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Better Health & Social Care

How are Co-ops & Mutuals Boosting Innovation & Access Worldwide?

An international survey of co-ops and mutuals at work in the health and social care sector (CMHSC14)

Jean-Pierre Girard
Lead Researcher & Editor

Volume 1: Report

With the support of Confcooperative Federazionesanitá, La Fédération des coopératives de services à domicile et de santé du Québec, Desjardins Insurance, International Health Co-operative Organisation, the Chair in Social and Solidarity Economy, NEOMA Business School, Université de Reims Champagne-Ardenne

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For the 54 national cases on which this Report is based, refer to *Better Health & Social Care.* Volume 2: National Cases. Note that certain national information is confined to Volume 1: Mali and the Democratic Republic of Congo (p. 19), and Palestine, Iran, and Sri Lanka (p. 50).

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To the women and men all over the world who prove every day that health is not only an issue for the State or for organizations based on capital, but co-ops and mutuals based on people. This report is a modest echo of your contribution to the well-being of millions of citizens, without regard to their financial status, creed, religion, or gender.

BETTER HEALTH & SOCIAL CARE

How are Co-ops & Mutuals boosting Innovation & Access Worldwide?

Edited by Jean-Pierre Girard, LPS Productions

From the local arena to the international, LPS Productions has been engaged in supporting collective entrepreneurship since 2002. It has undertaken research, produced reports, networked, and supplied technical assistance for the development of diverse projects.

This report is published in accordance with a mandate received from the International Summit of Cooperatives (ISC). The opinions and arguments expressed herein do not necessarily reflect the opinions of the ISC or any associated organizations.

Note: This report has been undertaken with meticulous care in order to collect and process data as accurately as possible. If you detect any errors or omissions, please contact the editor: jpg282000@yahoo.ca

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Acknowledgments

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This report first began to emerge near the close of 2013, courtesy of the trust and the financial engagement of the International Summit of Cooperatives. My thanks go to Summit Executive Director Stéphane Bertrand and Program Director Joanne Lechasseur. Despite her many other responsibilities Joanne has been always very pro-active in addressing our persistent questions and requests.

Finally, regardless of their status, whether director, officer, personal assistant, civil servant, researcher, professor, or student, I'd like to extend my sincere thanks to all the people around the world who generously gave of their time to share with us data, contacts, feedback, comments, and other important insights. I hope you will find an echo of your input in this report and moreover, food for thought and action!

Jean-Pierre Girard, research leader and editor
Montréal (Canada) September 24, 2014

Foreword

By Dr José Carlos Guisado, Chairperson, International Health Co-operative Organisation (IHCO)

It is finally here! After many efforts, false starts, and all manner of difficulties (administrative, financial, and many others) the work is done!

Still, it is by no means finished. This is just another point of departure in the eternal pursuit of greater excellence and visibility for our movement – the whole cooperative movement, and the health cooperative sector in particular.

Back in 2007, the IHCO Board decided to implement a survey on health cooperatives. It was to be conducted by Jean-Pierre Girard, a member of the IHCO Board by that time, in collaboration with IRECUS. But the results were few and far between, mainly for lack of financial resources and extensive sources of information.

The concept was not abandoned, however. Jean-Pierre, his commitment unfazed, gathered a new team and sought out more support, which he finally accomplished in conjunction with the organizers of the 2014 Quebec Summit. So when he explained the survey project to an IHCO Board meeting in Cape Town 2013, both our welcome and our support were unanimous.

The purposes of the survey are clear-cut and can be found in the text. But for us here, some other matters should be taken into consideration.

The cooperative movement is a reality which, perhaps because it is so much a part of all communities, is frequently either overlooked or underestimated. And, until very recently, our international profile has been seriously lacking.

In this respect we owe great thanks to the International Co-operative Alliance (ICA), especially since the United Nations' declaration of the International Year of Cooperatives in 2012, for its efforts with regard to the 2020 Vision and the publication and implementation of the ICA's Blueprint for a Co-operative Decade.

Now, what about health and the importance of health cooperatives to the world? They are not well-known, or at least, not nearly as well-known as they ought to be.

With our sense of co-responsibility we render a service to all communities. As we say, we are grassroots organizations focused on grassroots citizens. We endeavour to augment the concept of health from a holistic perspective, as a means to foster human development in many significant ways. It is our experience that wherever a health co-op takes root, society as a whole grows. We strive to influence the full range of determinants of health.

We are open to everyone: governments, international and national organizations and, essentially, to all the citizens of the world. (See the IHCO's Lévis 2012 Declaration.)

We have discovered and demonstrated that ours is a solution applicable both to developed and to the so-called developing countries, particularly in this era of financial crisis and ever-increasing health care costs.

The task has been hard. As Jean-Pierre and his team are wont to say, *"We thought we would be climbing the Alps; in fact, it turned out to be the Himalayas."*

But with resolution, energy, and the constant support of all ICA bodies and many other organizations, it has been accomplished. The results can be found here.

Some may say that, as inclusive as it is, the survey does not encompass each and every relevant organization. This may be true in some minor cases; still, the survey remains a good example of astute research. Now we have a comprehensive tool to apply again and again in the study of health co-ops around the world.

Let me to take this opportunity to thank all the contributors – the LPS team, IHCO, and ICA – for their contributions to the completion of this portrait of the health cooperative movement.

The movement is gaining more and more recognition across a wider spectrum of organizations and fora. The importance of the issue of health care nowadays is also apparent from the various symposiums, seminars, scientific meetings, etc. devoted to it. This Summit is one of the clearest examples, likewise the conferences of the "*Cooperativas de las Américas*" (former "*ICA Americas*") in Colombia in November 2014, and the one to be held in India in the very near future (January 2015).

It may be difficult for you, the readers, to grasp the complexity of the study, and of the movement itself. Ultimately, it is difficult to imagine a study which fully captures the realities and facts of health cooperatives. Yet we do exist; moreover, we move along without despair and without illusion. Therefore, I would like to encourage you to read and use this survey and embrace its simple conclusion:

We care! We are already providing health services to more than 300 million of our fellow-citizens worldwide! We want you all to get to know our model and just how much it contributes to communities, and then to extend its reach to every corner of the globe.

Best co-operative regards,

José Carlos Guisado

Chairperson

Executive Summary/Highlights

Why this research?

What is important about the engagement of cooperatives and mutuals in the health and social care sector? How do these organizations improve access to health care? How are they innovative?

How was the research carried out?

A global survey was conducted by an international research team from February to August 2014. It covered 59 countries from the five major regions of the world.

Key figures from the research

- Total number of persons worldwide using the facilities of cooperatives and mutuals engaged in the health sector: 81,000,081.
- Total number of cooperatives and mutuals engaged in health activity: 4,961.
- Number of countries with cooperatives and mutuals which own and/or manage such facilities as clinics, medical centres, hospitals: 43.
- Number of social care cooperatives worldwide: 14,806.
- The cooperative model is applied in the pharmacy sector at all levels worldwide: retail pharmacies, wholesalers, drug producers (laboratories).
- In developing countries, health plans provided by cooperatives or mutuals frequently are the only affordable option for millions of people.

Innovation

- Health cooperative contractors provide high quality, efficient services for Costa Rica's social security system.
- Continuum of care offerings by diverse types of cooperative in Italy.
- The Espriu Foundation network in Spain runs hospitals in collaboration with the government. This has led to cost savings for the national health system and to higher satisfaction among users.
- Cooperatives provide options for innovative Personal Health Record platforms in Finland.
- Mutuals provide health care to indigenous people in Paraguay.
- Women's Health Cooperative has become a model of community empowerment due to its provision of easily accessible and affordable health care services in Tikathali village in Nepal.
- Thanks to a fruitful partnership with a Public Health Regional Centre and municipal housing office, a home care cooperative in Canada provides overall service to seven homes for the elderly and six homes for the disabled.

Major players

- UNIMED (Brazil) brings together 354 medical (doctor) cooperatives which represent up to 110,000 doctors and provide services to more than 19 million people.
- In Italy, 10,836 cooperatives operate in the social sector, mainly in social assistance and individual services.
- NOWEDA is a retail cooperative of pharmacies. It has 16 outlets in Germany and one in Luxembourg and has 8,600 pharmacies in membership. It is among Germany's 150 largest enterprises.
- Close to 90% of Rwandans have a health plan with a Health Mutual Organization.
- ACHMEA (Netherlands) provides health and other insurance to about half of all Dutch households and is also active in seven other European countries as well as Australia.

LIST OF ABBREVIATIONS

Euricse	European Research Institute on Cooperatives and Social Enterprises
GDP	Gross Domestic product
GP	General Practitioners
HiAP	Health in All Policies
ICA	International Co-operative Alliance
IHCO	International Health Co-operative Organisation
ILO	International Labour Organization
ISC	International Summit of Cooperatives
IT	Information technology
MHO	Mutual Health Organization
NGO	Nongovernmental organization
NPO	Nonprofit Organization
OOP	Out-of-pocket
STEP	Strategies and Tools against Social Exclusion and Poverty (ILO program)
UHC	Universal Health Coverage
UN	United Nations
UNICEF	United Nations Children's Fund
USD	United States dollar
WHO	World Health Organization

Introduction

Your health is your most important asset.

Health is a central element of well-being and happiness. Good health enables a long and productive life. Good health is essential to the fulfillment not only of the aspirations of individuals and their relatives but also the aspirations of society as a whole.

The improvement of human health has a direct impact on many dimensions of life, not the least of which is life expectancy. As reported in World Health Statistics 2014, based on global averages, a girl who was born in 2012 can expect to live to around 73 years of age, and a boy to the age of 68. This is six years longer than the average global life expectancy for a child born in 1990.[1]

Given recent research and evidence as to the sources of good health, we know that it is much more than a question of the provision of health services. It is also the consequence of many other influences: age, sex, and factors of heredity; individual lifestyle factors; social and community influences; the environment, etc. In other words, "social health determinants," as a World Health Organization (WHO) report in 2009[2] has documented in detail. In this sense, at the level of public policy, as the 8th Global Conference on Health Promotion in 2013 in Finland has shown, health has to feature in all policies (HiAP).[3] Health is also closely linked with the question of equality, as Wilkinson and Pickett clearly demonstrated in their remarkable book, *The Spirit Level: Why Equality is Better for Everyone* (2009).[4] The book argues with scientific evidence that there are "pernicious effects that inequality has on societies: eroding trust, increasing anxiety and illness, (and) encouraging excessive consumption."

Nevertheless, we must not underestimate the impact of the health system on individual and collective health. If the health facility, the clinic for instance, is located too far away from home or work, it could discourage people from accessing services on a regular basis and aggravate their health problems. The same might happen if (as occurs in many low-income countries) people living on less than $1 a day have to pay for medical services out-of-pocket or on a "cash-and-carry" basis. They would rather avoid medical consultation than bear with its financial impact. Let's not forget what WHO[5] has already documented: 100 million people fall below the poverty line when forced to pay out-of-pocket for their health care.

In the long run, for certain, such behaviours also have serious consequences for individual health.

Alternatively, health systems which function under the influence of a bureaucratic or State apparatus, and without any contribution from civil society, can experience major asymmetry between supply and demand. The process of defining people's needs and how they are to be addressed can give rise to a "one size fits all" approach, without any consideration for citizens' output or attention to regional or

local needs. In other words, a negation of the principle of subsidiarity![6] On the other hand, the market-driven approach, far from being the ultimate mechanism for the efficient allocation of resources, in the health sector can seriously hamper access to products and services. The policies associated with this model (commercialized provision, cost recovery, and targeted social protection) have had dramatic consequences in the context of high poverty rates.[7]

Health systems, as this report explains, are complex organizations under many influences and with many stakeholders: health professionals, GPs, unions, big Pharma, associations of the sick or disabled, to name a few. By their very nature, health systems are always in a state of tension. Moreover, they are rooted in culture and history, which is why these systems vary from one country to another, even when countries have values and principles in common. Even in the same country, when health care responsibilities are decentralized, systems can differ from one state, province, or region to another. Ideally, health systems should enable civil society participation in the formulation of policies affecting the State or para-State apparatus. Unfortunately, this is not always the situation. In some cases, civil society "participation" is more akin to "exclusion"![8] We will return to the issue of participation later in this report.

