

In Lebanon, There are no effective coordination mechanisms between the different ministries in setting policies and plans, even though their activities may be complementary. Other government policies, which have an indirect impact on the poor, can be contradictory. As in the case in Jordan, formal coordination, between government agencies and civil society and within civil society is weak. There are few mechanisms through which such coordination can take place. Coordination between NGOs has also been problematic with infighting, jealousies and turf wars. [29].

(…) The interventions which have in some way helped to reduce exclusion can be grouped into several categories: Establishment of special non-contributory social security schemes (…); Voluntary insurance schemes subsidised by the Government (…); Limited choice of the providers of services (…); Community-based social protection systems (…); Gradual development of unified systems (…).

An initial conclusion can be drawn from the experiences just illustrated: reducing exclusion in the field of health requires an approach which allows for a mix of several methods of intervention. Joint efforts are needed to address the issues of the "pilotage" role, financing, insurance and health service delivery, so that the actions implemented in each of these areas are consistent and mutually reinforcing[30].

29 Source: paper by George Kossaifi, consultant.

30 Source: paper by Mr López Acuña, PAHO

Part 3: Support for the development of social protection at the international level

In this section, we have chosen to present the framework for action, the values underlying it and certain initiatives with regard to social protection undertaken by the World Bank, the ILO and the DGCID. The main objective is to show that, although these three institutions are coming from different perspectives, largely associated with their specific missions and their history, lines of convergence may be drawn to support collaborative efforts.

1. Framework for World Bank intervention: social risk management[31]

The World Bank has developed a new approach to social protection, social risk management. This is a holistic and flexible approach, which includes intervention to assist individuals, households and communities to face up to risks, the main one being falling into poverty, or not climbing out of it and passing it on to ones descendants. This new framework forms part of the struggle against poverty and the promotion of economic development: social protection must not only protect, but also act as a springboard for getting out of poverty. It represents an investment to strengthen the productive capacity of the poor through training and encourage them to undertake more risky, and presumably therefore more profitable, economic activities. This therefore involves both reducing exposure to risks through targeted interventions on the labour market, consolidating the capacity of the poor to face up to the risks they are running, through the pooling of risks in private or informal insurance schemes and alleviating the consequences of a risk which arises when the poor have no other fallback.

For the Bank, the concept of social risk management differs from the traditional one of social protection and redistribution, although they overlap in places. Social protection, in its traditional guise involving the direct public provision of instruments of risk management and redistribution are just one aspect of the new framework for intervention. In fact, redistribution is both an objective and a result of programmes of social protection, but not an instrument of such programmes: "strengthening the capacity for risk management has great redistributive effects on individual wellbeing and does not

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Consultation in a primary health care center in Kibagare, Kenya.

31 *Sources: Doryan Eduardo, Holzmann Robert, Lau Jorgensen, et al. The World Bank's Approach to Social Protection in a Globalizing World on site http://www1.worldbank.org/sp/.*


© ITC-ILO/K. Rossel

Workshop on the Strategies for the Extension of Social Security: Introduction to Health Micro-Insurance, Khartoum, Sudan.

require any interpersonal income redistribution in order to achieve a better distribution of wellbeing. Furthermore, not all redistribution is a form of social protection", following the example of tax transfers or public services (Doryan et al. 2001, p. 11). The management of social risk outside social protection and outside redistribution consists essentially of policies affecting the vulnerability and volatility of income: macro-economic policies, financial markets, property rights, observance of labour rights, etc. As regards social protection outside risk management and redistribution, this is designed as a set of measures to promote social inclusion, beyond the traditional considerations based on income: it covers support for the associative sector, social rights and social capital.

The framework of social risk management seems closer to the trinomial of promotion of human capital / growth policies / assistance under restrictive conditions than to the "European" vision of social protection. In particular, the position of insurance schemes is minimal: they are reduced to constituting just one of the methods of informal risk management, through mutual insurance funds, and one of the possible options available in the private sector.

In the World Bank's social risk management strategy, the preventative dimension of the role of the state rests above all in the field of labour: guaranteeing equitable access to well-paid jobs, not by means of a rise in the minimum wage, but owing to an increase in qualifications and the risks taken, formalisation of labour relations, struggle against discrimination, prohibition of forced labour and elimination of dangerous child labour, right to collective negotiations, education and training. However, since risk constitutes a factor encouraging effort and enterprise, the very motor of economic growth, it cannot be totally eliminated. The curative dimension of public action depends on the resources and capabilities of the state, which can put in place non-contributory social assistance programmes financed by public funds to deal with unemployment, occupational accidents, old age, invalidity, sickness and widowhood. These programmes must be intended for just the poor "for life", for whom informal mechanisms based on the family and the community continue to play a role which is essential but inadequate in periods of severe crisis or in cases of serious shock. For the poor "for life", the curative perspective supplements the preventative, which is expressed in the desire to hold back the intergenerational transmission of poverty and thus to reduce the risk of poverty in the future. The rest of replacement income is based on community support and private and contributory schemes, in addition to individual savings for pensions and redundancy payments. The establishment of unemployment insurance schemes is not deemed appropriate for developing or transitional countries, no more than the creation of

compulsory contribution systems, which come up against adverse selection mechanisms, the poorest being involved in them while the richest avoid them, and exclude non-formal workers. Finally, in cases of serious crisis and total destitution, the states may turn to the traditional assistance mechanisms: payments of money and food, targeted subsidies and exemptions, "self-targeted" public works.

For the Bank, the role of the state is thus essentially one of last resort, when informal or market schemes are non-existent, have failed or are malfunctioning. In fact, the application of the conceptual framework of social risk management to social protection consists essentially in reconsidering public sector programmes by "strengthening" them and extending the concept of social protection to market and informal activities. However, "the fact of placing more emphasis on social protection services based on the informal and communities should not be viewed as an "abandonment of public structures". On the contrary, (…), building community capabilities can only encourage the enhancement of public services (Doryan et al 2001, p. 35). The World Bank's strategy is directed towards support for informal and market schemes. The former cover capitalisation / decapitalisation in the form of livestock, gold, real estate, borrowing, crop diversification, stocks and solidarity. Social development funds are still an important instrument in the scheme, in their mission of "community development", in the fields of infrastructure, public services, the construction of social capital, targeting, micro-insurance, etc. As regards the private sector, apart from its function of employer, it is called upon to provide services in training, credit and insurance for those who can contribute and above all to assist with the establishment of and access to micro-finance. Its contribution to the protection of individuals and groups will be all the greater, the more effective the management of social risk, since people will then no longer be in a position to depend on public mechanisms. For the World Bank, it is through the juxtaposition, and sometimes the superimposition, of different schemes that the coverage of social protection can eventually become universal. But the concept of universality thus does not imply equality of access, or of services, since targeting and diversification are still the rule, and the market is still the main principle for the allocation of resources.

2. The ILO and the extension of social protection in developing countries[32]

The ILO continues to refer to a more classical definition, included in its standards: it defines social protection as protection which a society provides to its members through a series of public measures: i) to compensate for the absence of or a substantial reduction in working income owing to various contingencies (in particular sickness, maternity, occupational accidents, unemployment, invalidity, old age and death of the head of household); ii) to provide health care to the population and iii) to provide benefits to families with children. The two components of social security are i) social insurance financed by income-related compulsory contributions, possibly supplemented by

32 *Sources: Reynaud, Emmanuel 2002 - Sites: http://www.ilo.org/public/french/protection/socsec/step/index.htm and http://www.ilo.org/public/english/protection/index.htm.*

voluntary insurance schemes (micro-insurance or mutual insurance funds), the benefits of which are granted in case of temporary inability to work in order to compensate for unforeseen events, avoid indebtedness and spread household expenses; and ii) social benefits, targeted at the deprived and financed by the public budget, to assist low-income categories and reduce household expenditure on certain basic goods and services. Public subsidies on foodstuffs, education and housing may supplement the scheme.

Research carried out by the organisation on informal work has persuaded it to broaden the concept of social protection in order to face up to the specific problems of the developing world: it still covers essentially social security and labour protection, but also, for these countries, labour market policies and social services. The same for social security: an ILO document defining policies for the extension of social security to developing countries "defines social security not only as a protective policy, but broadens the concept beyond the nine traditional ILO[33] risks to include people's specific rights in the fields of food, housing and education" (Van Ginneken 2002, p. 5), and in particular the reduction of the impact of the costs of fundamental needs, such as health care, education, housing and food, on household budgets. These are therefore "benefits that society provides to individuals and households, through public and collective measures, to guarantee them a minimum standard of living and to protect them against low or declining standards arising out of a number of basic risks and needs" (idem). However, social security, which is aimed at protection should not be confused with policies to encourage employment and the economy. In this definition, the social element is provided within the context of not-for-profit, public or collective arrangements, often voluntary.

It is still the case that social protection and insurance schemes are often powerless to prevent the risk of poverty, owing to the fact that many people are unable to contribute. They are therefore dependent on social security benefits financed by the public budget, by transfers of social insurance contributions or even by international resources. For the ILO, it is however clear that these public assistance programmes should be linked with policies for the struggle against poverty and social security, employment, education, health and families, and that the low level of assistance benefits should be able to act as an encouragement to contribute to social insurance schemes. Moreover, as these are generally far more widely legitimised by the middle and upper strata of the population, it is understandable that assistance, conditional upon resources, appears to be a complement to insurance, rather than a separate branch intended for a distinct population.

The ILO has found that several middle-income countries have managed to extend health insurance to large sections of the population, or even to set up universal coverage. Most of those which have undertaken to extend compulsory coverage have, nonetheless, proceeded gradually, starting from large enterprises because of the material, political and financial constraints, the lack of experience of the administrators and gaps in the databases. Political commitment is the main factor determining the successful establishment of universal coverage. But socio-economic factors, the extent of informal and agricultural work, the extent of the inactive, and also the state of the institutions, health in this case, the level of services offered, the quality of the peripheral

33 *Sickness and maternity, unemployment, employment injury, old age, invalidity and death of the breadwinner, as well as medical care and family benefits.*

Making "Beedi" cigarettes at home, in the village of Puttige (Mangalore region), India.

infrastructures (water, sewers) and the inclination of the populations to contribute, also play a fundamental role. In the low-income countries, apart from a few exceptions, generally socialist regimes, the financing requirements often exceed the resources, even though the charges paid by the patients are often very high. The proportion of formal workers is often very low, making it difficult to have a system of transfers between funds, and the services offered are too low in quality to encourage voluntary contributions, especially on the part of poor workers. The solution recommended by the WHO and adopted by the ILO is to set up community-based mutual insurance or micro-insurance schemes. The same type of procedure is recommended for pensions and unemployment insurance, although they do not necessarily have the same degree of priority.

The ILO considers the development of decentralised schemes based on local initiatives to be an intermediate phase in the achievement of universal and relatively egalitarian ambitions and in the establishment of a culture of social protection. Recommending the establishment of links and partnerships between decentralised systems, community, cooperative, association or trade union schemes, would make it possible to strengthen their ability to negotiate with the public authorities and the providers, to have better sharing of knowledge and greater financial viability and stability. Placing voluntary mutual insurance systems under the supervision of the state, as a first stage towards compulsory coverage for all workers, once harmonisation has been established between the various types of schemes and contributors; or even encouraging the possibility of voluntary affiliation to compulsory public statutory schemes, would constitute advances towards uniformity under public control. Finally, the establishment of universal systems of the mutual type cannot follow from a simple quantitative juxtaposition of defined schemes: it is necessarily based on a political decision, determining a change in the nature of social protection.

The ILO therefore emphasises the role of the state and the preservation of the spirit and major values of social protection as established in the European and Latin American


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Patient being treated at the alcohol detoxification centre of the hospital in Bangalore, India.

countries, but recognises the limitations. In fact, the main obstacle facing the ILO in the poorest countries lies in the low institutional and financial capacity of the state, in particular to collect taxes. This is the reason why, in the poorest and uninstitutionalised countries, the ILO is following a double track: supporting the restructuring of social security systems and enhancing the quality and extent of their coverage, but also developing a culture of insurance and solidarity with regard to protection against social risks at the level of decentralised communities. The recommended method is not static: it must progress towards universal coverage, as we shall see. In this respect, the role of the state is central: starting with the direct provision of services, it can encourage and support schemes, or establish some of them, establish partnerships with groups in civil society, supervise the accumulation and reproduction of experiences, promulgate favourable laws and promote transparency and observance of the law, and organise training. It is also called upon to co-finance, or subsidise, access for the poorest groups and the self-employed, whose ability to contribute is low or zero and for whom no employer can be persuaded to pay for participation.

It is still the case that establishing universal social protection at the national level only is not sufficient: not only is there the problem of frequent exclusion of migrants, clandestines, the stateless and refugees, but social protection also has to be affirmed as a universal principle at the international level. The role of international organisations, as legitimate super-state authorities, is fundamental in this respect.

3. Support of the French Ministry of Foreign Affairs for the development of social protection in developing countries

France has long supported the development of social protection in developing countries and has done so while referring to the values underlying it. Its action was first of all based on a Bismarckian approach, with which it was familiar. Thus the concept of solidarity was devised so as to meet a double imperative: benefits matched to individual needs and contributions defined in proportion to each person's resources. Logically, the mutualisation of risks through insurance was adopted, providing the insurance was social in nature. The concept of equity was incorporated into the possibilities for vertical redistribution of the schemes. Universality was a legitimate objective and social protection was to cover most of the social risks, in particular those related to work.

The support given to the construction of social security systems in several developing countries at the time of independence, above all in West and Central Africa, has been the most direct expression of this commitment. Funds for retirement benefits, family

protection, the coverage of occupational diseases and work accidents have been established with the support of the DGCID. A few sickness insurance schemes have emerged in this context. From the technical point of view, the desire for regulation and also harmonisation of systems has justified a regional vision for the construction of social protection, which the establishment of CIPRES has translated into institutional terms. At the same time, cooperation agreements with respect to social protection, intended in particular for maintaining workers' rights in situations of mobility have been concluded with most countries.

The changes in the situation of the developing countries and the acknowledgement of the difficulty of extending social security systems persuaded France to modify its approach. Sectoral policy in France includes a "health finance" aspect associated in particular with the appearance in the 1980s of a constant reduction in the public budgets of the developing countries. One of the direct consequences of the retreat of the state was the inability to provide the sick with basic medicines, which produced both a significant drop in access to health care units and the emergence of illegal charging practices, in an officially free-of-charge context. The Bamako initiative was a response to this development, which it managed in part to stop. The availability of essential drugs, associated with the recovery of costs and the involvement of communities in the everyday management of health units has brought progress in relation to the previous situation.

The limitations and disadvantages of cost recovery, in particular for the most disadvantaged populations, explain the enthusiasm of the French services for alternative systems likely to bring down the financial barrier to access to care and to make it possible to cope with the demand. The support to health financing in general and to mutual insurance funds in particular constitutes an important arm of the policy of the Ministry of Foreign Affairs (MFA).

Initially, and in particular in the field of health, support for the creation of mutual insurance funds was encouraged, with targeting on the rural sector and the informal economy. At the same time, much consideration was given to the extension of compulsory social insurance in the knowledge that such initiatives are limited owing to the insolvency of the poorest, who often represent 70 to 80% of the global population (rural and informal sectors). It is also known that the penetration rate of the mutual insurance funds, which enable the most destitute to be covered, will not exceed 30% of this population if reference is made to the projects achieving the best performance with regard to membership (Benin, Mali, Guinée forestière). This assessment indicates that the mutual insurance funds may contribute to universal coverage, but are not enough to achieve it.

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International Symposium on Social Protection and Solidarity in Developing Countries. Ms. Vijayalakshmi Das, Friends of Women's World Banking (left) and Ms. Mirai Chatterjee, SEWA (right).

Is health insurance desirable in the PSZ?

a) It is desirable in itself if it can be used to supplement the coverage of wage-earning populations in the formal sector who are already covered for the other risks of existence (except unemployment for the private sector), but, if it is limited to this population (5 to 10% of the total population depending on the country), it may appear regressive except for acting as a starting point for extension to the rest of the population.

b) It is desirable in terms of equity if it permits an extension of coverage to populations which cannot at present pay for health services, produces more equitable health systems and is not limited to a small privileged portion of the population (workers in the formal sector).

The preceding point is particularly important for poor countries, since a general observation can be made: on average, the poorer a country is, the more its inhabitants are obliged to pay for health care at the time when they are ill. In more than 60% of countries with a GNP per capita of less than 1 000 dollars, payments by users represent more than 40% of all health expenditure, while the majority of countries with more than 1 000 dollars experience the opposite situation. This phenomenon is sometimes explained by the inadequacy of public funds, by the generalisation of the Bamako system (cost recovery payment system) and by the relative lack of insurance mechanisms. (…)

c) It is desirable if it can be used to bring significant and stable resources to the health system.

The need for resources is felt particularly keenly in countries where public health expenditure is modest and where the majority of the population is too poor to face up to the health risk without a form of social solidarity. At the same time, the mobilisation of resources by insurance should not be to the detriment of fundamental productive investments and, in many countries, the total health expenditure should increase along with productive expenditure to move the country from negative spirals to positive dynamics (health-nutrition-productivity-income).

It is desirable, finally, if it is able to achieve a relative consensus in its favour among the main actors concerned.

The degree of acceptability will be all the greater if the concept of sickness insurance does not clash with the culture, values and concerns of the population. The population must support the mechanism and believe in an improvement in the quality of the benefits offered to them. The extent of the political commitment is vital: the state may hope to encourage social stability through social protection actions in favour of poor and vulnerable people. The donors may take advantage of the reform of social security to promote significant changes in the country's health policy. (…)[34]

34 Source: Fouirry, J.P., Prieur C., Delesvaux C. et al.

The MFA's support for social protection in the developing countries takes account of the constraints encountered in encouraging access to social protection for the greatest number and in particular the most deprived. Support for the mutual health insurance funds forms part of a medium- and long-term process which will depend, among other things, on national political choices:

a) the first vision consists in considering the mutual insurance funds as a stage in the establishment of national social insurance. The mutual insurance funds make it possible to popularise insurance, to train a set of people qualified to manage it, before moving on to the generalisation of the system by imposing a principle of obligation. This vision of mutual insurance funds has a corollary in the state's interest in promoting these bodies and monitoring them, the results of which will be used in due course to construct universal coverage. Such a process takes time, as it did in the North, and some of the population risks remaining without coverage for a long time.

b) the second vision of the contribution of mutual insurance funds to universal coverage is that of supplementary coverage, either in terms of people, or in terms of benefits. It is designed as part of a national architecture, which would possibly be segmented by categories or which would only provide basic coverage. The juxtaposition of compulsory insurance for the formal sector, which the MFA also supports as part of its support for company mutual insurance funds in the private sector, voluntary insurance for the relatively well-off informal sector and assistance for the destitute constitutes a model which, on the face of it, is quite attractive, in which the position of the mutual insurance funds is quite well defined. The problem of equity associated with the difference in the amount of contributions and thus benefits according to socio-occupational categories is clear and difficult to get round in the short term. The alternative model is that of compulsory coverage for all, mixing contributory and non-contributory schemes, but only offering minimal benefits for all.

Taking account of these different national strategies, evaluations of the projects underway or completed have been collected. This process has led to a number of action principles. Although the values attached to social protection remain the basis for cooperation, a more pragmatic attitude has been advocated, so as not to favour one method of organisation and to encourage governments to construct coherent policies coordinating different forms of coverage. Support for mutual insurance funds is still important, but not exclusive. Furthermore, the desire for partnership and the wish for reciprocity have led the MFA to enter into technical collaboration arrangements and to approach experts in order to promote networks of operators (RAMUS for example).

The French approach has logically incorporated the recent international mobilisation in favour of emphasis on the struggle against poverty. Thus, the process of debt reduction has been an opportunity to emphasise and formalise the strategy previously defined.

The frame of reference for the action of the Directorate-General for International Cooperation and Development with regard to strengthening social protection in the priority solidarity zone countries is as follows[35]. Strengthening social regulation moves in particular through "expanded" social protection, encompassing the populations in the formal and informal sectors. This involves supporting social protection which, apart from coverage of the health risk, aims to prevent the effects of other types of traumas (loss of job, inadequate income, economic burdens associated with handicaps and different social and cultural obligations, etc). This vision of social protection assumes actions to re-establish equality of opportunity for all individuals and enable everyone to achieve his or her potential.

Social protection, an indispensable means of providing equitable access to social services, is at the centre of the action programmes to which each country taking part in the major international conferences is committed.

Apart from the need to take account of the social protection systems established informally, which can be used to open up the populations excluded from institutional systems, it is important also to include initiatives intended to link formal and informal systems of social protection.

Operational directions of the MFA with regard to social protection:

- Strengthening, in the PSZ countries, the ability of the public authorities, in partnership with civil society, to put forward programmes of social protection;
- Strengthening the ability of these countries to negotiate with the donor community to put forward their point of view and their interests in this field;
- Funding and developing research activities in this field by mobilising French institutions and competent partners in the countries with which France is in cooperation. For the Directorate for Technical Cooperation at the MFA, the active participation of researchers and professionals from these countries is one of the conditions for such research to be practical for developing countries and to take account of the various experiences involved in the informal sector ;
- Assisting with the networking of the partners (governmental or otherwise) with a view to identifying pilot projects, in relation to coordinated priorities;
- Setting up partnerships between donors in order to strengthen the effectiveness of joint action (ILO, etc);
- Supporting initiatives in the partner countries aimed at integrating these problems into their political processes and in particular as part of this initiative;
- Developing national competences with respect to support and management, thanks to training of the type organised by the MFA and ILO's STEP programme.

35 *Source: Ministry of Foreigh Affairs, 2002.*

In this context, the MFA is still keen to maintain values and emphasises the particular role of the state in the organisation and regulation of systems. This specific approach brings it closer to partners such as certain European cooperative efforts (Belgium, Germany) or the ILO. It highlights some differences of view with others. Nonetheless, in the field, all positions usually tend to come closer together.

France, by supplementing debt alleviation and cancellation for the highly indebted countries with a specific tool, the debt relief and development contract, has reinforced the trend towards the reallocation by the beneficiary countries of the budgetary resources thus released towards sector policies. This tool consists in fact in repaying to the beneficiary country the debt it has repaid, in order for it to be allocated to programmes playing a part in the objective of reducing poverty, in particular in the education, health and social fields. But this trend only makes real sense and produces results if it forms part of a true development strategy. This analysis is now shared by an increasing number of development partners[36]. Debt relief and development contracts are complementary to the MFA's strategy for social protection in so far as they reinforce the provision of care through the reallocation of funds to sector health policies[37]. Support for mutual health insurance funds or compulsory sickness insurance systems would only have a limited scope without the commitment to improve the provision of care.

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Young girl, illegal street merchant, in front of the Bahai temple, New Delhi.

36 *Source: Speech to open the Turin symposium by Ms Mireille Guigaz, Director of Development and Technical Cooperation at the Ministry of Foreign Affairs.*

37 *Bolivia, Cameroon, Guinea Conakry, Mozambique, Uganda.*

CONCLUSION: STRENGTHENING THE MFA / ILO PARTNERSHIP

The MFA and the ILO believe that health insurance has two important characteristics that justify its expansion in developing countries. It brings about the sharing of risk, which gives beneficiaries access to care costing more than their individual finances could bear. It aims to attract a sufficiently large number of members to establish a solid financial base, encouraging health care providers to control their charges and the quality of their service, with a view to concluding contracts with the insurance organisations.

Since 1999, France has had a special partnership with the ILO, based on shared values on matters of social protection and on the wish to rely on the expertise of the ILO in this field. This partnership, which has already been reflected in the establishment of several pilot projects on social protection in Burkina Faso, Ethiopia and Vietnam, supplements specifically bilateral projects which the MFA is undertaking as regards support for mutual insurance funds and support for the financing of health in about ten African countries. It will be supplemented in 2005 by a joint project with the ILO on HIV/AIDS in the workplace in Cameroon and Chad.

Under the terms of the partnership agreement between France and the ILO signed in November 2001, the Directorate for Technical Cooperation at the MFA has also undertaken, together with the ILO, to support the West African Economic and Monetary Union (UEMOA) in the establishment of a legal framework for mutualism in order to cover the health risk, a proposal which will ultimately have to be approved by UEMOA. The aim of the project, which is to start in 2004, is to develop a regional legal framework and a plan of action committing the public authorities in the UEMOA countries to adapting it to their own legislation.

Other initiatives involving the wider participation of other donors have been taken with the participation of the MFA and the ILO. In particular, a working group has been set up with a view to providing strategic coordination of support for health insurance systems, with the participation of the WHO, the World Bank, the German Technical Cooperation Agency (GTZ), the ILO, the MFA and the French Development Agency (AFD). The aim of this group, which was established in 2003, is to encourage the harmonisation of donor policies on this matter, which should make it possible for the actions of each institution to become more effective. The European Union (EU) also set up a working group in 2003, under the leadership of the GTZ, to look at the questions of equitable financing for health care. After first defining the values common to the Member States of the EU with regard to access to care – equity, social justice, equality, solidarity, etc. – this working group is making a contribution to the formulation of a European Commission policy on the subject of equitable financing (Schwefel, 2004), which might act as a framework for cooperation among Member States. The WHO and the ILO have also been invited to join this working group.

All these initiatives, it is to be hoped, should eventually result in the implementation of more concerted action in the field of social protection.

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ANNEX 1
PROGRAMME

INTERNATIONAL SYMPOSIUM ON "SOLIDARITY AND SOCIAL PROTECTION IN DEVELOPING COUNTRIES"

International Training Centre of the ILO,
Turin, 23-25 April 2003

23 April 2003

8:00 Registration – Pavilion L

9:00 Opening ceremony:

- Welcome by ***Mr. Frans Lenglet***, Director, Training Department, International Training Centre of the ILO
- Remarks by ***Ms. Mireille Guigaz***, Director, Development and Technical Co-operation, French Ministry of Foreign Affairs
- Remarks by ***Mr. François Trémeaud***, Executive Director of the ILO and Director of the International Training Centre of the ILO
- Welcome by ***Ms. Mariangela Cotto***, Councillor for Family and Social Policy, Voluntarism, Immigration and Emigration and International Affairs, Piedmont Region
- Welcome by ***Ms. Maria Pia Brunato***, Councillor for Social Solidarity, Youth, Health and Equal Opportunities, Province of Turin

10:00 Coffee break

PART I: APPROACHES, VALUES AND ACTORS

10:30 **Theme 1: What kind of social protection? The need for solidarity, the concept of universal coverage, the legal regime**
Mr. Michel Laroque, Inspector General of Social Affairs, former Deputy Director of Social Security, French Ministry of Social Affairs, Labour and Solidarity, Professor at the University of Paris I Sorbonne, followed by an open discussion.

Theme 2: Social protection, vulnerability and the fight against poverty
Mr. Bruno Lautier, sociologist, University of Paris I (Institute of Economic and Social Development Studies) followed by an open discussion.

Moderator: ***Ms. Lucy apRoberts***, Head of Project, "The ISSA Initiative", International Social Security Association.

12:30 Lunch

14:00 Part I (continued) – "Approaches, Values and Actors"

Theme 3: The ways and means of social protection: equity, redistribution and efficiency
Mr. François Bourguignon, economist, Director of Research at the School of Advanced Studies in Social Science (Paris), followed by an open discussion.

Theme 4: The roles of state and civil society actors in social protection
Dr. Jaime Z. Galvez Tan, Vice-chancellor for Research, University of the Philippines, Manila, followed by an open discussion.

Moderator: Mr. Serge Tomasi, Vice director of Social Development and Educational Co-operation, French Ministry of Foreign Affairs.