Too often we are "binocular" when thinking about health systems. On the one side, there are public organizations, and on the other, there are private ones, based on capital (not on members). In other words, we think of systems with two major actors, each with its own set of values and principles.

Unfortunately, this perspective totally overlooks millions of persons the world over, South and North, in high-, middle-, and low-income countries, who are engaged in health organizations of a different sort: organizations based on the values of equality, equity, and solidarity and which, day-in day-out, work hard to improve access to health care for their members, their members' dependents, and more widely still – for the whole community. Such people are not shareholders, but stakeholders in an organization they own and control!

PURPOSE & SCALE OF THE PROJECT

This report aims to show the variety of contributions made by cooperatives and mutuals in the health and social care sector and how innovative these contributions have been.

The research was undertaken by a team which sourced information and data from government offices, cooperative organizations, research centres, and in some cases, individual cooperatives. It provides an overview of the number and variety of member-based organizations which are involved in curative or health treatments but also in health promotion, prevention, rehabilitation, and social care. It describes a wide range of activities and confirms that cooperatives and mutuals in the health and social care sector are active in far more countries than one might assume.

The report provides information from 59 countries from the world's five major regions. It recounts how cooperatives and mutuals bring people together: from a small health mutual in Burkina Faso, in order to offer affordable health plans to poor people, to huge cooperative organizations in Brazil, by means

of which more than 100,000 doctor-members provide health services nationwide. It describes a women's health cooperative in a village near Kathmandu which went on to become a model for health care delivery in Nepal. It documents a paramedic worker co-op in the vicinity of Québec City, Canada, with state-of-the-art ambulances and first-responder equipment.

While the main focus of this report is health service provision and delivery, three other fields of activity closely connected to health care are also included: social care, pharmaceutical production and distribution, and health mutual organizations.

- Social care cooperatives play a crucial role in the maintenance or improvement of the social well-being of members and/or their dependents. Social care cooperatives usually provide only services, including special or protected employment. Payment often is secured on behalf of users from external funds, usually from the public sector. Social care cooperatives play a key role with targeted populations, including the disabled, seniors, and the mentally ill. Many of these co-ops adopt the model of the multistakeholder membership base.
- It is widely recognized that improvements to individuals' health status over the last century are in large part attributable to significant developments in terms of medical treatment, especially drugs. The prominence of prescription drugs or pharmaceutical products is readily apparent in any breakdown of health costs. The report confirms that cooperatives all over the world are involved in pharmaceutical production and retail.
- Cooperatives, mutuals, or subsidiaries of membership-based organizations also play a noteworthy part in health services, especially in terms of health plans. In many lower-income countries, these organizations are on the front line: the Mutual Health Organization (MHO) is the only one providing a specific population with an affordable health plan for basic medical coverage. The report cites the example of Rwanda. In recent years, that country has made impressive improvements in terms of health. How significant, then, that nearly 90% of Rwandans are covered by an MHO! This demonstrates that there is no contradiction between Universal Health Coverage and intensive engagement of membership-based organizations in the provision of health plans!

Finally, the report finds that cooperatives and mutuals whose primary activity is not health care may still provide or facilitate access to health care services. This latter point underscores the fact that, first and foremost, cooperatives serve member needs. If members decide that health care is an area of priority, the co-op will make the necessary investments and enter into the necessary partnerships to make those services available – to the members, and often to the wider community.

LIMITATIONS OF THE INFORMATION

At the beginning of this project (late 2013), the request of the International Summit of Cooperatives was at once simple and challenging:

> Show the contribution of co-ops and mutuals to improvements in health access all around the world, with special attention to innovation.

As explained in Annex 1, Methodological Framework, there is no worldwide database on co-ops and mutuals engaged in the health and social care sector. (If there was, this report would never have seen the light of day!) The last worldwide study was released by the United Nations in 1997. (See Annex 3.) It goes without saying that the world has changed a great deal in close to 20 years. Co-ops and mutuals, likewise!

In January 2014, research had to start practically from scratch, except for a few big health co-ops registered on the Euricse database.[9] Over the months which followed, after the mobilization of the research team, data arrived from many sources: government offices, co-op associations or federations, research centres, even individual co-ops in some cases. We did our utmost to validate the data received. Due to the short timeline of the research project, however, we were unable to double-check the results for each country. In addition, with few exceptions, we were unable to meet with practitioners in the field or to have direct communication with people involved in these organizations. In other cases, we could only find partial data.

The gaps in the data are at times mysterious, no question. In some countries, we are convinced there are many more health co-ops and other types of co-op or mutual engaged in health and social care than this report indicates. There simply is no up-to-date, efficient database in the country to draw upon. Indeed, in some cases, the co-ops themselves have no IT access or even internet facility. In others, we know that the health co-ops in question use only fax machines. Then again, some mutual health organizations work in remote locations without any permanent staff! Despite our best intentions, it is also possible that we simply missed existing information. As will be explained shortly, our first framework focus (modified in the course of the project) specified only health and social care co-ops, rather than all co-ops and mutuals involved in the health domain.

Finally, such co-ops and mutuals as manage to evolve in this domain suffer from major lack of information.[10] As a recent publication of WHO recognized, *many countries do not have strong health information systems so the data is not always available and varies in quality.*[11]

In other words, even though the research team strove to collect and process as much pertinent data as possible in a short length of time, **from a worldwide perspective, this is not an exhaustive survey of co-ops and mutuals involved in the health and social care sector**. Over the coming years, more research and field activity must be conducted on this subject, including the production of detailed case studies.[12]

One more note: since we had no single, unified database on which to rely, readers must use the data with careful attention to the relevant source citations. While we did our best to get the most up-to-date data, some may predate 2006.

All these limitations should not discredit the value added by the research methodology. It helped clarify the relationship between national health systems and the performance of the cooperative model in the health sector. It shows that in some countries there are opportunities while in others there are none – for the time being. Given changes to policies and legislation, however, cooperatives or mutuals could contribute substantially to improvements in health.

Operational Definitions[13]

HEALTH COOPERATIVE

A health cooperative is a cooperative whose business goals are primarily or solely concerned with health care. These cooperatives provide one or more services related to the following:

- Illness/accident prevention
- Wellness and health promotion
- Treatment and cure
- Rehabilitation

These cooperatives may combine these services with social care services and offer a health plan.

Based on the 1997 United Nations typology,[14] we identified at least three types of co-op:

- User (U): in which members are the users (or consumers) of the services.[15]
- Multistakeholder (MS): those which include at least two member categories (for instance, users and producers), or any other mixed member categories. Under the 1997 typology they are termed "jointly-owned cooperatives."
- Producers (P): A group of producers who band together to process or market their products or services (includes worker co-ops).

SOCIAL CARE COOPERATIVE

> "This type includes only those cooperatives whose original and current primary and sole function is to provide social care services to users, who are persons in need of that care. A distinction should be made between such cooperatives, whose members may be made up of the persons in need of social care themselves, and other cooperatives whose membership may also consist entirely or largely of persons in the same or similar conditions but whose business goals are different. For example, a cooperative whose members are young persons and whose business goal is to provide social care services to themselves or to other young persons in need of such care is included in the category of social care cooperative. Not included would be a cooperative whose members are also young persons, also in need of the same or similar type of care, but who have combined to set up a cooperative in order to secure employment and income, for example, an agricultural production cooperative, small manufacturing enterprise or computer software production and servicing cooperative".[16]

There may also be three types of social care cooperative: User, Multistakeholder, and Producer.

The goal of social cooperatives is to maintain the social well-being of members and/or their dependents or to improve their degree of social well-being.

In contrast to user-owned health cooperatives, most of which provide both insurance and service delivery, social care cooperatives usually provide only services, including special or protected employment, payment often being made from external funds on behalf of users, usually from the public sector.

Social cooperatives can provide services to address the following vulnerable populations:

- Persons suffering from physical conditions and sociocultural discrimination associated with age, including infants, children and young persons, and elderly persons.
- Persons suffering from physical conditions and sociocultural discrimination associated with disability.
- Persons suffering from substance abuse, including narcotic drugs and alcohol.
- Persons suffering from significant loss of association with material and emotional support systems whether kinship-based (family) or other (household, neighbourhood, community), such as orphans, including street children, and persons living in social isolation, particularly elderly persons.

COOPERATIVE PHARMACIES

Primary level user-owned cooperative pharmacies: These are specialized forms of customer-owned retail cooperatives, some of which have developed their own wholesale subsidiaries.[17]

Secondary-level cooperative networks of pharmacies: The 1997 UN typology recognizes two subgroups.

> "Secondary-level cooperatives owned by user-owned retail cooperative pharmacies.
>
> Primary level user-owned cooperative pharmacies set up their own secondary networks which undertake joint purchasing, common service and common marketing functions.
>
> Secondary-level cooperatives owned by independent (provider-owned) pharmacies.
>
> Independent for-profit pharmacies have established their own networks in the form of a secondary cooperative. Such purchasing, wholesale supply, common service and marketing cooperatives may extend vertically to establish their own drug, medicine and medical equipment manufacturing subsidiaries."[18]

CO-OPS OR MUTUALS OFFERING HEALTH PLANS &/OR MANAGING HEALTH FACILITIES

A Mutual Health Organization (MHO, also known as a Community-Based Health Financing/Insurance scheme, or CBHS) or insurance cooperative or insurance branch of a credit union organization or

insurance company owned by credit union organizations, which offers health insurance products and/or manages health facilities, like medical care centres.

HEALTH

> "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity... The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."[19]

HEALTH CARE

Services provided to individuals or communities by health service providers for the purpose of promoting, maintaining, monitoring, or restoring health.[20]

The Role of Co-ops & Mutuals in the Health & Social Care Sector: Overview

There is no simple way to describe the presence of co-ops and mutuals in the health and social care sector. A few key points will help to clarify matters.

HEALTH & SOCIAL CARE: A MAJOR, SECONDARY, OR TERTIARY ACTIVITY?

In this report, when we refer to health or social care co-ops or MHOs, their main focus is precisely this domain: health and/or social care. We also have another category of co-op or mutual for which health and social care is a second or even a third domain of activity. This applies to many sectoral co-ops (savings and credit, agriculture, coffee producer, etc.). An interesting case is that of the multipurpose co-op. It is like a tool in the hands of members to promote local or regional development, no matter the sector. Very often multipurpose co-ops combine economic (production of a good) and social activity (health and social care) in order to improve the well-being of members and the whole community. The reader may note how closely this connects to the WHO's concept of the social health determinant.

MEMBERSHIP BASE: NO SIMPLE (OR PERMANENT) MATTER

Health co-ops vary widely in their membership. They can be started by doctors; in this case, we have a producer co-op. In other instances, users could be the co-op founders; in this case, we have a consumer co-op. Finally there can be a variety of stakeholders: users, producers, workers, or even (as in Italy) volunteers. This is a multistakeholder co-op.

In the life of a co-op, the members may also choose to change the membership base. So what began as a consumer co-op may transition into a multistakeholder co-op, in order to address the needs of a more diverse group of stakeholders, for instance.

HEALTH CARE: WHAT DOES IT MEAN?