16:00 Coffee break

PART II: INITIATIVES AND PRACTICE

16:30 **The view of the development institutions on social protection**

Speakers:

- ***Mr. Alexander S. Preker***, Health Systems Development, World Bank,
- ***Mr. Azedine Ouerghi***, Social Protection Programme, World Bank Institute
- ***Mr. Emmanuel Reynaud***, Chief of the Social Security Policy and Development Branch, International Labour Office

Moderator: ***Ms. Lieve Fransen***, Head, Human and Social Development Unit, European Commission

24 April 2003

09:00 Part II (continued) – "Initiatives and practice"

Presentation of the role of workers' and employers' organizations in social protection

Moderator: ***Mr. Michel Thierry***, Inspector General of Social Affairs, French Ministry of Social Affairs, Labour and Solidarity, Deputy Representative of France to the Governing Body of the ILO

10:00 Coffee break/Group photo

10:30 **Round-table discussion on different practices:**

- ***Ms. Mirai Chatterjee***, Co-ordinator, SEWA social security, Self-Employed Women's Association, India
- ***Mr. Carlos Galián***, Department of Campaigns and Policy, OXFAM
- ***Dr. Jean-Michel Lichtenberger***, Co-ordinator, "AIDS Solidarity" Project, Health-cy

Moderator: ***Ms. Ginette Forgues***, STEP Coordinator for South Asia, ILO Subregional Office for South Asia

12:30 Lunch

14:00 Part II (continued) – "Initiatives and practice"

Round-table on regional diversities

- ***Mr. Miloud Kaddar***, Programme Officer, World Health Organization, on the situation in the Maghreb countries
- ***Mr. George Kossaifi***, Expert in Human Development, United Nations Economic and Social Commission for Western Asia, on the social protection situation and future perspectives in the Middle East
- ***Mr. Alain Letourmy***, Researcher at the National Centre for Scientific Research, mutual health schemes in West Africa
- ***Mr. Daniel López Acuña***, Director of the Office for Programme Management, Pan American Health Organization (PAHO), on the joint PAHO/ILO initiative on the extension of social protection in health in Latin America and the Caribbean
- ***Mr. Pascal N'Diaye***, Representative of the "Concertation" network of health mutual associations in Africa

Moderator: **Mr. Moucharaf Paraiso**, Director of the ILO Subregional Office for the Sahel Region

15:30 Coffee break

16:00 Debate on the five presentations

25 April 2003

PART III: SUMMARY, CONVERGENCE AND STRATEGIES

09:00 **Panel discussion among invited speakers from developing countries:** reactions to the debates of the Symposium relative to their respective countries, experiences and their expectations for social protection, chaired by Ms. Mireille Guigaz, Director of Development and Technical Co-operation, French Ministry of Foreign Affairs

10:30 Coffee break

11:00 **Summary of the previous discussions and a presentation** by ***Ms. Blandine Destremeau*** and ***Mr. Alain Letourmy***, Researchers at the National Centre for Scientific Research, question and challenges emerging from the debates.

12:00 **Presentation of the conclusions of the Symposium and future perspectives**, by the French Ministry of Foreign Affairs and the International Labour Office, on proposed actions on social protection and co-operation between France and the ILO in this field

Speech by ***Mr. Serge Tomasi***, Vice director of Social Development and Educational Co-operation, French Ministry of Foreign Affairs

Speech by ***Mr. Assane Diop***, Executive Director of the ILO, Social Protection Sector, followed by an ILO Declaration concerning the Global Campaign on Social Security and Coverage for All

12:30 Closing ceremony, lunch

ANNEX 2: OPENING SPEECH

Ms. Mireille Guigaz
Director of Development and Technical Cooperation at the Ministry of Foreign Affairs

I have been asked to set out the main thrusts and perspectives for this symposium on "solidarity and social protection in developing countries", which begins this morning.

This is a period of quality time, allowing all of us to set aside our everyday activities in order to ask fundamental questions lying at the heart of our work.

The first question concerns the very meaning of this symposium: why social protection? The expression in itself seems remote from the hard reality experienced by the populations of developing countries; in actual fact, the international community has been aware for at least a decade that the struggle against poverty and inequality is at the very heart of the development process and not its anticipated consequence or its end result. In other words, extreme inequality within societies and vulnerability when faced with the ups and downs of life undermine any development process.

This is why the construction of adequate social protection is a response to these two major dangers with respect to development, such social protection pulling on two levers, the coverage of risks on the one hand and solidarity on the other.

The second question in fact concerns solidarity: it may seem strange to refer to solidarity when neither the development process nor the implementation of social protection are firmly established. The concept of solidarity is based on a simple question: how to perform the collective function of social protection? When market forces alone are unable to perform this function, especially since a large part of the populations of developing countries do not have the financial means to gain access to it, there is a need to create viable mechanisms to substitute for or supplement the market.

In fact, this is not an abstract solidarity but above all a progressive pooling of initiatives of all kinds, sometimes coming from the populations themselves (for example through mutual funds) and sometimes resulting from public policies, generally in the formal sector. This process may rely on mechanisms for cost sharing, but with a broad social base, without exclusions, where redistribution goes hand-in-hand with insurance.

In a word, it is a matter of creating well-being at the same time as creating wealth. It is here that the role of the state comes into its own in regulating, organising and amplifying previously disparate initiatives.

It is a matter, indeed, of making a long-term commitment and in particular encouraging solidarity between generations so that periods of inactivity, especially retirement, are not accompanied by increased marginalisation.

This symposium in fact has a precise ambition, asking questions about both the concepts and the processes in order to produce operational strategies.

There is a need therefore to review the operational objectives, the actors and the tools in social protection.

To ask questions about the objectives of social protection means looking at its range (in other words, its universality) and its content. Looking at the problem of universality also involves the type of development, selective or, on the other hand, enabling. As regards the content, there is a need to think about the risks run by people in their health, their earned income and their old age, in a word, about what threatens their means of existence and thus their dignity.

To ask questions about the actor means above all rejecting any institutional scheme out of hand, since recent decades have often demonstrated the ineffectiveness of mechanisms transposed too directly from the industrialised countries.

Finally, to ask questions about the tools means seeking out good combinations of (i) public policies, based on contributions but above all redistribution, (ii) mechanisms desired and managed by the populations themselves, so precious in constructing development, and (iii) interventions by partners in the private sector.

Of course, in this huge area for consideration, the big question which arises, before any other, is the matter of financial resources; our symposium intends to address this problem without becoming a purely financial occasion. By this, I mean that the financial choices must be based on a total concept of social protection, including analysis of past experiences.

This is how, as regards health coverage, sub-Saharan Africa is today characterised by the approach based on what is known as "the Bamako initiative": in the late 1980s, faced with decline and inefficiency in the centralised public health systems, the African countries defined new objectives, namely: financing for minimum packets of activities including in particular an expanded programme of vaccinations, care for the most common diseases and finally services associated with childbirth. This new approach was based in particular on a decentralised system of community co-management and co-financing involving greater user responsibility.

This approach seems to have enabled the countries whose initial situation was least good to catch up, especially in vaccine coverage, access to drugs and above all the reduction in disparities between urban and rural environments. But the diagnosis is less positive when addressing questions of equity and the lasting nature of the system resulting from the Bamako initiative. There is a need in fact today, in order to support the system, to pursue several complementary objectives, namely: assessing the demand, increasing the resources available for health, improving the quality of care and striving for greater equity in the access to care.

The situation is perceptibly different in countries with intermediate income levels, in particular in Latin America and Asia, which are generally characterised by advanced coverage of greater or lesser proportions of the population. Here, the main need is to generalise the social protection systems, rationalise the management of them and look at the aspect of solidarity, through taxation to be devoted to social protection.

The response to many of these objectives directly involves the fund providers. So, by the end of this symposium, we shall try to gain a better understanding of the positions of the different partners in the development of social protection. The World Bank, ILO, public and private actors and organisations representing civil society, from every continent, will

describe their approaches and their experiences. These different experiences will also represent different stages of development, from Latin America to the Middle East and from Africa to Southeast Asia.

For its part, France has, since 1999, had a special partnership with the International Labour Office, based on a similarity of values with respect to social protection and on the wish to rely on the expertise of the ILO in this field .

This partnership, which has already resulted in the implementation of several experiments in social protection in Burkina Faso, Ethiopia and Vietnam in partnership with the ILO, complements specifically bilateral projects which the French Ministry of Foreign Affairs is conducting in order to support mutual funds and to support health financing in Africa. It will very soon be accompanied by a joint project with the ILO on AIDS in the work environment.

This is of course an open partnership, the aim of which is to join together in a broader movement, involving both international development institutions and developing countries. It is encouraging to note in this respect that recent considerations and actions with regard to the struggle against poverty now also involve social components; this development is more than a simple nuance but it has not yet become an indisputable foundation.

France, by supplementing debt relief and cancellation for highly indebted countries with a specific tool, the debt relief and development contract, has strengthened the movement towards the reallocation by the beneficiary countries of the budgetary resources thus released to social sectors. This tool in fact consists in paying back to the beneficiary country the debt which it has repaid so that it can be assigned to education, health and social programmes. But this movement really only makes sense and produces results if it forms part of a real development strategy. This analysis is now shared by an increasing number of partners in development.

Our discussions on social protection must therefore not remain within a narrow field but, on the contrary, must form an integral part of the widest possible doctrinal and operational trend.

ANNEX 3: CONTRIBUTIONS

UNE PROTECTION SOCIALE MUTUALISTE ET UNIVERSELLE: LA CONDITION DE L'EFFICACITÉ DE LA LUTTE CONTRE LA PAUVRETÉ EN AMÉRIQUE LATINE

M. Bruno Lautier
Sociologue, Professeur à l'Université de Paris I

Si la stabilisation macro-économique, la réduction de l'inégalité des revenus primaires et le développement de la demande interne sont des conditions nécessaires de la réduction de la pauvreté en Amérique latine, elles n'en sont pas les conditions suffisantes. Elles tracent le cadre de l'émergence d'une véritable sécurité (sociale), elles n'en donnent pas le contenu. Par ailleurs, des politiques sociales efficaces pour lutter contre la pauvreté ne peuvent se limiter à ce qui est actuellement dénommé «politiques de lutte contre la pauvreté». Celles-ci peuvent en effet être définies comme des politiques de compensation partielle de l'échec des politiques sociales; faute de s'attaquer aux causes sociales de la pauvreté, elles en reproduisent sans cesse les conditions d'émergence. La «lutte focalisée contre la pauvreté» est fréquemment un alibi pour justifier le démantèlement des politiques sociales (tant pour des raisons de limitation des ressources disponibles que pour des raisons politiques, à savoir que les aides ne vont pas aux plus pauvres). Mais, ce faisant, ce démantèlement accroît rapidement la vulnérabilité non seulement de ceux qui ne sont pas les «cibles» des politiques d'assistance, mais aussi de ces derniers eux-mêmes. De plus, le caractère largement procyclique de ces politiques «focalisées», et leur faible poids financier, tendent à accentuer l'instabilité de la demande interne. Et, de ce fait (il ne s'agit pas d'un effet pervers, mais d'une conséquence logique), la lutte contre la pauvreté accroît la vulnérabilité et la pauvreté. Enfin, les politiques «focalisées» échouent toutes dans leurs tentatives de fonder des droits sociaux, et donc les conditions d'exercice de la citoyenneté. Ces conditions ne peuvent émerger que dans le cadre d'une protection sociale fondée sur le «principe mutualiste»; c'est-à-dire que les droits sociaux ont pour contrepartie des contributions (même très faibles) de tous les assurés, qui permettent de fonder politiquement l'indépendance financière de la protection sociale, son unification institutionnelle, et les mécanismes de transferts redistributeurs que ces dernières permettent.

Cette argumentation est développée en quatre points; au cours de cette argumentation, six «propositions normatives» sont faites.

A. *Le premier point est une remise en cause des analyses néo-libérales dominantes de «l'échec» des politiques sociales latino-américaines mises en place durant les années 1940.*

Ces analyses mettent en avant le fait que les différents pays d'Amérique latine auraient «imité» les systèmes européens, fondés sur le principe mutualiste (défini comme reposant sur la socialisation obligatoire d'une partie du salaire et une tendance continue à l'universalisation), alors que les conditions économiques et politiques étaient totalement différentes.

Le caractère paradoxal des propositions et mesures libérales sur la protection sociale provient d'abord de ce qu'on a accusé les systèmes mutualistes de protection sociale d'engendrer de la pauvreté en Amérique latine, alors que c'est précisément le fait qu'ils n'étaient pas mutualistes qui a engendré le développement de la pauvreté. Ceci mène à une première proposition normative: le premier critère pour juger de l'efficacité potentielle d'une mesure de politique sociale en matière de lutte contre la pauvreté est de savoir si elle constitue une avancée dans la mise en œuvre du principe de mutualisation ou non. Il apparaît vite que la plupart de politiques «ciblées» d'aide aux pauvres sont de ce point de vue des politiques régressives. En effet, les politiques «ciblées» s'adressent principalement, sinon uniquement, à des inactifs (plus ou moins «inemployables»); de plus, le nombre et le volume des aides décroît en général dans les périodes de récession. A l'inverse le nombre de personnes assurées baisse de façon continue. Il se crée alors un «no man's land», ni assuré, ni assisté, où dominent non pas les inactifs, mais les «working poor» (dont la protection a, historiquement, été à l'origine des politiques sociales).

Les gouvernements latino-américains des années 1940-50 se sont appuyés sur un schéma théorique extrêmement proche de celui qui avait guidé les gouvernements européens. Ce schéma peut être résumé très simplement: a) les ressources permettant la couverture mutuelle des risques sociaux forment une partie du salaire; le problème financier de la protection sociale est donc d'abord un problème de décision politique, à savoir imposer cette socialisation partielle du salaire. b) trois variables déterminent le niveau de ces ressources et leur évolution: l'évolution du nombre des salariés, l'évolution du niveau des salaires et la part du salaire qui est socialisée; c) l'évolution relative des trois variables la plus probable est celle-ci: le nombre des salariés croît vite dans un premier temps, moins vite ensuite; la croissance des salaires est régulière et auto-entretenue; la part socialisée du salaire est régulièrement croissante. Contrairement au leitmotiv des analyses néo-libérales, cette conception de la protection sociale n'était pas plus «irréaliste» en Argentine ou au Mexique qu'en France ou en Suède. Toute mise en place d'un système de protection sociale repose sur un «pari» politique, et donc sur une capacité forte d'autonomie du politique. Historiquement, la protection sociale produit un consensus politique, mais elle ne repose jamais sur un consensus préalable, et cela a été vrai des deux côtés de l'Atlantique. Par contre, il est vrai que le facteur politique a joué de façon très différente en Amérique latine et en Europe. La pensé libérale accorde une importance déterminante à ce facteur politique; elle identifie deux «vices» des systèmes latino-américains: le corporatisme et le populisme. Le premier point de cette partie montre qu'il n'existe pas de «vice constitutif» des systèmes latino-américains de protection sociale, qui rendrait impossible à priori l'émergence de systèmes analogues à

ceux qu'on connaît en Europe occidentale. Par contre, il y a des histoires très différentes de celles de l'Europe, qui ont amené le «blocage» de l'avancée vers la généralisation de la mise en œuvre du principe mutualiste.