The question, "What is a health co-op?"[21] often receives the spontaneous reply, "a clinic." The latter refers mainly to treatment or curative services. A second look at the question suggests (as WHO has indicated) that health service has three other basic components: promotion, prevention, and rehabilitation. It is challenging to develop a sustainable business model for the promotion of health (including mental health), and the prevention of disease or disability. These activities will often be supported by volunteers or receive dedicated funds. It is not natural for individuals to pay for health promotion since the results can only be detected over the long run. (Changing lifestyle is not something you do in a day or a week!) At the same time, since co-ops work to meet the needs of their members, it may make sense to fund such activities or programme events, even if they are not in themselves sustainable. A co-op instead will apply the surplus gained from other activities or from monies raised

by a donation campaign. The value-added of the co-op model also can be seen when a co-op combines health and social care. In addition to health care, the co-op perceives how important it is to improve members' social well-being. It makes perfect sense for the co-op to strive to satisfy these diverse member needs, so long as the necessary spectrum of skill and sustainable business model can be devised. Finally, we should not underestimate the number of ways there are to practice health care. If over the last decade, Western medicine[22] was the approach taken by most co-ops or mutuals engaged in health care, others welcomed allopathic, alternative, and traditional medicine, like Ayurveda medicine in India.

FUNDING BASE: ANOTHER COMPLEX ISSUE!

There is no single and simple way to fund a co-op or mutual engaged in the provision of health care. This is due to the fact that this domain is heavily influenced by the role and rules of the State and para-State organizations. On behalf of the common good or general interest, States are encouraged to play an active role in the health system and this role can be of enormous significance. Just a few years ago, WHO called for governments to get involved in the implementation of Universal Health Coverage (UHC), in order to ensure that all people can obtain the health services they need without suffering financial hardship.[23]

As Annex 2 of this report explains, the public sector's share in total health expenditure can be as high as 85%. In such cases, the potential role of the mutual or insurance co-op in health plans will be quite limited. In low-income countries, by contrast, the public sector's spending could be at low as 15%. That makes room for a mix of affordable health plans and external support.

The State also could be heavily engaged in the provision of health services, hiring staff, owning and managing clinics and hospitals – in other words, leaving open only a very limited role in provision for others, including co-ops.

The most common role played by the State in the health system is one of stewardship. This role is performed by the health ministry directly or with the support of other, Para-state organizations.

The way in which co-ops and mutuals design their business model, including their sources of revenue, heavily depends on their situation vis-à-vis the State and their prospective users, that is, the presence or absence of a third party payer. Co-ops or mutuals may fund their health care work from one or a combination of the following revenue sources:

- Contract or service agreement with the State or a public body or para-statal[24]
- Billing individuals (which could be covered OOP or by insurance)
- Billing providers (for instance, charging a lease to GPs[25])
- Billing the insurance system (alternatively, the user could pay a user fee)
- Donations or grants

HEALTH INSURANCE: A NARROW RANGE OF OPTIONS

Since, two hundred years ago, the first "friendly" or mutual societies began to insure people against sickness and provide basic health care, co-ops and mutuals have made great strides in their health plans, as has the welfare state. On the basis of a 2011 report on mutuals in 21st century Europe, the role of mutuals in health insurance can be analyzed in the following terms:

When it comes to health insurance within national welfare systems, we must distinguish between compulsory and voluntary schemes. Compulsory health insurance provides basic coverage, either through a national health service or through health insurance funds. Voluntary health insurance may be classified as follows:

- ***substitutive*** *- offering the same coverage as compulsory health insurance (either to people who are excluded from the compulsory system or who choose to opt out).*
- ***supplementary*** *- offering services and coverage on top of/ as a supplement to compulsory health insurance (such as faster access and enhanced consumer choice).*
- ***complementary*** *- covering co-payments/cost-sharing and additional services excluded from the statutory system.*
- ***duplicative*** *– offering services and coverage next to national health systems.*[26]

So the mutual might be active in several ways:

- *in compulsory health insurance.*
- *in both compulsory and voluntary health insurance.*
- *in voluntary/supplementary health insurance, but not in compulsory health insurance.*

The situation is different in low-income countries, where limited resources severely narrow the role of the State. UHC, based on general taxation, is still the exception. In these countries, health care is financed through an OOP system for the majority of the population. In some countries, MHOs provide a small-scale, pre-paid or risk-pooled system based on membership.[27] The MHO is defined as

> "a voluntary association of people, without lucrative purpose, which is based on solidarity between all its members; through the contribution paid by its members and on the basis of decisions taken by the members themselves or by their management structures, it takes action to promote mutual help between members in view of the social risk they face."[28]

MHOs therefore can specifically address the management of health problems. The organization can offer members and their families affordable health plans covering basic health services.[29] It may be based on a territory or on a professional status (for instance, civil servants).

Co-ops & Mutuals in the Health & Social Care Sector: Global & Regional Data

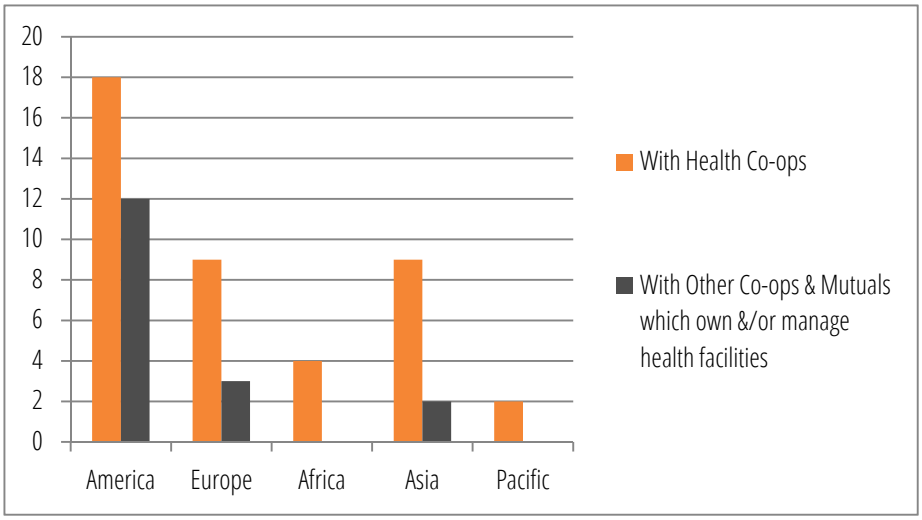
1. HEALTH CO-OPS

Table 1 (see pp. 21-22) demonstrates the importance of health co-ops around the world. Even without complete data for all countries, the importance of facilities, from clinic to hospital, is apparent. Some of these health co-ops may benefit from the value-added of membership in an association or a federation: access to training programmes, knowledge sharing, and funding resources. In terms of numbers of users, health co-ops in certain countries (Brazil, UK, Colombia, Japan, Spain, and the USA) encompass more than a million persons.

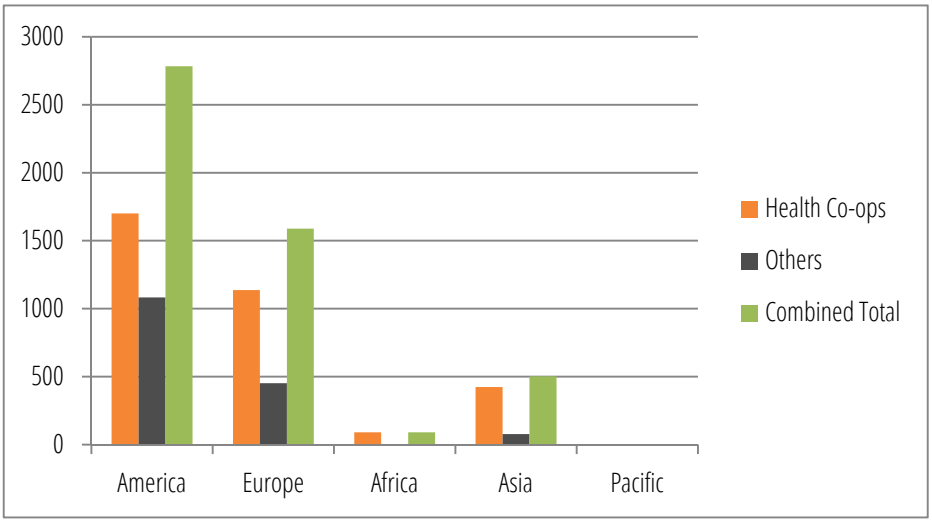
Geographical base

From a geographical point of view, as shown in graphics 1-4 below, health co-ops seem well-advanced in the Americas, especially in Central and South America (and to a degree in Canada). The same applies to European countries with Latin roots, like Italy, Spain, and Portugal. In Africa and the Middle East, health cooperatives are very limited in number. The situation is different again in the Asian region, where health co-ops are an important presence in Japan and the Republic of Korea and also, albeit to a somewhat lesser degree, in Nepal, Sri Lanka, and India. (Unfortunately, we only have partial data for the latter country.) In Annex 5 readers will find information about countries for which a national case was not possible due to the insufficiency of data (Palestine, Iran, and Sri Lanka).

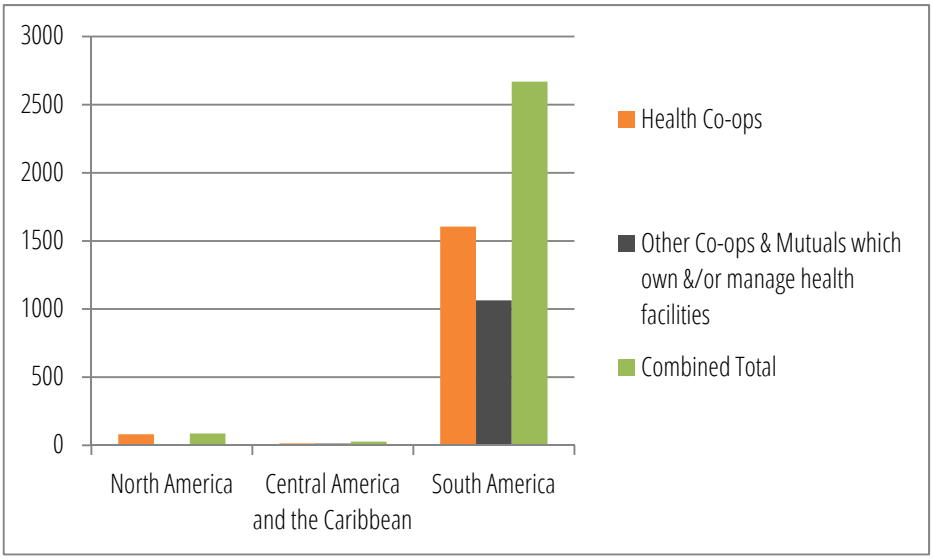
Graphic 1: Number of Countries with Health Co-ops, or with Other Co-ops & Mutuals which own &/or manage health facilities



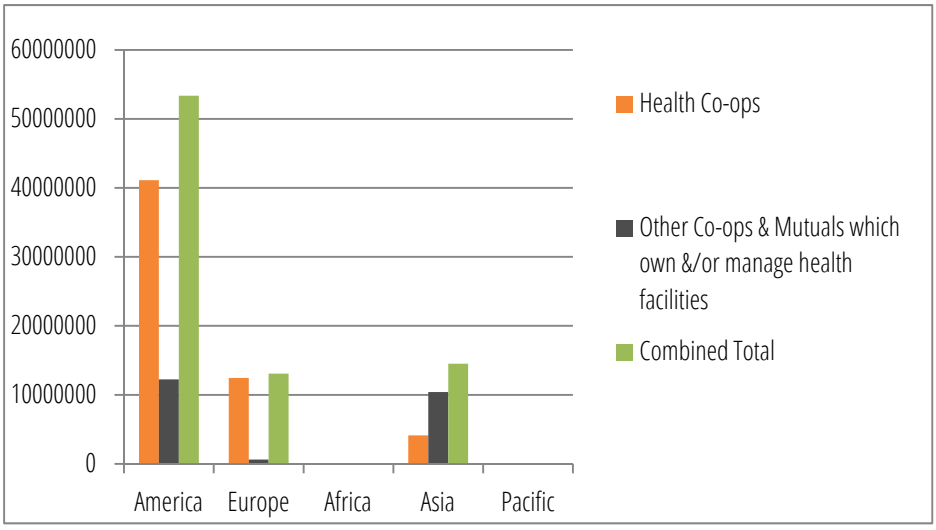
Graphic 2: Health Co-ops, Other Co-ops & Mutuals which own &/or manage health facilities, & Combined Total by Region



Graphic 3: Health Co-ops, Other Co-ops & Mutuals which own &/or manage health facilities, & Combined Total for the Americas



Graphic 4: Number of Users of Health Co-ops, other Co-ops & Mutuals which own &/or manage health facilities, & Combined Total by Region



What about Russia & China?