B. *Le second point concerne les causes de la non-mise en œuvre et de la disparition du principe mutualiste dans la protection sociale en Amérique latine*

Tout d'abord est réfuté l'argument classique selon lequel cette non-mise en œuvre est essentiellement due au développement de «l'informalité» (l'emploi indépendant ou de l'emploi dans des micro-entreprises). Cet argument a deux aspects; le premier est «technique»: sous-équipement de l'administration, difficulté à repérer et poursuivre les non-payeurs; mais le problème technique a toujours trouvé des solutions techniques quand une volonté politique a existé. Le deuxième aspect est politique et idéologique: il est très difficile d'imposer à des indépendants et petits patrons à bas revenus le paiement de taxes et cotisations dont ils ne voient pas quel avantage ils en retireraient. Mais alors il ne s'agit pas d'un refus a priori de la protection sociale, mais du refus d'un système qui serait perçu par les «informels» comme contre-redistributeur.

Les causes principales de la non-généralisation du principe mutualiste sont les trois suivantes:

1) l'importante et croissante hiérarchie des salaires. Cette hiérarchie (outre ses effets sur la demande interne) a pour conséquence de rendre quasi-nulle la capacité contributive des salariés proches du salaire minimum, et surtout de pousser les couches élevées du salariat vers des systèmes de protection à «mutualisme restreint», généralement privés, tant les effets redistributeurs du mutualisme généralisé apparaissent en leur défaveur. D'où une deuxième proposition normative: le développement du principe mutualiste suppose tout d'abord une forte réduction de la hiérarchie des salaires (avant même de s'attaquer au problème de la contribution des non-salariés). Celle-ci aurait pour implication première de renverser (ou au moins d'affaiblir) un système d'alliances politiques entre niveaux supérieurs du salariat et «couches moyennes non-salariées».

2) la redistribution très inégale des gains de productivité. L'affectation des gains de productivité au financement de la protection sociale a toujours été purement résiduelle en Amérique latine, contrairement à l'Europe. Quand ces gains ont été forts, partout, ils ont certes été affectés à la protection sociale, mais d'une façon très précaire et réversible, du fait de la non-séparation du budget de l'Etat et du budget social. D'autre part, de nombreuses prestations et cotisations ne sont pas proportionnées à la totalité du salaire, mais au salaire minimum. Le fait d'utiliser la manipulation monétaire pour réduire le salaire minimum –qui est très imparfaitement indexé sur l'inflation- a souvent comme conséquence une baisse des cotisations et des prestations sociales de base. Ceci vient appuyer une troisième proposition normative, selon laquelle un point-clé de toute politique de réduction de la vulnérabilité est d'une part d'instaurer une réelle séparation entre le «budget social de la Nation» et le «budget général de la Nation», et d'autre part de doter le premier de mécanismes d'indexation monétaire spécifiques.

3) Le fait que l'extension du salariat se soit faite sans extension proportionnelle de la base contributive.

Plus que la croissance du «secteur informel», au sens classique, les années 1990 ont été marquées par «l'informalisation du salarait». Celle-ci s'est accompagnée (contrairement au cas européen) de la «déconnexion» entre croissance du salariat et croissance des contributions sociales, qui est le phénomène majeur de la phase récente de précarisation/flexibilisation. L'informalisation du salariat n'est pas seulement une réaction «technique» à des chocs conjoncturels ou des phases brutales d'ajustement, mais une tendance longue et lourde. La plus immédiate des conséquences de cette «informalisation du formel» est une conséquence financière. Cette conséquence financière devrait a priori être faible: les travailleurs salariés «informalisés», certes, ne cotisent pas (ou plutôt: leurs employeurs ne cotisent pas, ne paient pas la part socialisée du salaire); mais ils ne touchent pas non plus de prestations. Mais cette neutralité financière est en partie illusoire: malgré la faible qualité des soins des régimes de santé de base, malgré le faible niveau des retraites de base, les salariés «informalisés» y ont accès. L'informalisation du formel produit alors un report (même à coût moindre) du système mutualiste de protection vers le budget général de l'Etat, et contribue à sa crise financière.

D'où l'on peut faire une quatrième proposition normative: la déconnexion entre les mesures réglementaires facilitant la flexibilisation de l'usage du travail, et celles qui instaurent l'exonération du paiement des cotisations des charges sociales. Le dégrèvement des cotisations sociales peut être légitime (zones franches etc.), mais il doit être compensé par une dotation budgétaire, tout en maintenant, évidemment, les droits sociaux des salariés.

C. *Des statuts dans l'emploi aux circuits de mobilité*

La cohérence des systèmes d'emploi latino-américains provenait, jusque vers 1990, de mécanismes de mobilité sociale qui (même quand il s'agissait de mobilité entre les statuts «formels» et «informels, était globalement un mobilité ascendante Dès les années 1992-96, le «blocage» de cette mobilité –même différée- se confirme. Non pas que les salariés «informels» (précaires et sans droits sociaux) d'une part, ou les non-salariés sans capital de départ restent de façon durable dans leur emploi; au contraire, ils «tournent» de plus en plus vite, entre emplois salariés précaires, ou non-salariés précaires, et entre ces deux types d'emploi. Mais la mobilité ascendante vers l'emploi salarié stabilisé et pourvu de droits, ou vers l'emploi de micro-entrepreneur, se raréfie. L'espoir d'être inscrit dans un système de droits sociaux contributifs s'éloigne au fur et à mesure que les perspectives d'emploi stabilisé diminuent. D'un autre côté, les salariés «non-précaires» ont vu leur nombre se réduire à la suite de divers phénomènes (privatisations; accroissement de la part de la main d'œuvre «extériorisée juridiquement»). Les travailleurs sont de plus en plus enfermés dans des «circuits de mobilité», entre emplois précaires d'un côté, «entre emplois stables» de l'autre.

Ceci rend impossible toute politique visant à attaquer la question de la protection sociale «au cas par cas», catégorie par catégorie. Au pôle inférieur, aucun système de protection

sociale propre à un circuit ne peut être mis en place: d'une part la capacité contributive est faible; d'autre part les «circuits» sont mal connus, et sont souvent «ouverts vers le bas», c'est-à-dire que les phénomènes de déclassement social se multiplient. C'est la majorité des personnes actives et leurs familles, qui sont dans une situation indécise: ils ne participent pas à un système mutualiste, puisqu'ils ne contribuent pas ou très peu au financement de la protection sociale. Ils ne sont pas «aidés», puisqu'ils échappent aux politiques «ciblées». Ils relèvent alors d'une «solidarité nationale» très inefficace. D'autre part, les salariés stabilisés, et à revenu relativement haut, revendiquent des caisses de sécurité sociale séparées (avec transférabilité des droits d'un emploi à l'autre).

Ceci mène à la cinquième proposition normative: la restauration d'un système de protection sociale de type mutualiste contributif doit être immédiatement «universelle», c'est-à-dire couvrir tous les actifs, qu'ils soient salariés ou non à un moment donné, et quel que soit le circuit de mobilité où ils se situent. Cela ne signifie pas que les taux de cotisation doivent être identiques pour tous, bien au contraire; mais cela signifie que tous les affiliés au système cotisent, et que tous sont détenteurs de droits sociaux, (dont une typologie est précisée dans le texte). En complément vient la sixième proposition normative: tout «droit social» n'existe que s'il y a une contrepartie identifiable. Autrement dit, les droits sociaux ne sont pas «octroyés», ils ne sont pas une faveur, et ne sont donc pas susceptibles de distribution clientélaire.

Il est en effet nécessaire que toute personne assurée cotise, même si les contributions de certaines catégories sont très inférieures aux prestations qu'elles perçoivent (-comme la montré la réforme de l'assurance-maladie en Colombie depuis 1993). D'un autre côté, il est nécessaire que les organismes de protection sociale soient centralisés, pour que les transferts entre catégories (qui correspondent à des «circuits de mobilité») puissent être organisés.

Techniquement, la solution existe: fixer des «assiettes» de cotisation forfaitaires relativement basses (pour éviter les «fuites»), mais néanmoins réelles, pour que l'existence de «droits sociaux avec contrepartie» puisse être politiquement affirmée. Mais tout cela repose sur deux conditions d'une importance politique majeure.

La première est que les employeurs des salariés précaires cotisent, ce qui ramène au problème de l'effectivité du Droit social en Amérique latine. La deuxième condition est qu'on puisse «convaincre» les non-salariés à bas revenus de cotiser, même faiblement, c'est-à-dire qu'on puisse les persuader -sur des bases objectives- qu'ils accumulent des droits transférables au cours de leurs trajectoires de mobilité. La mise en évidence de cet «avantage» qu'il y a à cotiser, dans une conjoncture de forte hausse des bas revenus, peut donner la capacité politique d'intégrer très rapidement la majorité des «non-protégés» actuels dans un tel système mutualiste. La difficulté politique majeure est à l'autre bout de l'échelle, dans la nécessité de convaincre ou d'obliger les couches supérieures du salariat d'accepter d'être intégrées dans un système mutualiste unique. Il s'agit donc d'une part de montrer qu'un système mutualiste généralisé est plus efficace qu'un ensemble éclaté de systèmes d'assurances privées; d'autre part de montrer aux catégories «perdantes» à court terme qu'elles peuvent également avoir intérêt à long terme à l'établissement d'un tel principe mutualiste universel, du fait de ses effets productifs.

D. Les «politiques ciblées» et leurs impasses

Les politiques "ciblées" en faveur des plus pauvres doivent être jugées selon le critère de savoir si elles contribuent à la mise en place de politiques mutualistes universalistes. Les politiques ciblées sont toujours mises en œuvre trop tard si on y voit des politiques «curatives»; si on définit la vulnérabilité comme la probabilité d'être la victime de «risques», les politiques ciblées ne réduisent la vulnérabilité que si elles s'adressent à une population entière avant que le risque soit effectif (si elles sont «préventives»). Autrement dit, le problème est celui du repérage de la vulnérabilité ex ante. Mais on entre alors dans un dilemme sans issue:

- soit on définit une catégorie très large de population; on l'inscrit alors dans des mécanismes d'assurance (quasi) gratuits, ou encore on fait vers elle un transfert constant de revenu. On réduit effectivement la vulnérabilité, mais à un coût élevé et en sortant de fait de la logique idéologique du «ciblage».
- soit on définit des conditions plus précises en essayant de limiter les effets pervers du «ciblage» (clientélisme, détournements etc.). Mais alors l'impact sur la pauvreté tend vers zéro.

On en arrive à cette conclusion paradoxale que les plus efficaces des «safety nets» ne sont en fait que très peu «ciblés», et que les mécanismes les plus efficaces de réduction de la vulnérabilité se rapprochent de très près des mécanismes assurantiels mutualistes «classiques» dominant en Europe occidentale.

Le débat sur les politiques «ciblées» devient un faux débat; il existe un ensemble de politiques publiques qualitativement différentes, dont une brève typologie est présentée:

1) les politiques semi-universalistes non-conditionnelles de hausse des bas revenu (par exemple: le doublement des retraites rurales au Brésil en 1993)
2) les politiques universalistes de couverture des risques, mais avec contribution d'une partie seulement de la population (par exemple: la réforme de l'assurance-maladie en Colombie en 1993).
3) les politiques conditionnelles de hausse du revenu, à ciblage sur des catégories et non des individus (par exemple: Progresa, au Mexique)
4) les politiques à fort ciblage visant à accroître les capacités d'accès au marché (par exemple: politiques de micro-crédit au Pérou).
5) les politiques à fort ciblage en vue de diminuer la vulnérabilité et la pauvreté (par exemple: la loi sur l'assistance de décembre. 1993 au Brésil).
6) les politiques qui mélangent aspects «sociaux» et aspects de «développement local» (par exemple, le Pronasol au Mexique).
7) les politiques favorisant le développement de mécanismes de protection à fort degré de «mutualisme rétreint, corporatiste et privé» (plans de retraites catégoriels ou plans de santé relevant d'assurances privées). Il s'agit là de politiques ciblées non pas sur les pauvres, mais sur les non-pauvres.

A l'heure actuelle (fin 2002), ce sont bien les politiques mises en œuvre par les gouvernements libéraux des années 1990 qui non seulement montrent des signes de faillite pratique (la pauvreté s'accroît, les inégalités face à la vulnérabilité également),

mais qui également montrent leur incohérence théorique, sinon le faible niveau de connaissance empirique et de simple bon sens des discours qui les ont organisées. Ceci dit, c'est bien un travail de reconstruction complète qui s'annonce. En tout état de cause, les propositions qui précèdent ne sauraient être évacuées au nom de ce qu'elles seraient «utopiques». Elles sont la seule forme de réalisme possible, pour peu qu'on en précise les conditions.

NOUVEAU CONSENSUS INTERNATIONAL SUR LA SECURITE SOCIALE

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La sécurité sociale est présentée dans les accords internationaux comme un droit universel de l'être humain. Pourtant, seule une personne sur cinq dans le monde bénéficie d'une couverture adéquate et plus de la moitié de la population mondiale n'a aucune protection sociale. En juin 2001, lors de la 89e session de la Conférence internationale du Travail, les gouvernements, les employeurs et les travailleurs sont parvenus à un nouveau consensus sur la sécurité sociale. Ils sont convenus que priorité absolue doit être donnée à la conception de politiques et d'initiatives propres à faire bénéficier de la sécurité sociale ceux qui ne sont pas couverts par les systèmes en vigueur. Ils ont défini les principes de base pour guider la mise en œuvre de cette priorité et ont appelé le Bureau international du Travail à lancer une vaste campagne pour promouvoir l'extension de la couverture de la sécurité sociale.

Principes de base pour l'extension de la sécurité sociale

1) ***La sécurité sociale est très importante pour le bien-être des travailleurs, de leurs familles et de la collectivité tout entière.*** C'est un droit fondamental de l'être humain et un instrument essentiel de cohésion sociale, qui par là même concourt à la paix et à l'insertion sociales. Composante indispensable de la politique sociale, elle joue un rôle capital dans la prévention et la lutte contre la pauvreté. En favorisant la solidarité nationale et le partage équitable des charges, la sécurité sociale peut contribuer à la dignité humaine, à l'équité et à la justice sociale. Elle est importante également pour l'intégration, la participation des citoyens et le développement de la démocratie. Si elle est bien gérée, la sécurité sociale favorise la productivité en assurant des soins de santé, une sécurité du revenu et des services sociaux. Associée à une économie en expansion et à des politiques actives du marché du travail, elle est un instrument de développement économique et social durable. Elle facilite les changements structurels et technologiques qui exigent une main-d'œuvre adaptable et mobile. Il est à noter que si elle représente un coût pour les entreprises la sécurité sociale est également un investissement dans l'être humain ou un soutien à celui-ci. Dans le contexte de la mondialisation et des politiques d'ajustement structurel, la sécurité sociale devient plus que jamais nécessaire.