In the case of Russia, an exchange of mail occurred with a representative of Centrosojuz, the Central Union of Consumer Cooperatives.[30] During the era of the USSR, he explained, consumer cooperatives arranged some medical care for their members on the basis of local medical organizations. The apex organization, Centrosojuz, had a private clinic and hospital for its workers. After 1990, no consumer co-ops kept their medical facilities running. Even Centrosojuz has been forced to give up its medical services. With the introduction of private medicine, it would appear that co-ops cannot compete in the provision of health services. Health or medical co-op facilities no longer exist in Russia.

Our source also explained that the situation is the same or worse in the former republics of the USSR, with the exception of Kazakhstan and Belarus. There, consumer co-ops are still to be found, but they are dependent on State support.

Very careful research has been done regarding China, a country of over one billion people. On that basis, we have concluded that **there are no organizations in China which meet our definition of a health cooperative**. There is some confusion due the name of one of China's new social insurance schemes, however. This New Rural Co-Operative Medical Scheme is one of three main types of social insurance. A more detailed explanation of the situation in China is available in Annex 4.

Business Model

The business models of health co-ops appear to be almost as numerous as the co-ops themselves. They vary from that of an isolated health co-op, unsupported by an integrated network, to Unimed in Brazil, Espriu in Spain, and HeW in Japan, the world's three largest health co-op networks, and to two other extensive, if lesser-known networks in Colombia, Saludcoop and Coomeva. In such cases, working together within a network facilitated the exchange of ideas, the sharing of resources, joint development projects, and of course, formidable lobbying! In terms of development, a health co-op could try to grow itself into a big organization by attracting new members and creating new services. Alternatively, it might choose to hold fast at a certain level of development and pool resources with other health co-ops. Members then can retain a sense of intimacy with the organization, rather than having to adjust to a large and less personal enterprise. Then again, it is also possible to develop activity in another country, as some insurance or pharmacy co-ops have done.

Health & Social Care

Being attuned to the needs of members and sometimes whole communities, some co-ops offer both health and social care, with a strong concern for mental health. That range of service requires a more diverse staff, from doctors, to social workers, nutritionists, psychologists, and nurses. This is the case for Canada's oldest health co-ops, in Saskatoon, Regina, Prince Albert, and Winnipeg. The clinic in Saskatoon is the only point of health service among over 30,000 First Nations people in the city's poor neighbourhoods. Many First Nations people are on staff. By combining expertise in health and social

care, it has been said, the co-op adopts a broader understanding of health, one much more closely aligned to the concept of social health determinants.

Public Recognition

In a few countries, like Costa Rica and Uruguay, the co-op model is clearly recognized by public authorities as a strategic business model to consider for the provision of health care to citizens. In some countries, like Italy, Spain, and Portugal, the contribution of the co-op model even warrants recognition in the State constitution! (In Spain, doctor co-ops which are members of Espriu Foundation network actually manage a few public hospitals.) In the UK, Out-Of-Hours (OOH) GP Practices, based on the model of the worker cooperative, are also formally integrated into the delivery of health care, offering such diverse services as emergency care, primary care, minor surgery, and dental care. Table 1 (pp. 21-22) indicates that these cooperatives have from 187,000 to 1,500,000 potential users in the areas which they cover.

Innovation: People First in Italy's co-ops

In the health systems of many countries, users can observe the fragmentation of services and the lack of integration between different providers. Out of its commitment to "people first," the **Consortium for Primary Care - CAP social coop** in Italy's Lazio Region has implemented a system which can respond to different levels of need, in a continuum of care which both conserves resources and integrates the actions of the different health providers. CAP is based on the best cooperative practices developed in the field of primary care within the region. Its membership comprises a social cooperative (OSA – a national leader in the field of social assistance), two cooperatives affiliating more than 800 pharmacies, cooperatives of general practitioners, and a cooperative diagnostic laboratory. CAP is also supported by a consortium of Lazio's main social care cooperatives. The impact has been so positive that the model may be applied nationwide!

2. CO-OPS & MUTUALS (OTHER THAN "HEALTH CO-OPS") ENGAGED IN HEALTH CARE

Table 2 (see p. 23) demonstrates the international significance of co-ops and mutuals, which, while not "health co-ops" *per se*, own and/or manage health facilities, including clinics, hospitals, offices, and laboratories.

One of the most important discoveries of this research may be this: many co-ops and mutuals whose main activity is not health care nevertheless are involved in its provision. They own and manage health facilities like clinics and hospitals and even conduct disease and disability prevention campaigns! These can be sectoral organizations – savings and credit, agricultural, transportation, butcher, or coffee producer co-ops, for instance[31] – but also multipurpose cooperatives. This is especially the case in Central and South America and seems to be sustainable over the long term.

Building on a long tradition of public interest activities, health mutuals in France (and to a lesser degree in Belgium) combine both roles. Like co-ops, health mutuals are membership-based organizations.

They provide health plans and deliver health care through networks of facilities, ranging from optical centres to hospitals. By these means, especially in France, they reach an impressive number of citizens and at the same time enjoy significant public recognition for their work. This report also identifies one mutual in the UK which provides a health plan and owns a hospital.

Innovation: Mobile Health Teams in Guatemala

El Recuerdo Cooperative, a multiservice agricultural cooperative, has been contracted by the Guatemalan Ministry of Public Health and Social Welfare since 2010 to extend health coverage in eight municipalities (90,429 inhabitants) in the department of Jalapa. Under the El Recuerdo model of service, each mobile health team includes a doctor, institutional facilitator, health educator, and rural technical specialist. In each municipality, 1-5 institutional facilitators or neonatal maternal nurses staff the convergence centres. They provide preventive and home care, and assist in deliveries. An average of 20 community facilitators trained by the cooperative and 30 midwives are found in each municipality.

3. PURCHASING, IT, OR SUPPORTING CO-OPS (IN THE HEALTH SECTOR)

These co-ops do not provide health services directly, but still get involved in health by other means. KDM in Malaysia upholds the economic and social interests of members, these being 600 doctors who own their own clinics (single- or multi-doctor clinics). In South Africa, the South African Medical Care Co-operative supports the development of General Practitioners with a variety of programmes, including an accreditation process. In Germany, the **Dienstleistungs- und Einkaufsgemeinschaft Kommunaler Krankenhäuser** (EKK) is a retailer cooperative of 70 hospitals. With an annual turnover of over $1 billion USD, EKK is one of the largest purchasing groups in Germany. It also provides its members with consulting and management control services. Also in this category are a few co-ops engaged in IT solutions in France and Finland.

Innovation: Personal Health Record Platform

In 2010, the Finnish Innovation Fund started a project to establish a Personal Health Record platform and ecosystem in Finland. **Taltioni** was established in 2010 to operate the technical platform and form the business ecosystem. The cooperative model was chosen because it enables easy access for companies to join/resign from the ecosystem. Taltioni is a user-based cooperative and aims to provide "citizens with a personal health account which will be available to the user throughout their life." It has 27 founding members and currently has 63 members. All are companies from the health IT sector, private and public.

4. SOCIAL CARE CO-OPS

Base on our research, the total number of social care co-ops is impressive – 14,811. See Table 3, p. 24. Still, we must recognize the importance of Italy, which alone has more than 10,000 social cooperatives active in a subject of this report, social care![32]

This business model, which combines strong social concern with diverse stakeholders (the reason for choosing a multistakeholder member base) also shows up in other countries, and with the same good results. That is the case in Spain, Portugal, and Greece (even Malta[33]), but also in the province of Québec in Canada. There, termed "solidarity cooperatives," they often specialize in home care for seniors, and with notable success.

There are social care co-ops in other Canadian provinces and in the USA. **Cooperative Home Care Associates** of New York has 2,000 staff. The recently established HomeCare Coop Foundation in the USA provides in-home care cooperatives with an array of capacity-building resources to improve the skills and lives of caregivers and ultimately, their clients.

We also identified 43 social care co-ops in South Africa. Unfortunately, the information available for them is limited. Apparently, they are multistakeholder or producer co-ops, offering a range of services to elderly persons: fitness associated with care and health, massage, home-based care, assistance to people living with disabling diseases, etc.

The evidence from all parts of the globe also affirms that we must not underestimate the supportive role of the State in the development of social care co-ops, which stand at the very crossroads of economic and social concerns. Among other actions, the State might put into effect a relevant law or regulation, programmes dedicated to social care co-ops, or a protected market.

Innovation: Social care co-ops building valuable links with public health organizations in Canada

The **Coopérative de solidarité de services à domicile du Royaume du Saguenay** (Québec) provides services such as personnel management, stewardship, cafeterias, and overall service to-seven homes for the elderly. It is also the owner of one of these homes. Since 2000, the cooperative has been in a partnership with the municipal housing office and the Public Health Regional Centre to support six homes, each accommodating nine disabled persons who are at least 65 years of age. The cooperative is responsible for monitoring these clients 24 hours a day, seven days a week. It has 260 employees in a region with 125,000 inhabitants.

5. PHARMACY CO-OPS

No one should underestimate the importance of pharmacies and pharmaceuticals to the health care sector. They are a part – some would say, an essential part – of modern health. This is another key finding of this research: from a retail pharmacy to a laboratory producing drugs, the co-op model is widely used in the pharmacy sector. In some countries, pharmacy co-ops are among the sector's leaders. In Colombia, **COPIDROGAS** was ranked as the second largest cooperative in terms of turnover in 2012. In Germany, **Noweda** has an annual turnover of close to $6.2 billion USD. In Turkey, the **Association of All Pharmacists Cooperatives (TEKB)** with its five wholesaler co-op members, counts 13,000 facilities across the country and hires 40,000 staff. In Belgium, pharmacy co-ops command close

to 20% of the whole market. In this report, there are many examples of second-level pharmacies or wholesalers, that is, cooperatives which bring together individual pharmacists.

Even if pharmacy co-ops are well-developed in many countries, they have no single international association or umbrella organization. As it is explained in Annex 2, Operational Definitions, some are consumer retail cooperatives and thus members of consumer federations. Others are producer cooperatives. Still others are active in the pharmaceutical sector, but focus on transport, stocking, and other logistical areas of the chain of production and distribution. For this reason, it again was challenging for our research team to find data and discern the big picture.[34]

Bear in mind that in many countries pharmacies are closely linked with health co-ops and/or co-ops and mutuals engaged in the provision of health care. Sometimes they are integrated with consumer cooperative organizations. This is the case in Switzerland (the association of COOP Vitality with the Coop Suisse Group) and Canada (the association of The Medicine Shoppe with Coop Atlantic).

Unfortunately, according to our research, the pharmacy co-op model does not seem to have taken root in Africa, a region of the world in which the affordability of health services, including pharmaceuticals, is a crucial issue. We found an old reference to an interesting community-based experience in Madagascar, but it appears to have gone out of business.[35]

Innovation: Passion & belief in natural health!

The pharmacy co-op wholesaler **Health 2000** was founded in 1993 in New Zealand. This cooperative group is active in the natural health retail sector, having been formed by members with "a passion and belief in natural health." Many of them are naturopaths, homoeopaths, herbal specialists, or sports therapists who own their stores independently. These 82 stores are spread over 15 of New Zealand's 16 regions.

6. MUTUALS & CO-OPS PROVIDING HEALTH PLANS

Again, the capacity of a membership-based organization like a co-op or mutual to provide health plans depends on how the national funding of health care is organized. The role of the State in this matter is not to be underestimated.

The aim of this report was not to present a global and detailed view of all health plans offered by co-ops or mutuals. Rather, we sought to focus on those salient situations in which they are taking charge of health responsibilities in addition to their conventional role in insurance, and where otherwise access to health plans is very limited, as is often the case in low- or middle-income countries.

In high-income countries, like France, the role of mutuals can be very important not only in terms of health plans but also in the provision of health care. **Harmonie Mutuelle**, for one, has created an impressive network of clinics, hospitals, daycare centres, etc. In the UK, **Benenden Health** and the public authority operate under another kind of arrangement: the mutual provides complementary health insurance and owns an hospital. In the Netherlands, **Achmea** has an impressive record as a

provider of health plans, life and non-life insurance, reaching half of all Dutch households. It has a market share in seven other European countries and in Australia as well. In all, Achmea serves eight million users and employs 17,000 staff in the Netherlands and 4,000 abroad. Apart offering a complementary health plan, many insurance co-ops provide Internet resources concerning individual health. Desjardins group insurance (Canada) has a questionnaire to assess lifestyle habits and health knowledge, for example.[36]

In low- and middle-income countries, risk-pooling remains an important mechanism for individuals or families who otherwise are left to cover the cost of basic services OOP. This report shows different ways of meeting this challenge:

- MHOs organized on a community basis (as in many parts of Africa) or on an employment basis, like a civil servant mutual in Morocco, the Mutuelle Générale du Personnel des Administrations Publiques (MGPAP).
- Existing insurance co-ops which offer a health plan at an affordable cost, like the Co-operative Insurance Company of Kenya (CIC).
- Savings and credit co-ops which offer health plans in many Latin America countries.

Let's not overlook the unique case of Rwanda, which is all the more inspiring when we remember what this country has come through. After suffering genocide in 1994, Rwanda put in place a series of measures aimed to make significant improvements in the health status of the population. In terms of delivery, a decentralized, multi-tiered system was designed, starting from district health centres and going all the way up to regional and national referral hospitals. In terms of funding, there as a formal recognition of the decisive role of the MHO across the country, on the basis of two principles: membership is voluntary, and payment of premiums is based on economic status. As a result, 91% of the population was insured through an MHO in 2010. That is solid proof of the potential of MHOs to become full partners in Universal Health Coverage strategies, as envisaged by WHO.

Innovation: Financial access to care

One of the world's poorest countries, Burkina Faso counts 188 functioning MHOs with 103,373 members and 256,015 beneficiaries. The main reasons for membership in MHOs are financial access to care; quality health services, and geographical accessibility to health centres.

In recent years, many of the African countries included in this study have altered the legal framework for MHOs and other types of membership-based organization, like cooperatives. It is important to keep this in mind, if the current and upcoming situation is to be fully understood. Annex 6, Legal Considerations regarding Health Cooperatives and Mutual Health Organizations in Western and Central Africa, explains this new legal context.

Other than the cases included in this report (and notwithstanding the difficulty of collecting data from the field), there appear to be few other examples of MHOs in Africa. Basic information was available on only two other instances, one in Mali and the other in the Democratic Republic of Congo.

Mali

In 2011, an ILO report[37] mentioned the role of MHOs in Mali. The key figures are as follows:

- 80 MHOs
- An umbrella organization gathering all MHOs under the name of the Union Technique de la Mutualité Malienne (UTM)
- 5,200 beneficiaries in villages
- 60,000 beneficiaries in the country's nine main towns

The Canadian NGO SOCODEVI has been involved in supporting the development of the network in collaboration with France's MACIF. In conclusion, the ILO report identifies a problematic lack of information from the authorities "on decisions made by the State with regard to provision of coverage to informal and agricultural work."

Democratic Republic of Congo

Desktop research indicates there are also some MHOs in the Democratic Republic of Congo. In 2012, the establishment of the MHO Tosungana-Lisanga in Kinshasa, the capital of the Democratic Republic of the Congo, was reported. Six months after its founding, it already had 1,219 members and benefited from what seems to be a supporting organization, the Centre général d'accompagnement des mutuelles de santé.[38]

7. INTERNATIONAL COOPERATION SUPPORTIVE OF THE DEVELOPMENT OF CO-OPS & MUTUALS IN THE HEALTH & SOCIAL CARE SECTOR

"Cooperation" is a key concept among cooperatives. In this research we found many cases of collaboration between high-income countries and low- or middle-income countries– sharing knowledge, resources, funding, etc. Collaboration gets initiated by an existing co-op or by some other kind of organization, like an NGO, or a government agency dedicated to international development, or an international organization. Here are some examples:[39]

- The Japanese Health and Welfare Co-operative Federation (HeW) has been active for many years in the Asia-Pacific region, animating the Asia-Pacific Health Co-operative Organization (APHCO) and supporting hospitals or dental clinics in Nepal, Sri Lanka, South Korea, and Mongolia.
- One leading health co-op in the USA, HealthPartners, committed itself wholeheartedly to the development of health co-ops in Uganda. It recently secured a significant grant from the Bill and Melinda Gates Foundation and other funding partners.
- CLUSA, the international programme of the National Cooperative Business Association (USA), is very active in Kenya in a variety of ways: the creation of health associations, development of community health plans, and training of community health workers. It is estimated all these activities have impacted the lives of one million people.

- Espriu Foundation (Spain) is involved in several projects – Nemba Hospital in Rwanda, Goundy Hospital in Tchad, Bata Hospital in Guinea, and the Saham diagnostic centres in Morocco. (These are expected to start up by November 2014.) None of these are strictly "cooperative" hospitals or centres. Nevertheless, they draw support from the Espriu organization in terms of implementation, collaborative funding, management, equipment, and even in some cases the hiring of staff and building of the facilities.
- The Swiss Agency for Development and Swiss Cooperation supports a programme that has provided direct support to 45 partner health facilities (including MHOs) in Rwanda.
- Cooperativa Sagrada Familia was founded February 14, 1969 by three Canadian priests. It became the largest savings and credit cooperative in Honduras. More to the point, it has made great strides in the health sector.
- A number of Spanish organizations, Confederación Española de Personas con Discapacidad Física y Orgánica (COCEMFE), Comunidad de Madrid y Fundación ONC, and the InterAmerican Development Bank support a social care co-op in El Salvador. It works with groups of visually and hearing impaired young people.
- The World Bank has supported COTONEB, a multiservice savings and credit cooperative which provides health care in a department of Guatemala.
- SOCODEVI, a Canadian NGO, supports an MHO in Mali as well as a multipurpose co-op in Peru (SERVIPERÚ) which provides a health plan package and health care.
- The United Nations Development Program (UNDP) and the World Health Organization (WHO) supplied Benin health co-ops with start-up grants during the 1990s.
- Louvain Coopération (an NGO from Belgium) and SOS Médecin (an international NGO) work with an MHO in Burundi.
- GIZ, the German international development agency, supports MHOs in Cameroon.
- The Centre International de Développement et de Recherche (CIDR, a French NGO) has been working with an MHO in Guinea.
- For many years the ILO has made great efforts especially in regard to the promotion of MHOs under the STEP programme.

A particularly interesting case is the role being played a Canadian NGO based in Québec, Collaboration Santé Internationale (CSI).[40] Founded 40 years ago by a catholic priest, CSI accepts donations of surplus equipment and medical supplies from Québec's hospitals and sends these materials all over the world to health projects in need. In 2013, CSI sent 39 containers to 20 different countries.[41] This research came across co-ops in Paraguay and Peru which have benefited from these resources. Moreover, CSI sends pharmaceuticals, since it buys low-cost generic drugs from the IDA Foundation in the Netherlands.[42] The shipment of these medications can form the basis of an inventory; in turn, the revenue generated from their sale can provide working capital for a long-term pharmacy service!

Table 1: Health Cooperatives Around the World[43] (NB: references for tables 1-3 are located on pp. 25-26)

Country	Number	Type[44]	Number of members	Number of employees	Number of users	Facilities
Argentina[45]	195[46]	N/A	2,700,000	N/A	2,700,000[47]	377 hospitals, 238 clinics and medical centres, 111 pharmacies
Australia	2	U: 2	32,000	105	32,000[48]	7 clinics
Belgium	13	P: 1 MS: 12	N/A	5410[49]	N/A	N/A
Benin	18	P: 18	N/A	200[50]	5,500	N/A
Bolivia	1	N/A	N/A	73[51]	N/A	N/A
Brazil[52]	848[53]	N/A	296,547	77,066	21,700,000	107 hospitals[54] 11 day hospitals 189 emergency units, 74 laboratories 88 diagnostic centres 120 pharmacies, 8,345 hospital beds
Canada	73	U: 25 P: 8 MS: 35	88,128	1,452	178,000	65 of various types, but mostly clinics[55]
Chile[56]	5	U: 5	29,902	88	48,000[57]	N/A
Colombia[58]	457	P[59]: 392	112,997	106,570	12,152,437	N/A
Dominica Republic[60]	5	U:5	23,740	N/A	23,740[61]	N/A
Equator[62]	2	N/A	196	N/A	N/A	N/A
Finland	92[63]	N/A	N/A	N/A	N/A	N/A
France	7	P: 7	N/A	N/A	N/A	N/A
Germany	1	P: 1	N/A	N/A	N/A	N/A
Ghana	1	P: 1	21	20	4,000	N/A
Honduras	2	N/A	N/A	N/A	N/A	4 clinics[64]
India	221[65]	N/A	155,978[66]	450[67]	155,978[68]	N/A
Iran	9[69]	N/A	N/A	N/A	117,000[70]	N/A
Italy	945	N/A	50,000	28,124	865,000	N/A
Japan[71]	111	U: 111	2,840,000	35,131	3,550,000	Medical facilities: 77 hospitals (12,511 beds), 348 primary health care centres, 69 dentistry offices, 202 home-visit care stations Nursing care facilities: 26 nursing care homes, 181 helper stations, 161 ambulatory rehabilitation offices
Mexico[72]	5	U: 2 P: 1 MS: 1 1 N/A	12[73]	78[74]	2,491[75]	6 health centres 2 clinics 1 medical office
Nepal	54	N/A	14,000	N/A	14,000[76]	15 hospitals 20 clinics 20 pharmacies

Country	Number	Type[44]	Number of members	Number of employees	Number of users	Facilities
New Zealand	2	P: 2	N/A	N/A	N/A	13 facilities
Nicaragua[77]	2	U: 2	N/A	N/A	16,800[78]	N/A
Palestine	1	N/A	N/A	N/A	N/A	1 hospital
Panama[79]	1	P:1	37	N/A	N/A	N/A
Paraguay[80]	5	U: 1 P: 4	834	N/A	257,627	1 hospital, I laboratory[81]
Poland	17	P: 17	N/A	N/A	N/A	N/A
Portugal	38[82]	N/A	18,000[83]	N/A	18,000[84]	N/A
Republic of Korea	17	N/A	30,000	N/A	30,000[85]	N/A
Singapore	2	U:2	18,518	500	18,518[86]	56 pharmacies, 15 denticare clinics, 1 family medicine clinic
South Africa	69	N/A	39[87]	45[88]	1,836[89]	N/A
Spain	6	P: 5 MS: 1	179,529	33,458[90]	2,080,000[91]	14 hospitals, 9 clinics, 13 dental clinics, 48 medical centres, 110 medical offices and 3 hospitals run in collaboration with the government
Sri Lanka	6	N/A	12,490	N/A	12,490[92]	N/A
Uganda	2	N/A	N/A	N/A	6,000	N/A
United Kingdom[93]	20	P: 11 MS: 9	3,320[94]	6,280[95]	9,484,652[96]	27 primary care centres, 3 walk-in centres, 6 GP-led practices, 4 community hospitals, 1 pharmacy[97]
United States of America	3	U:3	2,180,000	23,300[98]	2,180,000[99]	6 hospitals, 75 primary care clinics, 5 medical clinics, 24 urgent care locations, 15 pharmacies, 6 eye care centres, home care, 22 dental locations, online care services, 4 outpatient surgery centres
Uruguay[100]	88	N/A	1,690	12,823	1,067,453	Hospitals, polyclinics, sanatoria, infirmaries, laboratories, blood banks, orthodontic clinics and dental offices, pharmacies, rehabilitation centres
Venezuela[101]	3	U: 1 P: 1 MS: 1	21,300[102]	1,342[103]	300,000[104]	1 hospital 9 clinics, 1 pharmacy
Vietnam	3	U: 1 P: 1 MS: 1	770	50	224,000	N/A
South Africa	69	N/A	39[105]	45[106]	1,836[107]	N/A
TOTAL	**3,358**	**U: 160 P: 462 MS: 60**	**9,330,498**	**328,293**	**57,732,272**	