2) ***Il n'y a pas, en matière de sécurité sociale, de modèle unique exemplaire.*** Celle-ci croît et évolue avec le temps. Divers régimes existent: assistance sociale, régimes universels, assurance sociale et dispositifs publics ou privés. Il incombe à chaque société de déterminer la meilleure manière d'assurer la sécurité du revenu et l'accès aux soins de santé. Ce choix est le reflet de ses

valeurs culturelles et sociales, de son histoire, de ses institutions et de son niveau de développement économique. C'est à l'Etat que revient en priorité le rôle de favoriser, d'améliorer et d'étendre la couverture de la sécurité sociale. Tous les systèmes devraient se conformer à certains principes de base. En particulier, les prestations devraient être sûres et non discriminatoires; les régimes devraient être gérés avec rigueur et transparence, engendrer des coûts administratifs les plus faibles possible et accorder un rôle important aux partenaires sociaux. La confiance qu'ils inspirent à la population est un facteur déterminant de leur réussite. Pour établir cette confiance, une bonne gouvernance est indispensable.

3) ***Priorité absolue doit être donnée à la conception de politiques et d'initiatives propres à faire bénéficier de la sécurité sociale ceux qui ne sont pas couverts par les systèmes en vigueur.*** Dans nombre de pays, il s'agit des salariés des petits établissements, des travailleurs indépendants, des travailleurs migrants et des personnes occupées dans l'économie informelle, dont beaucoup sont des femmes. Quand la couverture ne peut être accordée immédiatement à ces groupes, on pourrait introduire des mécanismes d'assurance – le cas échéant sur une base volontaire – ou d'autres mesures telles que l'assistance sociale, puis les étendre et les intégrer au système de sécurité sociale à un stade ultérieur, une fois que l'intérêt des prestations a été démontré et que cela est économiquement viable. Certains groupes ont des besoins différents, d'autres ont une capacité contributive très réduite. Pour que l'extension de la sécurité sociale soit une réussite, ces différences doivent être prises en compte. Il faudrait également explorer de manière rigoureuse le potentiel de la microassurance: quand bien même elle ne peut être la base d'un système complet de sécurité sociale, elle peut constituer une première étape utile, notamment pour répondre à l'urgente nécessité d'améliorer l'accès aux soins de santé. Les politiques et initiatives relatives à l'extension de la couverture doivent s'inscrire dans le contexte d'une stratégie nationale intégrée de sécurité sociale.

4) ***Le principal défi que pose l'économie informelle est celui de son intégration dans l'économie formelle.*** C'est une question d'équité et de solidarité sociale. Les politiques mises en œuvre doivent encourager les mouvements vers l'économie formelle. C'est à la société dans son ensemble qu'il incombe de financer le soutien apporté aux groupes vulnérables de l'économie informelle.

5) ***La sécurité sociale devrait se fonder sur le principe de l'égalité entre hommes et femmes et le promouvoir.*** Cela suppose non seulement l'égalité de traitement des hommes et des femmes se trouvant dans des situations identiques ou similaires, mais aussi des mesures qui garantissent des résultats équitables pour les femmes. La société tire grand bénéfice des soins non rémunérés que les femmes en particulier dispensent aux membres de leur famille - enfants, parents, personnes handicapées. Les femmes ne doivent pas être ultérieurement pénalisées pour cette contribution faite à l'âge actif. Celui des deux parents qui s'occupe des enfants devrait bénéficier des prestations de la sécurité sociale correspondantes. En outre, chaque société devrait envisager d'instituer une discrimination positive en faveur des femmes lorsqu'elles font l'objet d'une discrimination systémique. Les mesures qui facilitent l'accès des femmes à

l'emploi renforceront la tendance à garantir aux femmes une protection sociale à titre personnel, et non en tant que personnes à charge.

6) ***La sécurité sociale couvre les soins de santé et les prestations familiales et garantit la sécurité du revenu*** en cas d'éventualités telles que maladie, chômage,vieillesse, invalidité, accidents du travail et maladies professionnelles, maternité et perte du soutien de famille. Il n'est pas toujours nécessaire, ni même dans certains cas possible, de prévoir la même gamme de prestations pour toutes les catégories de personnes. Toutefois, les systèmes de sécurité sociale évoluent avec le temps et peuvent devenir plus complets quant aux catégories protégées et à l'éventail de prestations servies, à mesure que la situation nationale le permet. Lorsque la capacité de financer la sécurité sociale est limitée, que ce soit par le biais des recettes fiscales générales ou de cotisations, – et notamment lorsqu'il n'y a pas d'employeur pour payer une partie de la cotisation – priorité devrait d'abord être donnée aux besoins jugés les plus pressants par les groupes concernés.

7) ***Dans le cadre des principes de base exposés précédemment, chaque pays devrait définir une stratégie nationale pour atteindre l'objectif de la sécurité sociale pour tous.*** Celle-ci devrait être étroitement liée à la stratégie qu'il a adoptée en matière d'emploi et à ses autres politiques sociales. Des programmes ciblés d'assistance sociale pourraient constituer un moyen d'amorcer l'introduction de la sécurité sociale pour les groupes exclus. Les recettes publiques des pays en développement étant limitées, il peut se révéler nécessaire de diversifier les sources de financement de la sécurité sociale, en prévoyant par exemple un financement tripartite. Dans la mesure du possible, l'Etat pourrait prendre à sa charge les coûts de démarrage, fournir des apports en nature – installations et équipements – ou un appui aux groupes à faible revenu. Le dialogue social est nécessaire pour assurer l'efficacité des initiatives visant à instituer ou à étendre la sécurité sociale. En cas de modification des systèmes établis de sécurité sociale, il faudrait prévoir une protection suffisante des bénéficiaires existants. Il faut encourager la mise en place de régimes pilotes novateurs. Des recherches bien conçues et d'un bon rapport coût-efficacité sont nécessaires pour pouvoir procéder à des évaluations objectives de ces régimes. Il convient de prévoir des recherches et une assistance technique en vue d'améliorer la gouvernance des systèmes.

Campagne mondiale sur la sécurité sociale et la couverture pour tous

En réponse à la requête de la Conférence internationale du Travail, le BIT a conçu une campagne mondiale dont l'objectif global est d'étendre la sécurité sociale à ceux qui ne sont pas couverts et d'assurer à tous l'accès aux soins de santé et la sécurité du revenu. Cette campagne prévoit de mettre en œuvre et de combiner trois modes d'action complémentaires :

Améliorer la compréhension globale de la sécurité sociale...

- Réaliser des recherches sur l'extension de la sécurité sociale
- Analyser et diffuser les meilleures pratiques à l'échelle mondiale
- Contribuer à une meilleure compréhension des besoins en sécurité sociale non satisfaits
- Développer de nouveaux mécanismes pour assurer une couverture aux travailleurs de l'économie informelle
- Elaborer des lignes directrices pour étendre la sécurité sociale

Parvenir à des améliorations concrètes de la couverture sociale...

Le BIT a lancé des projets d'assistance technique en matière de sécurité sociale dans plus de 30 pays. Ces activités comprennent les éléments suivants:

- diagnostic des besoins en sécurité sociale non satisfaits et élaboration des moyens d'y faire face
- formation des acteurs concernés et discussions sur les politiques à suivre
- renforcement des institutions et du dialogue social
- élaboration et mise en œuvre de plans d'action
- création de réseaux de personnes et d'institutions soutenant la démarche
- contrôle et évaluation des résultats

Sensibiliser et mobiliser les principaux acteurs...

- Gouvernements et organisations d'employeurs et de travailleurs
- Institutions de sécurité sociale et organisations de la société civile
- Organisations internationales et gouvernements donateurs

La campagne mondiale sur la sécurité sociale et la couverture pour tous fournit un cadre intégrateur pour l'ensemble des activités du BIT en matière de sécurité sociale. Elle va permettre de mieux focaliser les interventions dans ce domaine et de leur donner plus de cohérence et d'efficacité. Des initiatives régionales ou sous-régionales seront conçues en fonction des demandes spécifiques et des capacités de mobilisation de ressources (par exemple, l'initiative conjointe avec l'Organisation pan-américaine de la santé sur l'extension de la protection sociale en santé en Amérique latine et aux Caraïbes).

Le nouveau consensus tripartite de juin 2001 offre une chance exceptionnelle à l'OIT de promouvoir la sécurité sociale au plan international et d'obtenir des résultats concrets en matière d'extension de la couverture. La campagne mondiale constitue un instrument novateur pour développer des partenariats et fournir aux Etats membres et aux mandants l'assistance dont ils ont besoin pour améliorer de façon significative la couverture des groupes actuellement exclus.

LES POLITIQUES ET LES TENDANCES DE LA PROTECTION SOCIALE AU MAGHREB

M. Miloud Kaddar
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Les politiques de protection sociale au Maghreb sont en crise depuis au moins 10 ans. Pendant près de trois décennies les Etats maghrébins ont affiché une volonté d'élargir le système hérité de la période coloniale et de s'inspirer du modèle occidental fondé sur l'emploi salarié et la redistribution des revenus. Les résultats sont aujourd'hui peu probants malgré quelques avancées remarquables au cours des années 70 et 80. Au Maroc, le système de protection sociale reste très limité tant au niveau des populations couvertes que des prestations servies (seule 18 % de la population bénéficie d'une assurance maladie). En Algérie et en Tunisie, les systèmes de protection sociale après s'être largement étendus (plus de 60 % de la population est couverte) et diversifiés (assurance maladie, vieillesse, maternité, accidents du travail et même chômage) connaissent des reculs certains et des difficultés croissantes de financement et de régulation. Dans les trois pays, des réformes sont en cours ou envisagées, des voies nouvelles de couverture des risques sont recherchées. En Tunisie, l'harmonisation des systèmes en place de même que la contractualisation des relations entre acteurs concernés est recherchée. Au Maroc, l'extension de l'assurance maladie et de l'assistance aux indigents ainsi que la régulation des régimes de retraites sont à l'ordre du jour depuis des années. En Algérie, l'effondrement partiel des caisses de retraites, l'explosion des dépenses de santé couvertes par l'assurance maladie et la montée croissante du chômage suscitent des débats visant une profonde reconfiguration du système de protection sociale. Parallèlement à ces changements partiels dans les institutions et politiques du système formel, ancien, de protection sociale, on voit se développer de nouvelles formes d'intervention visant la génération de revenus, le soutien au micro-projets et l'accès à certaines prestations de base. Ces actions sont menées sous la conduite de nouvelles structures, comme l'Agence du Développement Social au Maroc ou à l'initiative des collectivités locales comme en Tunisie ou en Algérie.

Cependant, les réformes menées par les Etats ont du mal à émerger, à sortir des modèles conventionnels et à se concrétiser à grande échelle dans les faits. Il est paradoxal de constater que pendant des années, les avancées des systèmes de protection sociale moderne étaient le résultat de la montée de l'industrialisation, de l'urbanisation, de l'élargissement du secteur public et de la croissance de l'emploi salarié alors que ces dernières années, les nouveaux développements de la protection sociale sont réalisés dans le cadre de la lutte contre la pauvreté et en accompagnement des mesures de libéralisation de l'économie et de réajustement du rôle de l'Etat.

Pour comprendre ce renversement, il faut rappeler quelques tendances de fond des évolutions socio-démographiques et économiques au Maghreb : une transition démographique rapide avec un vieillissement significatif de la population à terme, une transition épidémiologique inachevée (de plus en plus de maladies dites de «civilisation» venant s'ajouter à des maladies transmissibles de la pauvreté, de la carence et, pour

certaines, évitables par les vaccinations), une transition sociologique avec une urbanisation forte et de nouvelles configurations et valeurs autour de la famille, une transition économique avec passage d'une économie de rente, dominée par le secteur public à une économie ouverte mais encore peu compétitive et dépendante, une transition politique inégale avec une ouverture limitée du champ politique se traduisant par une émergence de la société civile mais aussi un maintien de diverses formes de violence et de répressions.

Ces transitions s'opèrent actuellement dans un contexte de crise économique et sociale que révèlent le niveau élevé de chômage dans les 3 pays (autour de 25 % en Algérie et au Maroc), l'expansion considérable du secteur informel sous diverses formes, la faiblesse de relais et leviers intermédiaires de régulation et enfin la perte de crédibilité et d'espace de pouvoir des Etats en place.

Les transitions vécues et le contexte actuel de crise rendent totalement inopérant le modèle conventionnel de protection sociale. Ce dernier suppose une croissance continue de l'emploi salarié, une capacité de prélèvement sur tous les revenus, des mécanismes actifs et ciblés de redistribution de ressources et enfin un Etat régulateur et des partenaires sociaux légitimes.

Les évolutions récentes des politiques et pratiques de protection sociale au Maghreb sont multiples et menées par différents acteurs:

- Il y a d'abord celles produites dans le sillage des mesures d'ajustement structurel et de lutte contre la pauvreté. Elles visent à mettre en place un «filet social» de protection des populations vulnérables. Dans les trois pays, on a vu des projets et des mesures visant à garantir à certains groupes de la population un niveau minimum de revenu ou d'accès à certaines prestations de base. L'ampleur et la continuité des actions menées dans ce cadre sont restées modestes, comparées aux besoins des groupes concernés. L'obsession d'identifier les indigents, les individus vulnérables a souvent pris le dessus sur l'analyse des phénomènes en cause et le contenu de la politique à mener.
- Il y a ensuite celle émergentes et provenant des initiatives, portées par les communautés et les associations y compris syndicales. Elles sont nombreuses, diversifiées mais souvent sporadiques et sans capacité significative. Elles visent à organiser la solidarité au sein des groupes de population autour des questions de santé, de protection de l'enfance, des handicapés,.

Au total, la protection sociale étatique au Maghreb, en restant centrée sur le secteur urbain formel, participe à la reproduction des inégalités de revenus. L'incapacité à concevoir et surtout à mettre en œuvre une véritable politique fiscale et de redistribution des revenus dans le nouveau contexte économique et social décrit plus haut révèle l'ampleur des réformes à entreprendre. Les mesures et initiatives induites par les mesures d'ajustement structurel et par l'action des milieux associatifs s'avèrent trop faibles pour aboutir à un rééquilibrage de la répartition des ressources et une meilleure couverture des risques liés entre autres au chômage, à la maladie, à la vieillesse. Cette impasse est maintenant assez largement reconnue. Elle est une condition favorable à de vrais débats sur la recomposition de la protection sociale.