Table 2: Co-ops (other than health co-ops) & Mutuals engaged in health care around the world

Country	Purchasing, IT, or supporting co-ops[108]	Other kinds of co-op or mutual	Number of users	Facilities
Argentina[109]	N/A	861[110]	N/A	N/A
Belgium	N/A	1	609,465[111]	14 clinics
Bolivia	N/A	2[112]	100,000[113]	1 clinic, 4 medical centre
Brazil[114]	N/A	N/A	N/A	N/A
Chile[115]	N/A	3	4,400,000[116]	N/A
Colombia[117]	N/A	5[118]	5,717,111	N/A
Dominican Republic[119]	N/A	3	50,000[120]	medical and dental clinic[121]
El Salvador	2	N/A	N/A	N/A
Equator[122]	N/A	2	85,000[123]	N/A
Finland	1	N/A	N/A	N/A
France	2	450[124]	N/A	111 facilities and hospital services 82 health care and nursing facilities 453 dental centres 355 hearing centres 715 optical centres and services for low vision 60 pharmacies
Germany	2	N/A	N/A	N/A
Honduras	N/A	5	3,446[125]	N/A
Japan[126]	N/A	36	10,400,000	130 hospitals 110 visiting nurse station 26 health facility for elderly
Malaysia	1	N/A	N/A	N/A
Mexico[127]	N/A	6[128]	14,160[129]	2 family medical service unit, 2 hospitals, 3 clinics, 3 medical offices
Nicaragua[130]	N/A	1[131]	36,000[132]	Rural clinic, pharmacy
Panama[133]	1	N/A	N/A	N/A
Paraguay[134]	N/A	107[135]	323,389[136]	N/A
Republic of Korea	N/A	42	N/A	N/A
South Africa	1	N/A	N/A	N/A
United Kingdom[137]	N/A	1	19,097[138]	1 hospital
United States of America	2	N/A	N/A	N/A
Uruguay[139]	N/A	9	880,000[140]	N/A
Venezuela[141]	N/A	3	14,000[142]	N/A
TOTAL	**12**	**1,620**	**23,267,809**	

Table 3: Social Care Cooperatives Around the World

Country	Number of co-ops	Type[143]	Number of members	Number of employees
Argentina	N/A[144]	N/A	N/A	N/A
Australia	34	N/A	N/A	N/A
Belgium	12[145]	N/A	N/A	N/A
Bolivia	19	N/A	N/A	N/A
Brazil	9	N/A	393	N/A
Canada	58	U: 18 P: 3 MS:37	40,000	3,000
Chile	1	P: 1	25	N/A
Colombia	457[146]	N/A	N/A	N/A
Costa Rica	7[147]	U: 3 P: 4	N/A	N/A
El Salvador	1	P: 1	20	5
Equator	2[148]	N/A	N/A	N/A
France	11	P: 5 MS: 6	N/A	95
Greece	16	MS:16	N/A	N/A
Italy	10,836	(Most) MS	N/A	N/A
Japan	2,449[149]	N/A	N/A	N/A
Malaysia	13	N/A	N/A	N/A
Mexico[150]	5	N/A	N/A	30[151]
Netherlands	2	P: 2	N/A	N/A
Nicaragua	1	N/A	N/A	N/A
Panama	9	P, U	20[152]	N/A
Paraguay	110	N/A	N/A	N/A
Peru	2	N/A	N/A	N/A
Portugal	209[153]	N/A	22,000[154]	2,700[155]
Republic of Korea	42	U: 7 P: 24 MS: 12	N/A	N/A
Singapore	6	U: 2 P: 2	917[156]	38[157]
South Africa	43	N/A	N/A	N/A
Spain	399	P: 399	N/A	N/A
Switzerland	2	P: 2	317	1470
United Kingdom	26	P: 12 MS: 14	2,347[158]	N/A
United States of America	21	U: 2 P: 16 MS: 3	N/A	2,000[159]
Uruguay	9	U: 4 P: 4 MS: 1	N/A	N/A
Total	**14,811**	**U: 36 P: 475 MS: 89**	**66,039**	**7,338**

Tables 1-3: Sources

[43] The reader must take into consideration all the data references. Please refer to Volume 2: National Cases for additional information. For references 1-42 and 160-223, see pp. 59-62.
[44] U: Users; P: Producers (including worker co-ops) and MS: Multistakeholder.
[45] 2006 data.
[46] Including 59 medical and dental cooperatives.
[47] Based on the number of members. The number of users could be higher.
[48] Based on the number of members. The number of users could be higher.
[49] For 2 cooperatives out of 13.
[50] Data only for 9 cooperatives out of 18.
[51] Data for doctors only.
[52] 2012 data.
[53] 322 medical cooperatives, 118 dentist cooperatives, 408 psychologist and other user cooperatives.
[54] Data (2013) only for UNIMED organization.
[55] Partial data.
[56] 2013 data.
[57] Data are for only 2 cooperatives (SERMECOOP and ISAEDUCOOP) out of 5.
[58] 2012 data.
[59] Based on the fact that 85.7% are worker cooperatives. (See national case.)
[60] 2010 data.
[61] This is the number of members.
[62] 2014 data.
[63] Base on 2010 data. No other information is available.
[64] Owned by 2 credit unions.
[65] 2009-2010 data.
[66] 2009-2010 data.
[67] Data only for one coop in 2012.
[68] Based on the number of members.
[69] Based on Farahbakhsh, Mostafa et al. 2012. "Iran's Experience of Health Cooperatives as a Public-Private Partnership Model in Primary Health Care: A Comparative Study in East Azerbaijan." *Health Promotion Perspectives* 2(2):287-298. (http://journals.tbzmed.ac.ir/PDF/HPP/Manuscript/HPP-2-287.pdf).
[70] Based on an average of 13,000 persons served by each health cooperative. See Farahbakhsh et al. 2012; and Nikniyaz, Alireza et al. 2006. "Maternity and child Health Care Services Delivered by Public Health Centers Compared to Health Cooperatives: Iran's Experience." *Journal of Medical Science* 6(3):352-358. (http://docsdrive.com/pdfs/ansinet/jms/2006/352-358.pdf).
[71] 2014 reference.
[72] Data from 2013.
[73] Data for 1 out of 5 health cooperatives.
[74] Data for 4 out of 5 health cooperatives.
[75] Data for 1 out of 5.
[76] Based on the number of members. The number of users could be higher.
[77] 2012 data.
[78] Only for one cooperative out of two.
[79] 2013 data.
[80] 2011 data.
[81] Partial data.
[82] Based on Instituto Nacional de Estatística (INE), Cooperativa António Sérgio para a Economia Social (CASES). 2013. *Conta Satélite da Economia Social 2010*. Lisbon. (http://www.ine.pt/xportal/xmain?xpid=INE&xpgid=ine_publicacoes&PUBLICACOESpub_boui=157543613&PUBLICACOESmodo=2&xlang=en).
[83] Partial data: data only for one health cooperative.
[84] Partial data, based on the number of members of one cooperative.
[85] Base on the number of members. The number of users could be higher.
[86] Base on the number of members. The number of users could be higher.
[87] Data for 3 cooperatives.
[88] Data for 2 cooperatives.
[89] Data for one cooperative.
[90] Partial data, 3 cooperatives out of 4.
[91] Idem.
[92] Based on the number of members. The number of users could be higher.
[93] 2012 data.
[94] Partial data, for 10 out of 19 cooperatives.
[95] Partial data, for 11 out of 19 cooperatives.
[96] These are the potential users, according to the data collected for 16 out of 19 cooperatives
[97] According to the data collected for 16 out of 19 cooperatives.
[98] According to the data collected for 2 out of 3 cooperatives.
[99] According to the data collected for 2 out of 3 cooperatives. The number of users is higher. (In at least one cooperative, non-members can use the facility in cases of emergency.)
[100] 2013-2014.
[101] 2012 and 2013 data.
[102] Base on data for 2 out of 3 cooperatives.
[103] Idem.
[104] Idem.
[105] Data for 3 cooperatives.
[106] Data for 2 cooperatives.
[107] Data for one cooperative.
[108] Cooperatives which support medical or health care activities, including those which provide IT or new IT applications.
[109] 2006 data.
[110] Number of mutuals.
[111] The data pertains to the number of users of the 14 clinics of Mutualité Socialiste du Brabant in 2013.
[112] There certainly are more cooperatives (other than health cooperatives) offering health services. No information on them was available. (See the Bolivia national case, Volume 2, p. 16.)
[113] This is only the number of members of the Jesús Nazareno savings and credit cooperative. There is at least one multipurpose mining cooperative which offers its members access to a health centre.
[114] 2012 data.
[115] 2013 data.
[116] This is the number of members of three mutuals which have access to the mutual's health care facilities or to others under contract.

[117] 2012 data.
[118] These five mutuals are health promotion entities.
[119] 2010 data.
[120] Number of patients of one savings and credit cooperative.
[121] For one cooperative only.
[122] 2014 data.
[123] Data from Cruz Blanco, a company owned by a health cooperative in Ecuador (25,000 users) and a savings and credit cooperative (60,000 members).
[124] Partial data. This is the number of mutuals which are members of Mutualité Française and active in the health care sector.
[125] Data only for the medical services of 2 cooperatives.
[126] 2014 reference.
[127] Data from 2013.
[128] UniMedCoop (owned by Caja Popular Atemajac), Médica Azul S.A. (owned by Cruz Azul Group), and the medical offices run by Caja Popular San Nicolas, by a butcher cooperative, by a childcare cooperative, and by a transport cooperative.
[129] This is partial data from two cooperatives which operate medical facilities: Caja Popular San Nicolas, serving 13,000 members and the wider community (no estimate for that community); and Médica Azul S.A., owned by Cruz Azul Group (which served 2,160 persons in 2012).
[130] 2012 data.
[131] There is more than one cooperative providing health care.
[132] Number of patients served by a women's worker cooperative which offers medical services.
[133] 2013 data.
[134] 2011 data.
[135] In addition to these 105 cooperatives, we have one insurance cooperative and one mutual offering health services. The census identifies seven cooperatives whose secondary activity focuses on health and five others whose third most important activity is health services.
[136] This figure is the sum of the following: 280,277 persons who receive health services from 105 cooperatives (exclusive of those served by Paraguay's 5 health cooperatives); 18,112 from an insurance cooperative (SPS); and 25,000 from a Mutual (AMH).
[137] 2012 data.
[138] These figures pertain to Benenden Hospital in 2013.
[139] 2013-2014.
[140] Nine mutuals provide care to 880,000 FONSA, affiliates. (See the Uruguay national case, Volume 2, p. 179.)
[141] 2012 and 2013 data.
[142] Data only for one multipurpose coop, Cooperativa La Bermúdez.
[143] U: Users; P: Producers (including worker co-ops); and MS: Multistakeholder.
[144] Clearly, there are social care cooperatives in Argentina, but we have not been able to obtain any details about them. (See the Argentina national case, Volume 2, p. 1.)
[145] The same as the number of health care cooperatives (12/13), which offer social as well as health care services.
[146] The same the number of health care cooperatives, which offer social as well as health care services.
[147] This figure includes four health cooperatives, becausesocial care is part of their mission.
[148] The same as the number of health cooperatives, which offer social as well has health care services.
[149] This figure is the sum of the following; 2,262 diverse cooperatives engaging in social care; 40 consumer cooperatives providing social care; 111 health cooperatives providing social care; and 36 Koseiren Federation members.
[150] 2013 data.
[151] For four cooperatives.
[152] Data for one cooperative only.
[153] 2014 data.
[154] 2012 data.
[155] Idem.
[156] For two out of a set of six cooperatives.
[157] For three out of a set of six cooperatives.
[158] According to the data collected for 10 out of 27 cooperatives.
[159] For one cooperative out of 21.