Au moins trois questions sont au centre de ces débats:

- Quels sont les droits et les prestations à mettre au cœur du nouveau système de protection sociale?
- Comment prendre en compte secteur formel et secteur informel?
- Comment promouvoir les initiatives et le partage le plus large des responsabilités sans diminuer pour autant le rôle essentiel de l'Etat?

LES MUTUELLES DE SANTÉ EN AFRIQUE DE L'OUEST

M. Alain Letourmy
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1. Vue d'ensemble

L'intérêt accordé aux mutuelles de santé depuis une dizaine d'années en Afrique de l'ouest mérite une attention particulière. La promotion de ces organismes mobilise des ressources importantes, a fait naître beaucoup d'espoir au sein des populations et se traduit sur le terrain par un dynamisme incontestable. Les caractéristiques des mutuelles donnent une première explication de cet engouement. Elles représentent à la fois une modalité technique intéressante de financement en organisant des régimes volontaires d'assurance maladie; une contribution à la démocratie en donnant le pouvoir aux représentants des cotisants; un mouvement social fondé sur la solidarité à travers la démarche de fédéralisation des groupements. Le développement des mutuelles de santé s'inscrit ainsi dans plusieurs registres du changement économique, social et politique des pays africains.

L'examen des données factuelles fait porter un autre regard sur la promotion des mutuelles de santé en Afrique de l'ouest. Les effectifs de population qu'elles représentent restent modestes, le montant du financement sectoriel qu'elles mobilisent est faible et, d'une façon générale, leur impact sur le fonctionnement de l'appareil de soins ou sur l'accès à la médecine moderne est difficile à estimer. En fait, le développement des mutuelles constitue un processus lent, dont les effets ne peuvent se faire sentir qu'au bout de plusieurs décennies, ce qui pose diverses questions par rapport à un objectif général d'extension de la couverture maladie et de la protection sociale dans la région.

On observe en même temps que, tout en se référant à un concept assez homogène et avec des formes d'appui qui se standardisent, les démarches de développement des différents pays sont assez disparates. Plusieurs sources agissent séparément ou en synergie. Selon le pays, l'initiative et le dynamisme des sociétés civiles, l'activisme des professionnels de santé, la volonté politique nationale, l'engouement des bailleurs ou des experts à partir de l'analyse du financement sectoriel, l'engagement d'ONG compétentes fournissent des ressorts plus ou moins déterminants au développement des mutuelles.

2. Les mutuelles de santé comme instrument de l'extension de la protection sociale

Indépendamment de leur impact sur les systèmes de santé, les mutuelles représentent a priori, pour les groupes du secteur de l'économie informelle, un outil de lutte contre la pauvreté. Il est difficile d'imaginer des dispositifs de couverture maladie qui soient plus adaptés à ces groupes et divers exemples d'association de mutuelles à des dispositifs de

micro crédit ou de création en milieu rural indiquent la pertinence de ce mode d'organisation du financement des soins.

Il reste que le développement mutualiste est par nature fragmenté et qu'il ne suffit pas à constituer les bases d'une couverture universelle. Il existe toutefois, à travers la mutualisation des groupes de l'économie formelle un certain nombre de pistes qui conduisent à l'extension de la couverture maladie. De ce point de vue, la relation entre le développement des mutuelles et l'organisation de régimes d'assurance maladie obligatoire au Mali, au Sénégal et en Côte d'Ivoire sont assez instructifs.

Les mutuelles de santé définissent une protection maladie fondée sur une solidarité restreinte et ne peuvent, en dehors de situations très particulières, résoudre le problème de la couverture des indigents. C'est moins sur le terrain de l'équité que sur celui de l'efficacité que leur apport est important. En donnant un contenu à la fonction de payeur, les mutuelles contribuent activement, comme le montrent des exemples béninois et maliens, à l'essor des contrats avec les prestataires de soins. Cela induit une clarification du fonctionnement des formations de santé et une évolution positive des comportements des agents qui y travaillent.

Organismes privés, les mutuelles ne peuvent pourtant se développer de façon significative sans l'appui de l'Etat. Le rôle de l'Etat ne découle pas de façon évidente de ce principe et diverses tensions apparaissent ici et là. Tantôt l'administration veut trop en faire et stérilise l'initiative privée, tantôt l'Etat se révèle incapable d'exercer une tutelle propice à la pérennisation des mutuelles. Les situations du Mali, du Sénégal, du Bénin et de la Guinée illustrent les divers registres du processus d'accompagnement du développement des mutuelles par l'Etat.

3. Les perspectives

L'analyse des conditions de développement des mutuelles met en avant deux facteurs essentiels: la disposition à payer des populations et la nature de l'offre de soins; et deux autres facteurs moins déterminants: le rôle de l'Etat et la qualité de l'appui.

La combinaison de ces facteurs indique que le processus d'arrivée à maturité des mutuelles demandera du temps dans la plupart des pays d'Afrique de l'ouest. La question se pose de la démarche permettant d'arriver le plus vite possible à des résultats significatifs: démarche ascendante assurant mieux les bases sociales du mouvement ou démarche descendante donnant plus vite les moyens techniques et la légitimité politique du développement.

PRESENTATION OF THE "AIDS SOLIDARITY!" PROJECT: ATTEMPT TO CREATE A SPECIFIC HIV/AIDS SOLIDARITY FUND WITHIN A POPULATION OF COMPANY MUTUAL FUNDS IN THE IVORY COAST PROJECT FINANCED BY THE GSK FOUNDATION

Dr Jean-Michel Lichtenberger
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The aim of the project is to enable company mutual health funds to take responsibility for financing the prevention of HIV / AIDS transmission, as well as the treatment of infected people, through the creation of a Solidarity Fund.

The contracting authority for this is the FEMCI (Ivory Coast Federation of Mutual Health Funds). This non-governmental association is an independent grouping of company mutual health funds, covering about 38 000 people, employees, spouses and children.

The population covered by the project is well known since it is being monitored as part of a medical mutual fund management programme, assigned to a private service provider specialising in the field, MCI (Managed Care International). Thus, the project has data concerning this population. It also has analysis facilities for detailed monitoring.

The programme is linked with the supervisory ministries. It forms part of the national policies for combating HIV / AIDS.

The GSK Foundation has allocated a grant with the aim of establishing, measuring and demonstrating the effectiveness, experimental and acceptability of a solidarity system for the benefit of FEMCI mutual funds.

It is interesting to note that an experimental Foundation, a pioneer in the field, has been able to provide resources in response to this vital question of financing.

The "AIDS Solidarity!" project is based on the creation of a "Solidarity Fund", which will be made up of contributions made by employers and employees. This project broadly aims to determine the acceptability by all concerned, and the technical and financial feasibility of the establishment of such a Fund. This will be set up after a six month observation period, everything having been explained from the very start to those concerned.

The patients being screened and treated will continue to be so whatever happens.

A contribution corresponding to what is deemed necessary for the perpetuation of the system will be determined. The amount of this is estimated today at 3 000 FCFA per contributor and per month.

This experience has specific special features, which may not apply when reproducing it, in particular:

- The assets available (MCI management, an approved centre prepared to take on responsibility, an experienced coordinator, financing) and supporting it.
- The "privileged population" concerned, especially in relation to the most deprived.

Acceptability has been the initial preoccupation. This concerns the members of the mutuals, company managements and occupational doctors. The initial findings are excellent: there is astonishing motivation. However, the development of the project requires time and teaching skills. Far more than we anticipated.

The pitfalls encountered were:

- The time required to overcome apprehension
- The distrust on the part of the members of the mutuals, in particular fearing that their revealed status would be used against them by their employers
- The fears of employers, fearing opening a Pandora's box whose consequences they cannot control, in particular financial ones
- The difficulties of doctors, fearing losing their prerogatives by passing their HIV positive patients to the outside

However, everyone carried on regardless, despite the rather unfavourable Ivory Coast context.

The initial results are encouraging: after three months, the first Mother-to-Child Transmission Prevention Projects (PTME) have been undertaken and the first treatments have started.

The prevalence of seropositives among the initial requests for screening is very high, but there is a clear bias.

Indicators have been established for monitoring the project, clinical, operational and administrative and also economic, specific to each company (absenteeism, productivity, amount of funeral costs, number of deaths - if possible due to HIV / AIDS, costs associated with replacements and with the training of replacements temporary or permanent).

We are encouraged by the change in the attitude of the actors in the project, who are increasingly providing the means for its success. Thus, in early May they are organising a workshop among themselves in order to prepare IEC campaigns.

The programme is yet to be finalised, carefully monitoring all its components, lessons of all kinds are to be drawn from it without complacency, a "model" is to be deduced along with a few rules of conduct and disseminated in their entirety.

In conclusion, let us emphasise the significance of an innovative programme, added to that of innovative financing by a pharmaceutical laboratory Foundation.

If the programme confirms it significance, it will be useful to disseminate a case study on it and the experience acquired in order to reproduce it, of course with modifications, in particular for less fortunate populations.

QUELLE PROTECTION SOCIALE? DROITS À LA PROTECTION SOCIALE ET DÉFIS DE L'UNIVERSALISME À L'ÈRE DE LA MONDIALISATION

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INTRODUCTION

Le besoin de protection sociale est un besoin ancien et naturel. Certes, les hommes ont un certain goût du risque, mais celui-ci ne les empêche pas d'avoir besoin pour eux et leur famille d'une sécurité minimale face aux aléas de l'existence.

Cette sécurité peut dans les sociétés traditionnelles être partiellement assurée par les familles étendues, des entraides locales, professionnelles ou religieuses. Les mutations sociales ne permettent plus aujourd'hui à ces formes anciennes de garantir une sécurité suffisante.

L'organisation d'une protection sociale doit permettre d'atteindre deux objectifs concrets:

-assurer une certaine sécurité de revenu, et particulièrement du revenu professionnel et familial, face aux aléas de l'existence: cette sécurité contribue à la reconnaissance et au respect de la dignité de l'individu et de sa famille ainsi protégés;

-assurer la réparation et si possible, la prévention des risques et la réinsertion des personnes frappées par la maladie, l'accident ou l'invalidité mentale ou physique.

Les droits à la protection sociale sont aujourd'hui largement reconnus, mais restent toutefois, compte tenu de leur ambition, en cours d'évolution, de construction ou de conquête (I).

A l'ère de la mondialisation, la couverture universelle des droits à la protection sociale soulève d'importants défis (II).

I Les droits à la protection sociale sont aujourd'hui largement reconnus, mais restent toutefois, compte tenu de leur ambition, en cours d'évolution, de construction ou de conquête.

La reconnaissance et l'évolution des droits à la protection sociale doivent être examinées tant au niveau des Etats qu'au niveau international.

1.1 Au niveau national

L'étendue de la protection sociale varie considérablement selon les Etats.

1.1.1 Les formes privées de protection contre les risques sociaux conservent un rôle essentiel

Dans de nombreux Etats continuent à prévaloir des formes privées de protection contre les risques sociaux.

Les formes traditionnelles de protection subsistent partout: la famille, la communauté locale, les organisations professionnelles, les organisations caritatives à caractère religieux ou associatif jouent un rôle qui n'est jamais négligeable.

S'y ajoutent des formes nouvelles de prévoyance privée, reposant soit sur la volonté individuelle (épargne, mutuelle, assurance), soit sur l'entreprise dans laquelle s'exerce l'activité professionnelle du salarié (elles peuvent revêtir des formes similaires et impliquer ou non des modes de gestion paritaire).

Avant de construire des systèmes publics de protection sociale, les pays industrialisés ont généralement développé ces nouvelles formules privées qui subsistent aujourd'hui de manière diverse et y complètent désormais la protection obligatoire.

1.1.2 La protection sociale obligatoire a été construite par les Etats de manière progressive et évolutive dans le temps et selon des schémas variables

Les formes privées de protection se sont en effet révélées insuffisantes face aux grandes mutations:

- les mutations économiques ont entraîné l'exode rural rompant les solidarités traditionnelles de proximité. Elles ont généralisé le salariat dans le cadre de la concurrence capitaliste rendant précaire la situation du travailleur entièrement dépendant de son revenu salarial,
- la mutation scientifique a érigé la médecine en science et rendu l'accès à des soins adéquats de plus en plus coûteux, après toutefois la mise en place d'une politique d'hygiène publique assurant l'accès à l'eau potable et des procédés d'assainissement,
- les mutations démographiques et sociologiques se traduisent par le vieillissement des populations et le rétrécissement du noyau familial reposant de plus en plus sur la famille conjugale, lorsqu'elle n'est pas monoparentale.

Une protection sociale des périodes de chômage, de maladie, de maternité, d'invalidité, de retraite ainsi que la prise en charge des soins est donc apparue indispensable pour permettre au salarié de faire face à ses charges en cas de survenance d'un risque social le privant de son salaire ou l'obligeant à des soins coûteux pour lui-même ou un membre de sa famille.

L'approche a varié selon le développement des Etats.

1.1.2.1. Les pays industrialisés ont progressivement construit une protection sociale obligatoire:

1) Cette organisation publique a souvent été bâtie par étapes successives:

Ainsi en France, on distingue habituellement quatre étapes:

- Un système d'assistance publique ou d'aide sociale, instauré à la fin du dix neuvième siècles.

Il ouvre des droits, mais ces droits donnent lieu à appréciation et sont subsidiaires: ils sont accordés sous conditions de ressources et d'absence de possibilité de faire jouer des créances alimentaires familiales suffisantes. Les prestations en espèces ou en nature (vieillesse, infirmité, maladie, enfance) accordées dans ce cadre sont en outre susceptibles d'être récupérées sur le bénéficiaire revenu à meilleure fortune ou sur sa succession.

L'aide sociale est gérée par des collectivités locales. Des commissions composées d'élus et de fonctionnaires examinent les demandes.

- Seconde étape, un système d'assurances sociales et de prestations familiales dans les années 1930 vient améliorer considérablement la protection sociale : il prévoit pour les salariés non cadres les diverses assurances sociales et délivrent, en contrepartie de cotisations, des prestations accordées en fonction de règles objectives ne laissant guère de marge d'appréciation aux gestionnaires. Une inspection d'Etat contrôle le fonctionnement des organismes gestionnaires des assurances. Des tribunaux garantissent le respect des droits sociaux.
- La troisième étape en 1945 va être une généralisation des assurances sociales par la mise en place de la sécurité sociale couvrant les principaux risques sociaux et visant à couvrir progressivement l'ensemble des travailleurs et leur famille, puis l'ensemble de la population, ce qui sera atteint en 2001 avec la couverture maladie universelle.
- Une quatrième étape est le développement d'une protection sociale complémentaire, s'ajoutant aux régimes de base pour améliorer leur niveau de couverture, soit à l'initiative des partenaires sociaux dans le cadre d'accords collectifs professionnels ou interprofessionnels, obligatoires une fois conclus, soit dans le cadre facultatif d'assurances individuelles principalement de type mutualiste, c'est à dire dans le cadre de mutuelles, organismes à but non lucratif gérés par les assurés qui y adhèrent.