Co-ops & Mutuals in the Health & Social Care Sector: Major Players & the Innovation Table

For the first time, an international study has shown with practical examples the many ways in which co-ops and mutuals contribute to health care innovation and access worldwide. In addition to the examples of innovation cited in the previous section, the following snapshots offer a glimpse of what these little-known initiatives mean to the well-being of millions of people around the world.[160]

Major Players

- **UNIMED** (Brazil) is the largest health cooperative system in the world. It currently embraces 354 medical (doctor) cooperatives which represent nearly 110,000 doctors and provide services to more than 19 million people.
- In Spain, the **Espriu Foundation** draws together several actors in health provision and insurance (doctor and user co-ops, and insurance companies). The cooperatives have a total membership of 179,437, including 17,835 medical professionals. They provide health services to approximately 2 million people through 14 hospitals, 13 dental clinics, 48 medical centres, and 110 medical offices. They also run 3 hospitals in collaboration with the government.
- **Saitama Medical Co-operative** is located in Saitama Prefecture near Tokyo. It is a member of HeW, the Japanese Health and Welfare Co-operative Federation. With a population of 2.88 million people, this region is described as the most rapidly aging in the country. Meanwhile, it has the lowest density of physicians. In 2013, Saitama had 242,098 members and 2,072 employees. It had a total of 33 facilities, including 4 hospitals, 8 medical clinics, 2 dental clinics, and 19 home care support offices. One of the hospitals, Saitama Co-operative Hospital, was established in 1978. On average it receives 1,044 outpatients per day. Because of the high quality of its medical services, it ranks second among 20 emergency hospitals in its city, and first in the private sector.
- Founded in 1969, **"COPIDROGAS" Cooperativa Nacional de Droguistas Detallistas** (Colombia) has 3,900 members with 5,200 pharmacies. It has outlets in 31 of the country's 32 departments. A turnover of $777 million USD made COPIDROGAS rank as Colombia second largest cooperative in terms of turnover in 2012.
- **NOWEDA** is a 75-year-old retailer pharmacy cooperative. It has 16 offices in Germany and one in Luxembourg and has 8,600 pharmacy members. It is one of Germany's 150 largest companies. Its annual turnover approaches $6.2 billion USD.
- A member of the big cooperative retail group Coop Suisse, **Vitaly** has 55 pharmacies in Switzerland. A second-level co-op, **OFAC,** provides nearly three in four Swiss pharmacies with administrative and financial services (e.g., billing, IT support).

- In Turkey, the **Association of All Pharmacists Cooperatives (TEKB)**, a group of five wholesaler pharmacist cooperatives, provides pharmaceuticals to 13,000 pharmacies across the country.

Linkage of health co-ops to social security: Successful & efficient!

In 2013, representatives of health cooperatives in Costa Rica reported they provided services to approximately 450,000 people. They are considered a strategic arm of social security. Studies on the efficiency and quality of health care provided through cooperatives confirm that the model has been successful and financially efficient.

Health co-ops in low-income countries

Women's Health Cooperative is located in Tikathali village near Kathmandu in the Himalayas. Beginning with 25 women, it now has more than 300 members and is a model initiative in Nepal. Membership is awarded to family units. Local women value the initiative for its easy access and affordable health care services. The cooperative pays close attention to health promotion and prevention. Entrenchment in the community facilitates this by enabling villagers to engage in prolonged conversations on long-standing health issues (to address the problem of rampant alcoholism, for example).

In 2013, **HealthPartners** (USA) participated in a competition for the most innovative ideas for Saving Lives at Birth, sponsored by the Bill and Melinda Gates Foundation and many other organizations. Out of over 500 applicants, HealthPartners' cooperative development strategy was one of 65 finalists and one of 15 winners! They received a 1-year $250,000 USD seed grant to make the **Mama Coop** a reality in Uganda. The objectives of the Mama Co-op project are:

1. to increase access to quality health care for pregnant women and newborns.
2. to increase the access of pregnant women to health education and to support for healthy, treatment-seeking behaviours.

The project addresses the quality, accountability, and accessibility of health care through the development of one community-owned health co-op that will serve at least 900 women and newborns (6,000 people in total).

Coffee & cocoa production cooperatives taking action in health

In Peru, in addition to their primary activity, coffee and cocoa production cooperatives provide essential health care services to populations in the inter-Andean forests. The sector involves more than 50,000 families (approximately 250,000 people) in 78 coffee cooperatives and 180 small-producer associations. Their activities thus may have an impact on a very large segment of the population with limited access to health care.

Savings & credit cooperatives taking action in health

The largest savings and credit cooperative in Bolivia, **Cooperativa de Ahorro y Crédito Jesús Nazareno Ltda,** has made health care a priority since its foundation nearly 40 years ago. It provides members

with health care free of charge and since 1989 has run its own pharmacy. Today, it operates in total four medical centres including an infirmary and pharmacy, and serves over 100,000 members.

Mutipurpose cooperatives & health care

The **Central Cooperativa de Servicios Sociales (CECOSESOLA)** is a cooperative central in Venezuela. Initially it catered to its member cooperatives, then later to a wider group of associations. Today they number 50 and have 20,000 members. CECOSESOLA currently engages in agricultural production, small-scale agro-industrial production, funeral services, and transportation. It provides savings and loans and health care services; it manages mutual aid funds and the distribution of food and household items. Operating under a non-hierarchical management system, the CECOSESOLA network provides health services to more than 200,000 people.

Alternative medicine & cooperatives

With the aims of making acupuncture accessible to all, and of supporting the sector's professionals, the **People's Organization of Community Acupuncture (POCA)** is a rapidly growing cooperative of people involved in the community acupuncture movement: acupuncturists, patients, clinics, and supportive organizations. Originally a single clinic in Portland, Oregon (USA), this multistakeholder cooperative now counts 1,684 members, including patients, organizational members, clinic employees, and acupuncture practitioners. Between 2012 and 2014, the number of POCA's new members almost doubled.

Mutuals & Health Care among Native People

Ayuda Mutual Hospitalaria provides mutual health insurance and comprehensive medical care to indigenous communities in the Chaco region of Paraguay. Established in 2006 by law, this decentralized organization works through 26 funds. In 2009, it served 25,000 people.

Dentist Co-ops & Innovative Management

RedDentis, Cooperativa Odontológica de Montevideo de la Asociación Odontológica Uruguaya, is a dentist cooperative based in Uruguay's capital, Montevideo. A worker cooperative, RedDentis has 268 dentist worker-members. Nearly all (260) run their own dental offices. It has established an innovative management model to provide both quality employment and better and more affordable dental health care. RedDentis can attend to 5,000 patients daily, so patients have to bear with few delays, particularly for urgent care. More than 150,000 people receive dental care through RedDentis.

Insurance Co-ops & Health Education

In the Dominican Republic, **Cooperativa Nacional de Seguros (CoopSeguros)** is an insurance cooperative which also plays an important role in health promotion. Initially with the support of international donors, CoopSeguros initiated an HIV/AIDS education programme. Through its member

cooperatives, it provided information on HIV/AIDS prevention to 350,000 people. The programme continues through a partnership with local organizations.

Social Care Co-ops: Improving the lives of the disabled!

The **Social Cooperative with Limited Liability (KoiSPE) of Chania** is located on the Grecian island of Crete. KoiSPE represents a new pathway to social inclusion for persons with psychosocial disabilities. It serves both therapeutic and entrepreneurial purposes. It aims to broaden the quality of life of those suffering from mental illnesses and to improve their career opportunities. The co-op's products and services are characterized by quality, ecological responsibility, and competitive prices. The co-op has 129 members: 59 of them are people suffering from mental illness, 46 are mental health professionals, and 23 are individuals and sponsoring organizations, including the Prefectural Administration of Chania, the municipalities of Chania, Kissamos, and Souda, the General Hospital "St. George," and the Cooperative Bank of Crete.

In El Salvador, **Asociación Cooperativa del Grupo Independiente Pro Rehabilitación Integral de R.L. (ACOGIPRI)** provides employment and training opportunities in a ceramics workshop, Shicali Cerámica. Its workers (of whom three-quarters are hearing impaired) turn out quality products, highly regarded in El Salvador and even abroad, where they are marketed through the European fair trade network. The cooperative has trained over 1,000 disabled people and thanks to its job placement service many have found formal employment.

In Australia, **Radio for the Print Handicapped Co-operative,** registered in 1979, provides a radio reading service for people who cannot see, handle, or understand printed material. The service is provided 17 hours a day from seven stations: Melbourne, Canberra, Sydney, Brisbane, Adelaide, Perth, and Hobart.

The **CERCIs (Centro Especial de Reabilitação de Crianças Inadaptadas** are cooperatives in Portugal that provide rehabilitation services to children with disabilities and their families. There are 209 CERCI cooperatives of which 150 are recognized by the State as Private Social Solidarity Institutions. This recognition (which must be requested from and granted by the State) entitles them to a special tax regime and access to financial support subject to compliance with reporting and regulations.

Observations & Development Considerations

This report shows the "best" as "possible." It shows the vital role played by membership-based organizations like co-ops and mutuals in the health and social care sector, not only for the benefit of their members but very often for the whole community. Since by their very nature membership-based organizations have a strong focus on the satisfaction of members' needs, such organizations clearly might have a substantial impact on the well-being of millions of other people around the world, North or South, in high- and middle-income, as well as low-income countries.

Furthermore, these organizations are rooted in member input. In this sense, they are in total accord with numerous WHO appeals that citizens play a significant role in the health system, not just as a patients, taxpayers, or observers but as actors, engaged in the planning and implementation of their health care. These appeals started with the WHO's declaration at the Alma Ata conference in 1978[161] and have been repeated many times since. Take for instance, the 2007 publication: *People at the Centre of Health Care: Harmonizing mind and body, people and systems.*[162] Likewise, another in 2008: *Primary health care: Now more than ever.*[163] Or again in 2014:

> "Health governance is no longer the exclusive preserve of nation states. Civil society networks, nongovernmental organizations, philanthropic foundations, trade associations, the media, corporations and individuals have all found a new voice and influence on health, in part thanks to information technology and social media."[164]

The co-op or mutual benefits from its members' contributions ... yet at the same time, the members feel empowered by their contribution! They get a better idea of *what it is to be engaged in the life and the well-being of their community*, *instead of simply being a consumer!*

Furthermore, by organizing member meetings, soliciting member voluntary contributions to different campaigns – and all the other initiatives which challenge simple market relationships (I pay you, you provide a service to me) – co-ops and mutuals generate social linkage, interaction, and social capital. More and more studies are recognizing what a positive impact social relationships have on mental health, healthy behaviours, and physical health. Social relationships, evidently, are as fundamental to good health as eating well and engaging in physical activity![165]

Based on this report, one might say, "What impressive achievements co-ops and mutuals have made in the health and social care sector! That's really something to be proud of!" That would be true. But from a worldwide perspective, such a response tends to distract from major current and imminent challenges, not the least of which is the growing importance of non-communicable disease.[166] What follows is a short list of key issues in health, and the possible role which co-ops and mutuals might play with respect to each – while appreciating how intimately each is linked to the rest.

POOR & RICH

The situation may have changed slightly in the interim, but a 2006 publication of the World Bank[167] drew attention to a huge gap between health expenses and health needs in rich countries relative to poor countries. While constituting up to 84% of the world population, low-income countries experience fully 90% of illnesses but have only 20% of the GDP and disburse only 12% of the world's annual health expenditures. The health expenditures of rich countries per citizen are 100 times greater than those of poor countries. More than 50% of the health expenses in poor countries are charged to the patient. Last but not least, while the USA represents 5% of the world's population, they spend 40-50% of the world's entire health expenditure – at a time when 5% of the American population lives on less than $2 a day! Poverty in a high-income country!