2) Dans les pays industrialisés, deux approches dominent,en matière de régimes de base de sécurité sociale, avant de tendre plus ou moins à converger:

- l'approche bismarckienne d'assurances sociales pour les travailleurs assurant la sécurité du niveau de vie et la prise en charge financière

des soins dans le cadre de caisses de protection sociale à la gestion desquelles participent les partenaires sociaux et auxquelles cotisent employeurs et travailleurs,

- l'approche beveridgienne d'une protection universelle contre la pauvreté et contre la maladie, financée essentiellement par l'impôt et gérée par l'Etat.
- la convergence est illustrée, entre autres, par l'approche française. Celle-ci s'inscrit, dans la perspective bismarckienne, d'un système autonome décentralisée, financé par des cotisations sociales. Elle y ajoute, dans une logique beveridgienne, des volets de minima sociaux, notamment un revenu minimum d'insertion, et une couverture financière de l'assurance maladie complémentaire pour les plus défavorisés, appuyés sur un financement fiscal.

1.1.2.2. Les pays en développement disposent de systèmes variables selon leur état économique, leur culture et leurs conceptions politiques et sociales.

Ils se réfèrent souvent aux modèles des pays industrialisés, mais appliquent parfois des formules propres, comme des fonds de prévoyance dans les anciens territoires de l'Empire britannique.

Si certains pays, notamment en Amérique latine, ont construit très tôt des systèmes de sécurité sociale, dans d'autres cette construction est plus récente ou reste centrée sur une partie restreinte de la population relevant du secteur formel de l'économie.

La solvabilisation de l'économie et le développement de l'état de droit sont des facteurs essentiels pour permettre le recouvrement de ressources permettant d'assurer des prestations.

1.1.2.3. La couverture de la population mondiale par la protection sociale reste limitée

Comme l'indiquent les travaux du BIT, plus de la moitié de la population mondiale ne dispose d'aucune protection sociale. En Afrique subsaharienne et en Asie du Sud, seulement 5 à 10% de la population est couverte par un régime légal de sécurité sociale. Dans le reste de l'Asie et en Amérique latine, les taux de protection sociale varient de 10 à 90%.

Dans la plupart des pays industrialisés, il arrive que certaines branches ou catégorie de la population ne soient pas couvertes. Dans les pays en transition, notamment les pays d'Europe centrale et orientale, le taux de protection sociale a eu tendance à décliner.

Beaucoup reste donc à faire au niveau national.

1.2 Au niveau international

L'extension de la protection sociale est une préoccupation mondiale et a fait l'objet en 2001 dans le cadre de la conférence annuelle de l'OIT d'une Commission dont j'ai eu l'honneur d'être élu rapporteur.

Par ailleurs, la mondialisation qui implique la globalisation des échanges économiques pose la question de la protection sociale. Cette dernière peut-elle n'être qu'une simple prestation de service, gérée de manière privée? N'est elle pas plutôt un élément de solidarité et de cohésion sociale, équilibrant les excès possibles du libéralisme économique et devant donc échapper à la sphère commerciale?

Il est important d'examiner la place de la protection sociale dans l'approche des organisations internationales.

1.2.1 *Au niveau des Nations-Unies, cette place est clairement reconnue*

La Déclaration universelle des droits de l'homme du 10 décembre 1948 protège certes les droits civils et politiques, mais proclame également des droits sociaux. L'article 22, en particulier, dispose que «toute personne, en tant que membre de la société, a droit à la sécurité sociale».

Cet article est développé dans le Pacte des Nations-Unies relatif aux droits économiques sociaux et culturels du 16 décembre 1966, qui institue un mécanisme de suivi.

Ce thème a, notamment, été abordé lors du sommet de Copenhague sur le développement social en 1995.

1.2.2 *Au niveau des autres institutions internationales existe un débat entre les institutions sociales et les institutions financières et commerciales*

L'OIT et l'OMS sont spécialisées sur ces questions et ont montré leur attachement à une vision adaptée de ces sujets. L'action de l'OIT s'inscrit dans le cadre de sa Constitution de 1919 qui justifie son rôle par le fait que «une paix universelle et durable ne peut être fondée que sur la justice sociale» et que «la non-adoption par une nation quelconque d'un régime de travail réellement humain fait obstacle aux efforts des autres nations désireuses d'améliorer le sort des travailleurs dans leur propre pays». Elle s'appuie sur une composition tripartite, associant les représentants des travailleurs et des employeurs à côté des représentants gouvernementaux. L'OIT et l'OMS préconisent la prise en compte des dimensions sanitaire et sociale dans le cadre d'une mondialisation où ne saurait seule prévaloir la libre concurrence commerciale, en négligeant l'intérêt sanitaire et social des populations.

L'intérêt pour la protection sociale s'est toutefois étendu à la fin du 20è siècle aux institutions financières et commerciales internationales, compte tenu de l'impact financier des systèmes de protection sociale et de la nécessaire finalité sociale du développement économique. Toutefois, l'approche de ces dernières organisations où les représentants gouvernementaux émanent des ministères des finances et dont les fonctionnaires sont issus des milieux financiers et économiques les amènent parfois à méconnaître les réalités de la protection

sociale, en préconisant des modèles reposant plus sur l'individu, l'épargne et la gestion privée que sur la solidarité, la redistribution et la gestion collective.

Les débats nationaux sur la place relative de la protection sociale se retrouvent ainsi au niveau international.

II *A l'ère de la mondialisation, la couverture universelle des droits à la protection sociale soulève donc d'importants défis.*

Peut-on étendre la protection sociale et selon quelles formes? Les défis rencontrés sont d'une part des défis face aux autres politiques, d'autre part des défis de conception même de la protection sociale.

2.1 Des défis face aux autres politiques

Trois grands défis de la protection sociale face aux autres politiques sont débattus. Je ne ferai que les évoquer, car les interventions suivantes seront amenées à les approfondir.

2.1.1 *La protection sociale face à l'objectif de compétitivité et de croissance économique*

La protection sociale est-elle ou non une menace pour la croissance et la compétitivité des Etats?

- Elle est certes un coût au niveau micro-économique pour l'entreprise qui, en plus d'un salaire direct, paie un salaire différé sous forme de cotisations sociales et pour le travailleur qui voit limiter son revenu immédiat pour être prémuni de risques futurs
- Mais, elle est aussi un facteur de croissance possible au niveau macro-économique par ses effets anti-cycliques et par le développement d'un secteur sanitaire et social qui constitue un pan du développement économique.
- Enfin, si elle est bien conçue, elle n'est pas un handicap dans la compétitivité internationale, dans la mesure où elle ne représente pas au niveau macro-économique un coût, mais est principalement une technique de redistribution au sein de la population nationale du produit du travail

La protection sociale est-elle un handicap ou un investissement économique ?

- Les charges sociales sont souvent présentées comme une entrave pour la croissance.
- Mais la protection sociale contribue directement à la valorisation du capital humain en favorisant la bonne santé des travailleurs par les dépenses qu'elle supporte, l'éducation des enfants par les prestations familiales, la réadaptation fonctionnelle et la formation professionnelle des chômeurs ou accidentés. Elle constitue donc bien une forme d'investissement pour le développement économique.

- De manière plus générale par la sécurité sociale qu'elle assure, elle contribue à la dignité du travail, contribuant ainsi à l'autonomie des travailleurs et à une productivité meilleure.

2.1.2 *Interventionnisme solidaire et redistributif face au libéralisme et à la concurrence économique*

Les systèmes de protection sociale s'étaient jusqu'à présent largement fondés sur des solidarités à dominante soit socio-professionnels (système bismarckien) soit de solidarité nationale (système beveridgien). Dans les deux cas, ils s'appuyaient sur une redistribution des revenus, soit de type plus horizontal, vers les familles ayant charge d'enfants, des biens–portant vers les victimes de risques sociaux, prévenant ainsi la pauvreté, ou les périodes de responsabilité parentale, soit de type plus vertical entre riches et pauvres.

Si les modèles préconisés par les institutions financières internationales l'emportaient, cette solidarité et cette redistribution ne risqueraient-elles pas de se trouver limitées par une capitalisation individuelle et une gestion privée, généralisant le libéralisme économique au secteur jusque-là social?

Face au chaos de la concurrence économique, la sécurité sociale assure une stabilité minimale aux assurés sociaux, victimes des aléas économiques. N'est-elle pas la contrepartie d'un libéralisme des échanges qui n'est acceptable qu'avec une protection suffisante des acteurs humains?

2.1.3 *La protection sociale, instrument de cohésion, démocratie et paix*

Solidarité et redistribution contribuent également à la cohésion nationale en gommant certaines des inégalités et en contribuant à l'équité et à la sécurité sociale de chacun.

Elles sont un élément de la démocratie qui implique un consensus suffisant des populations et une maîtrise des choix collectifs qui ne peut reposer sur le seul libéralisme économique.

L'amélioration du sort de chacun contribue à l'aspiration à la paix sociale interne et à la paix internationale, en limitant les frustrations.

A condition d'être bien conçue, la protection sociale n'est-elle donc pas un élément d'équilibre du développement national et mondial ?

2.2 Des défis de conception de la protection sociale

2.2.1 *Conception solidaire ou conception individualiste*

Le débat entre une protection sociale solidaire ou une protection individualiste est particulièrement présent dans les divers systèmes nationaux et attisé par les positions des organisations internationales. Deux exemples peuvent en être donnés:

- le premier est celui des pensions de retraite. Doivent elles reposer sur des systèmes de solidarité entre générations assurant des prestations définies

aux retraités liées à l'évolution du pouvoir d'achat et reposant principalement sur la technique de la répartition? Ou convient-il de développer des systèmes reposant plus sur l'épargne, à partir de cotisations définies accumulées selon la technique de la capitalisation pour assurer la pension de retraite individuelle le moment venu, compte tenu du produit des placements sur les marchés?

Une articulation entre une part de solidarité nationale, une part de solidarité professionnelle, une part individualisée, est, bien entendu possible, mais le dosage prévu ou non par la collectivité reflète un choix de société entre une volonté de solidarité et de cohésion ou un libéralisme ouvert aux disparités sociales attisées par la concurrence économique.

- Un second exemple est celui du système de santé ou de prise en charge de la maladie.

  Il peut également reposer sur des assurances individuelles conduisant généralement à une sélection des risques qui peut laisser en-dehors d'une protection ceux qui en ont le plus besoin (phénomène d'exclusion) ou s'inscrire dans une véritable protection sociale reposant sur une mutualisation du risque financée collectivement.

  Une conception solidaire de la protection sociale débouche sur une obligation de contribution, fonction du revenu.

  Sa mise en œuvre nécessite toutefois une solvabilisation minimale des revenus du travail ainsi qu'un état de droit qui permette un recouvrement de contributions destiné effectivement au paiement de prestations sociales. Comme on l'a vu, de tels systèmes ne se sont construits généralement que progressivement dans les pays industrialisés et sont passés par une phase antérieure de développement d'une prévoyance souvent semi-collective, par exemple dans le cadre de mutuelle ou de systèmes professionnels.

2.2.2 *Gestion publique, gestion privée; efficience et modernisation*

Un des éléments du débat concerne le mode de gestion de la protection sociale. Doit-il être privé ou public? Deux dogmes s'opposent souvent:

- ceux qui considèrent que le secteur public est inefficace, impuissant et parfois corrompu et qu'il convient donc de lui préférer le secteur privé,
- ceux qui considèrent que le secteur privé à but lucratif ne peut rendre des services sociaux, ces derniers ne pouvant répondre à la logique du profit: comment une assurance privée qui cherche à maximiser le profit de ses actionnaires pourrait-elle en même temps maximiser les droits de ses assurés et accueillir les plus malades avec plaisir?

La difficulté de choix peut être réelle et il n'y a pas de modèle simpliste. Dans un pays donné, la déficience du secteur public sera souvent parallèle à la déficience du secteur privé. Un service public efficace sous-traitera souvent une part de son activité à des entreprises privées, par exemple pour la mise au point d'éléments du système informatique.

Des systèmes mixtes sont donc concevables, soit par des distinctions de modes d'activité, soit par le développement d'organismes autonomes à but non lucratif sous le contrôle conjoint des bénéficiaires, des cotisants et des Etats.

L'essentiel est d'assurer l'honnêteté, la sécurité et l'efficience de la gestion. Dans tous les pays du monde, s'imposent la modernisation et l'amélioration du service rendu à l'usager. La France développe ainsi des contrats pluriannuels d'objectifs et de gestion entre l'Etat et les organismes de sécurité sociale pour la définition conjointe de progrès de gestion avec des indicateurs de suivi. Les résultats sont ensuite évalués et contrôlés.

Le bon recouvrement des contributions est, dans ce cadre, un enjeu essentiel. Outre des conditions minimales de solvabilisation et d'état de droit, il implique un intérêt des employeurs et des travailleurs à payer ce qu'ils doivent, ce qui nécessite un lien suffisant entre contributions et prestations, ainsi que des procédures extrêmement simples réduisant au minimum la charge administrative des déclarations et des paiements de contributions ou prestations.

Un autre enjeu essentiel est une efficience dans la gestion des risques sociaux. La protection sociale ne peut se contenter d'offrir de manière passive des prestations. Elle doit s'efforcer d'accompagner les victimes de risques sociaux et, s'il y a lieu (chômeurs, accidentés, handicapés) les aider à se réadapter et se réinsérer professionnellement ou socialement. Une véritable sécurité sociale exige aujourd'hui une démarche active au service aussi bien des usagers que de la maîtrise des coûts.

Ces enjeux de gestion sont essentiels pour favoriser l'extension de la sécurité sociale.

2.2.3 *Universalité nationale et universalisme international*

Au niveau national, l'universalité de la protection sociale est souvent un idéal, presque atteint dans certains pays développés, très éloigné dans la plupart des pays en développement. Cet objectif qui découle de la Déclaration universelle des droits de l'homme implique sans doute une démarche progressive fonction des progrès économiques. Des stratégies nationales de sécurité sociale avec leurs moyens de mise en œuvre devraient être définies par les Etats avec l'assistance technique le cas échéant du BIT, comme recommandées par la résolution et les conclusions concernant la sécurité sociale de la Conférence internationale du travail de 2001.

Les éléments de cette stratégie peuvent varier selon les branches de la protection sociale. Il n'est pas toujours possible ou nécessaire de prévoir la même gamme de prestations pour toutes les catégories de personnes. Des priorités doivent être définies ainsi qu'une évolution dans le temps. Des programmes ciblés peuvent constituer un moyen d'amorcer l'introduction de la sécurité sociale pour les groupes exclus. Pour le BIT, «priorité absolue doit être donnée à la conception de politiques et d'initiatives propres à faire bénéficier de la sécurité sociale ceux qui ne sont pas couverts par les systèmes en vigueur. Dans nombre de pays, il s'agit des salariés de petits établissements, des

travailleurs indépendants, des travailleurs migrants et des personnes occupées dans l'économie informelle, dont beaucoup sont des femmes. Quand la couverture ne peut être accordée immédiatement à ces groupes, on pourrait introduire des mécanismes d'assurance-le cas échéant sur une base volontaire-ou d'autres mesures telles que l'assistance sociale, puis les étendre et les intégrer au système de sécurité sociale à un stade ultérieur, une fois que l'intérêt des prestations est démontré et que cela est économiquement viable…Il faudrait explorer de manière rigoureuse le potentiel de la microassurance: quand bien même elle ne peut être la base d'un système complet de sécurité sociale, elle peut constituer une première étape utile, notamment pour répondre à l'urgente nécessité d'améliorer l'accès aux soins de santé.»

Au niveau international, ne convient-il pas de développer une coopération technique pragmatique en ce sens. Elle devrait éviter les modèles internationaux plaqués et aider les Etats à définir, compte tenu des réalités culturelles nationales et avec leurs partenaire sociaux, leur stratégie nationale de sécurité sociale. La résolution de 2001 de la Conférence de l'OIT, qui préconise une vaste campagne pour promouvoir l'extension de la couverture de la sécurité sociale, avance des lignes d'action en ce sens qu'il conviendrait de mettre en œuvre.

Peut-on aller plus loin pour atteindre un universalisme de la protection sociale? Une proposition de fiducie internationale est étudiée par certains fonctionnaires du BIT, mais ce projet assez flou est-il réaliste?

CONCLUSION

La mondialisation des échanges peut économiquement être très positive pour notre planète, dès lors qu'elle ne néglige pas la finalité sociale du développement économique.

L'extension parallèle et progressive d'un système de protection sociale améliorant la santé des hommes et leur sécurité sociale n'en serait-elle pas une garantie?

Pour que l'accroissement de la concurrence économique et commerciale soit supportable, ne conviendrait-il pas que les normes pertinentes de l'OIT en la matière, correspondant aux objectifs de travail décent et de la Déclaration de Philadelphie de mai 1944, s'imposent aux autres institutions internationales.

Ainsi, une meilleure prise en compte de la finalité sociale dans une croissance économique, assortie d'une protection sociale dynamique et active, pourrait contribuer à un développement durable au service de l'humanité.

INTEGRATED SOCIAL SECURITY FOR INFORMAL WOMEN WORKERS: THE EXPERIENCES OF THE SELF-EMPLOYED WOMEN'S ASSOCIATION (SEWA) IN INDIA

Ms. Mirai Chatterjee
Coordinator, SEWA Social Security

SEWA is a trade union of 680,000 informal women workers in India. Founded in 1972 by a labour organizer and lawyer, Ela Bhatt, in Ahmedabad, Gujarat, it has a membership of 535,000 in this state. Manual labourers and service providers (construction workers, agricultural workers, headloaders etc.), street vendors, home-based workers like garment workers and embroiderers and small producers like salt manufacturers constitute SEWA's membership.

Full employment and self reliance are SEWA's two main goals. The first goal means work security, income security, food and social security. Social security includes health care, child care, insurance and shelter.

After witnessing first-hand the impact of repeated and frequent crises in women's lives, we understood that insurance can provide essential protection against the multiple risks that poor women workers face everyday. Thus, SEWA developed an insurance programme with the support of SEWA Bank. We initially linked with the government insurance companies. Now we insure our members with both government and private insurers. We ourselves insure women for maternity.

Today we have 101,926 insured women, men and children. The women are the policy-holders and insure their families for life, accidents, sickness and asset loss. Over the past ten years of insuring women, we have learned that insurance for the poor can be viable and must be contributory, with the government, employers and worker's all contributing to a common solidarity fund. Insurance should strive to cover as many risks as possible. Further, if services are run by women and in a timely and efficient way, the demand for insurance grows. In addition, there is a need to spread an understanding of insurance and risk reduction among workers. Risk prevention strategies, like primary health care programmes with a strong educational focus, reduce women's vulnerability and also enhance the viability of insurance. Most of all, a strong, membership-based organization helps micro-insurance efforts to grow and flourish.

While the potential of extending insurance to the poor is considerable and viable, the challenges are also significant. The importance of a strong and growing membership, while retaining the insureds, cannot be over-emphasised. The latter, in turn, can only be achieved if services are appropriate, affordable and timely. Capacity-building and building up competency among workers and the insurance team is also critical. Finally, legal frameworks to create, build and develop worker's own insurance organization, a people's alternative for social security in partnership with the state and private sector, must be developed so that the poor can themselves run, own and plan for their own security.

SOCIAL PROTECTION: OXFAM'S APPROACH

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In increasingly competitive globalised trade, many governments perceive that 'cheap labour' is their only competitive advantage. Creating badly needed jobs and export income through promoting investment in manufacturing in trade zones, plantations and processing plants is perceived to be a successful economic development strategy. In an attempt to remain competitive and attract foreign investment, governments often weaken or fail to enforce labour rights in zones or with flexible workers and home workers. This trend poses a threat on social protection since national labour codes usually do not protect these workers and they cannot organise to demand their rights either.

Weakening national labour codes, or exemptions on the enforcement of existing labour regulations, may also be due to pressure from international institutions. International Financial Institutions may advise national governments on labour market liberalisation or include conditionality on labour legislation as part of loan agreements. National governments may also be limited by bilateral or regional trade agreements in terms of what labour protections can require from employers.

Policy makers too easily ignore the costs of export employment for individuals, families and communities. Promoters of export zones reinforce the myth that 'these women have work for the first time', erasing consideration of the tradeoffs in caring and domestic work, and women's former (unpaid) contributions to agricultural production and informal services.

Women workers are at the forefront of export-oriented growth. For example, more than one third of the manufacturing labour force in developing countries is women (almost half in some Asian countries); women are 70 percent of the workforce in Export Processing Zones; and up to 80-90% of garments home workers are women. Women workers struggle to have their labour rights recognised. Often women workers are regarded as expendable, secondary workers, not the 'real' providers for their families. In addition, since export workers tend to be young, unmarried women - expected to be replaced within a few years - it is too easy to ignore this female workforce's rights to social insurance, health, pensions or statutory leaves. When employers and governments fail to provide these, women workers are impoverished.

Women workers, as well as societies, also face a problematic mix of benefits and costs. Many women workers value the economic independence and social status gained through these jobs. For the years they are employed in these export industries, women workers often enjoy higher than average wages. But for these short-term gains, they trade away the longer-term health and welfare of themselves, their children and their families. Often on returning home to rural areas, former workers find themselves stigmatised. As women become 'wage earners', male relatives may reduce their traditional support to households, leaving women more vulnerable in times of crisis.

On the one hand governments bear enormous pressures from different agents to weaken labour codes and to reduce social expenditure. On the other hand, as women increasingly participate in the labour market, their role in providing social protection to their families and communities diminishes. Therefore, neither the State, nor the communities can provide the required social protection at a time when it is most needed.

CONCERTATION ENTRE LES ACTEURS DU DÉVELOPPEMENT DES MUTUELLES DE SANTÉ EN AFRIQUE: RESUME DE LA COMMUNICATION AU SYMPOSIUM SUR LA PROTECTION SOCIALE

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Concertation des acteurs de développement des mutuelles de santé en Afrique

Différents partenaires internationaux ont décidé en juin 1998 de se réunir afin de définir les stratégies d'appui au mouvement mutualiste naissant en Afrique. Un atelier, tenu à Abidjan (Côte d'Ivoire), a réuni différentes organisations: fédérations mutualistes d'Afrique et d'autres régions du monde, organisations internationales, États, agences de coopération, prestataires de soins, ONG locales et internationales, universités, centres de recherche et confédérations syndicales. Des représentants de neuf États et d'une cinquantaine de structures ont participé aux travaux. C'est au cours de cet atelier qu'un document de référence a été réalisé: la Plate-forme d'Abidjan. Elle est le produit de l'expérience des principaux artisans du développement des mutuelles de santé en Afrique de l'Ouest et du Centre.

Les participants à l'atelier ont exprimé le besoin de créer un mécanisme plus structurel de collaboration entre les acteurs du développement mutualiste. Cette idée s'est concrétisée par la mise en place d'une «**Concertation des acteurs du développement des mutuelles de santé en Afrique**», appelé «La Concertation» basée à Dakar au Sénégal. La «Concertation» est un mécanisme innovateur et stratégique. Elle permet de créer des liens stratégiques et techniques, des collaborations et d'établir un dialogue entre les mutuelles de santé africaines, les partenaires sociaux, les acteurs du développement et les communautés par le biais d'activités concrètes, comme des formations, des ateliers d'échanges et des discussions thématiques. Depuis sa création, à travers la dizaine de lettres d'information et le site Internet de la «Concertation», de nombreux acteurs ont pu partager leur point de vue, leurs connaissances et leurs expériences. Tous les mois de nouveaux utilisateurs rejoignent la «Concertation» qui en compte plus de cinq cents en 2002. La «Concertation» est active dans onze pays d'Afrique francophone: Sénégal, Mali, Burkina Faso, Niger, Côte d'Ivoire, Bénin, Mauritanie, Cameroun, Guinée, Tchad et Togo.

La «Concertation» est basée sur le partenariat entre les acteurs du développement des mutuelles de santé en Afrique. Quatre structures interviennent concrètement pour lui donner vie:

- ***Les promoteurs*** qui s'unissent afin d'harmoniser leur mode d'intervention et appuient financièrement et techniquement les activités de la «Concertation», à savoir le BIT-STEP, l'USAID-PHRplus, la GTZ, l'AIM, l'ANMC, la WSM, le réseau RAMUS et l'UNMS.

- ***La cellule de coordination***, sous la supervision d'un Secrétariat Technique, assure la gestion quotidienne des activités. Le Secrétariat Technique a aussi pour mission d'établir le lien entre les différents partenaires.
- ***Les membres.*** Ils sont en 2002 au nombre de cent cinquante, constitués d'organisations mutualistes, de fédérations syndicales, de structures publiques, de centres de recherche, de structures d'appui aux mutuelles en Afrique et au niveau international. D'autre part, plus de cinq cent utilisateurs des services de la Concertation sont inscrits en ligne dans les différentes bases de données. Dans chaque pays, un cadre national de concertation réunit les acteurs du pays autour des préoccupations spécifiques.
- ***Les points focaux*** jouent un rôle clé dans le fonctionnement de la «Concertation» en facilitant la communication avec la Cellule de coordination et jouant d'interface entre les membres nationaux, les acteurs locaux et leurs partenaires régionaux et internationaux.

Cette structure a mis en place un système d'information opérationnel autour de quatre activités prioritaires:

- ***Un site Internet.*** Il fournit des informations sur les organisations mutualistes, les institutions et autres structures d'appui au mouvement mutualiste, une bibliographie des systèmes existants, ainsi qu'un calendrier des activités prévues dans la région et au niveau international, en particulier les ateliers thématiques et les formations destinées aux acteurs du développement des mutuelles de santé. Le site avec son système de flash-news, informe et offre une vision systématique des événements qui se produisent dans le secteur, à ses centaines d'utilisateurs. Le site est également un lieu d'échanges (forum de discussions) et de connaissances, à travers des thèmes proposés et la mise à disposition d'une variété importante de documentation relative aux mutuelles de santé. Plus de deux cent documents sont répertoriés : articles, brochures, études, monographies, études de cas, textes juridiques, etc. La lettre d'information de la «Concertation» est également disponible en ligne.
- ***Une lettre d'information.*** Cette lettre appelée le «Courrier de la Concertation» complète le site Internet et permet de mettre en contact et d'informer un public cible dont l'accès aux technologies modernes est limité ou inexistant. Le «Courrier de la Concertation», distribué gratuitement dans les onze pays couverts, contient des articles sur des sujets spécifiques, des interviews de responsables et d'acteurs travaillant au développement des mutuelles, des échanges d'expériences et des informations sur les événements à venir. Une version légère en anglais est également produite et distribuée aux partenaires.
- ***Un système de suivi du développement des mutuelles.*** Différents travaux sont réalisés pour suivre l'évolution des mutuelles de santé en Afrique : études de cas, synthèse, travaux de capitalisation. Ainsi, en 1998, une étude a été menée dans neuf pays d'Afrique de l'Ouest et du centre sur la contribution des mutuelles de santé au financement, à l'accès aux soins de santé. De nombreuses conclusions et recommandations ont été établies, notamment sur la fragilité des mutuelles étudiées, leur dépendance au contexte institutionnel, leur impact, leur contribution en termes d'équité, d'efficacité d'amélioration de la qualité et de l'accès aux soins de santé. Ces conclusions ont permis aux acteurs du développement des mutuelles de consolider ou

réorienter leurs stratégies d'appui. Cette étude a été réactualisée en septembre 2000, en effectuant un inventaire des mutuelles dans les pays couverts par la Concertation. Un suivi systématique et régulier (tous les trois ans) est mis en place pour appuyer les acteurs à identifier les pistes et les actions de consolidation du mouvement mutualiste.

- ***L'organisation de forums.*** En complément des autres outils d'information, sont organisés tous les deux ans des forums réunissant l'ensemble des acteurs afin de partager leurs expériences, comparer leurs analyses et définir des actions conjointes ou coordonnées, initier ou renforcer des partenariats. Le premier atelier a eu lieu en septembre 2000 à Dakar et a réuni 80 participants de 18 nationalités (autour de 2 thèmes et 10 expériences). Le deuxième s'est également organisé à Dakar en septembre 2002 et a réuni 190 participants de 24 nationalités (autour de 3 thèmes et 29 communications orales).

Les «Actes du Forum» sont édités et diffusés auprès d'acteurs qui n'ont pu participer au Forum. Les discussions sur les thèmes du Forum et sur d'autres continuent en ligne, sur le site web de la Concertation.