Membership-based organizations active in health and social care can't overcome this situation on a national scale. (To quote Wilkinson and Pickett, we need more equality at the national level.) But would it be possible to realize the positive impact of co-ops and mutuals on the health and social situation of local populations? Through the singular way in which these organizations mobilize citizen engagement, for instance?

In a recent interview in *Global Health*, Dr. David Barash argues:

> "The next stage of global health will focus on non-communicable and chronic diseases, which requires scalable and sustainable programs delivered and maintained by local communities. Partnering is the key to building the scale and implementing health system changes to drive measurable, sustainable improvements in both outcomes and impact."[168]

Co-ops and mutuals engaged in health and social care (especially in low-income countries) also need to become more open-minded about IT, even if IT alone can't solve all the problems of poverty. One interesting example among others is the project Mwana:

> "In Zambia, community health workers, HIV experts from UNICEF and national health officials came together to create Project Mwana. This program uses simple mobile phones and text messages to link Zambia's national labs with rural communities. The program is getting HIV test results to mothers in less than half the time, which can mean the difference between life and death for infants born with HIV."[169]

Another key issue is gender. In lower- and middle-income countries like Nicaragua, co-ops and mutuals have an interesting track record when it comes to women's involvement:

- Cooperativa María Luis Ortiz is a women's cooperative which runs a rural clinic providing basic medical care as well as a pharmacy. It has treated more than 36,000 patients, but also has activities in housing and latrine construction. It operates a seed bank, runs a literacy programme, and trains health workers.

Over the last decades, MHOs have been widely used in many African countries with varying results. Some are working well, others face serious problems and are in decline. Based on numerous studies and reports,[170] we can learn from these experiences. For instance, we now know that, barring access to a targeted fund, MHOs must avoid trying to provide coverage for chronic diseases like HIV-AIDS. The MHO niche is much more in the realm of non-communicable diseases. Support for the management and governance of MHOs is also a key factor in the success of their projects. So is cash flow.[171]

UNIVERSAL HEALTH COVERAGE

For many years, WHO has appealed for worldwide UHC. Factors essential to UHC success are:

- A strong, efficient, well-run health system which meets priority health needs through people-centered integrated care (including services for HIV, tuberculosis, malaria, non-communicable diseases, maternal and child health) by:
  - informing and encouraging people to stay healthy and prevent illness;
  - detecting health conditions early;
  - having the capacity to treat disease; and
  - helping patients with rehabilitation.
- Affordability – a system for financing health services so people do not suffer financial hardship when using them. This can be achieved in a variety of ways.
- Access to essential medicines and technologies to diagnose and treat medical problems.
- A sufficient capacity of well-trained, motivated health workers to provide the services to meet patients' needs based on the best available evidence.

How, practically-speaking, can membership-based organizations be engaged to realize these needs? Cooperatives and mutuals cannot do everything themselves, that is certain (even if HMOs are at the forefront of health plans in Rwanda). But they do have assets which could help achieve the objectives.

HEALTH SYSTEMS

Only a small number of countries around the world have established health care systems.[172] In some countries, preoccupied as they are with privatization, deregulation, and decentralization, major health expenses have been transferred from the State to households. In Vietnam, this situation is responsible for one-third to one-half of the population suffering from a lack of regular access to health services.[173] In India, more than 70% of the population uses the private health service instead of the public one.[174]

Could co-ops and mutuals offer a way for such populations to get involved in the solution to their dilemma, rather than silently suffering with it? One major health reform which took place over the last year has been OBAMAcare in the USA, a high-income country. By June 30, 2014, 24-29 million Americans had obtained new coverage.[175] As this report indicates, part of this transformation is due to the establishment of Consumer Operated and Oriented Plans (CO-OPs). It was made possible because the federal government provided start-up funds.

The latter example illustrates how important it is for *the recognition of the role of membership-based organizations in health care to be more than "idealistic." It must come with concrete support for new and existing projects*. That means:

- Access to knowledge
- Resources to support new projects and to empower project leaders
- A risk fund dedicated to co-ops and mutuals

We have examples from every corner of the globe of willful blindness on the part of the State. As if only public or private for-profit or capital-based organizations are worthy of consideration in the design of a health system! Hopefully, such a view or understanding of the health system is not universal! From Guatemala, Rwanda, Costa Rica, Uruguay, Spain, and Canada, case after case demonstrates the value-added of formal recognition by the State of the role of membership-based organizations! By their very nature, they are concerned for the satisfaction of members' needs and more globally for the well-being of the community, informing and encouraging people to stay healthy and prevent illness! Moreover, such organizations don't distinguish between members on the basis of income level, sex, age, citizenship, or ethnic origin. For co-ops and mutuals, this is not just a principle or wishful thinking – it's ingrained in their genetic code!

DEMOGRAPHIC BOOM

We must not underestimate the demographic shock bearing down on Africa over the next decades. As reported in a recent UNICEF study,[176] by 2050, African people will represent 25% of the earth's population. This figure will climb to 40% by 2100. Two major trends will accompany this metamorphisis. First, by 2050, 41% of the world's newborns will come from Africa or 1.8 billion babies. Second, the urbanization process will accelerate, embracing 60% of the continent's population by 2050 as opposed to 40% today.

To a great degree, this boom therefore will coincide with a process of urbanization, and very often urbanization instigates the proliferation of disease. How can membership-based organizations like co-ops and mutuals assume a greater role in the health and social care sector as it undergoes such momentous change? Certainly, we must not underestimate the need to educate a greater number of young people in this business model.

AGING POPULATION

If some countries are facing a tremendous population boom, in others, the percentage of the population over 60 is reaching new heights. The forecast for the next 20-30 years is for more – much more – of the same. 2012 data show that in Italy, the UK, France, Portugal, and Germany up to 23% of the population is 60 and over. In the case of Japan, that percentage is 31.92%, a figure which the Republic of Korea and Taiwan will soon reach.

What does it mean for the future? According to WHO, by 2050, two billion people will be aged 60 and older and 80% of them will be living in what are currently low- and middle-income countries. In other words, between 2000 and 2050, the proportion of the world's population over the age of 60 will double, from about 11% to 22%.[177] To address this "Pappy-Boom," we face some key challenges:

- Difficulty with pension plans and the cost of health systems.
- A lack of active people to support the retired. In Japan, there will be one retired person for every two active people by 2025.
- Social isolation among seniors.

This report highlights some interesting cases of social care cooperatives which are active among seniors, very often to enable them to remain in their homes as long as possible by means of a diverse service offering: maintenance, of course, but also "activities of daily living." These are the activities which are essential to independent living, like eating, bathing, and grooming.

The report does not dwell on residential care facilities for elderly. Still, in many countries, public sector residences have long waiting lists whereas the private, for-profit variety is often too expensive. Then there is the whole issue of programming for elderly residents. Older people are known to deteriorate rapidly once deprived of their ability to choose their daily activities and schedule.[178] Presented with such situations, the co-op model could well enhance seniors' sense of community-belonging, provide support, and create a safe environment.

There is plenty of room for innovation on the part of co-ops and mutuals! Already, more and more co-op housing projects target seniors by introducing the types of service valued by those in a process of losing their autonomy, such as cafeterias and health centres.[179] In fact, if seniors' needs are understood as a continuum, co-ops could offer intriguing options at a number of points:

1. The senior wishes to remain at home as long as possible - a home care co-op offers maintenance and other domestic support services
2. The senior chooses to live in a housing co-op - co-ops make supportive services available.
3. The senior is experiencing a significant loss of autonomy - a residential care co-op offers an extensive repertoire of services and living arrangements.

A truly comprehensive co-op response to the challenge of aging populations could also mean the integration of health co-ops (and funeral co-ops) into the continuum.[180]

Finally, let us not underestimate the pro-active role of health co-ops for the promotion of WHO's Age Friendly-Cities programme, as has been demonstrated in Japan.

READINESS TO CONSIDER ALTERNATIVE PATHS OF HEALTH CARE

Treatment is a key component of health. But what kind of treatment? Western or occidental medicine is primarily based on doctors and drugs. More and more people are suspicious of the medicalization of

life and the industrialization of medical care. (Many 65-year-olds take seven different pills daily.[181]) Isn't it time to introduce a wider recognition of alternative or traditional medicine into the cooperative and mutual business model?

PROXIMITY ORGANIZATIONS: WORKING TOGETHER!

From north to south, many NGOs or NPOs engaged in health and social care don't work within the cooperative or mutual legal framework. Nevertheless, they share many of the characteristics, values, and principles of that world. This report does not cite many instances of this. But perhaps co-ops and mutuals should consider reaching out to these organizations if they have not already done so.

Consider just two examples. In Belgium,[182] Maisons médicales (medical centres) number more than 100, with 1,600 health professionals on staff and serving 220,000 patients. Their goals, their connection to community, their sensitivity to patient needs – in many respects, the Maisons resemble the co-op model. In Mali,[183] there are 954 ASACO (Associations de santé communautaire, community health associations). These combine a concern for health care and for social care. They have developed strategies to mobilize women and children and 40 GPs have received special training in nutrition for young children, pregnant and lactating women, and the sick.

BE INNOVATIVE!

When asked what he sees as one of the most influential global health innovations in the world today, Dr Mark Ansermino of LionsGate Technologies explained:

> "Innovation in global health can be segmented into technical innovation, social innovation and business innovation. These segments overlap but the most influential innovation is in business. We need business models that will ensure healthcare can be affordable for everyone, everywhere."[184]

The engagement of co-ops and mutuals in health and social care appears a minor issue beside the fundamental requirements for health – things like safe drinking water, adequate shelter, and a nutritious food supply. But co-ops and mutuals do have the potential to design, build, and run the businesses that can make those fundamentals available and affordable over the long term, in vast array of circumstances.

The Dalai Lama, when asked what surprised him most about humanity, said:

"Man.

Because he sacrifices his health in order to make money. Then he sacrifices money to recuperate his health. And then he is so anxious about the future that he does not enjoy the present; the result being that he does not live in the present or the future; he lives as if he is never going to die, and then dies having never really lived."

Next Steps

Having corresponded intensively with many people all over the world from January to September 2014, the members of the research team have identified some paths for further research and field activities. This is only a very brief selection of promising research subjects for the future.

Public policies need evidence. We need comparative studies between membership-based organizations – co-ops, mutuals, and other kinds of organization – in order to assess such key points as service quality, programme satisfaction, access, visitation rate, etc.

The Chameleon Dimension. This report has documented cases of co-ops and mutuals in health and social care sector which have evolved in all four of types of health funding system. (See Annex 2.) How this is possible? What specific adaptations must a co-op or mutual undertake in each of these funding environments? In instances where co-ops or mutuals act independently of the public health system, why were they established in the first place? To address gaps, simple issues of access, quality of care, or cost?

Governance. By definition, membership-based organizations welcome the input of members. Do we have inspiring models of governance in co-ops and mutuals engaged in health and social care? If so, there can be no more original and effective way to encourage member input!

The Innovation Path. We need a much closer understanding of how co-ops and mutuals welcome and implement innovation in their health and social care activities. Who instigates innovation – members, staff? By what processes does it take shape and take hold?

The Innovation Path (2). Multipurpose co-ops show a great capacity to integrate different sectors into their business model. Are there examples (apart from health and social care) which display concern for such key factors in our common future as water, energy, and food?

Annex 1: Methodological Framework

The original target of this project was to describe as accurately as possible health and social care co-ops around the world, focusing on how they improve access to health care and generate health care innovation. In light of previous research we had undertaken,[185] the challenge was apparent: lacking any centralized, current, and unified database on the subject, the project would involve intensive investigation and networking. Moreover, the notion of "health cooperative" could well differ from one country to another. For example, what do we mean by "health care"? Only its curative aspects? Must a "health co-op" own a clinic or/and a hospital, or could it simply manage a preventive health programme?

A. THE PROCESS

As a consequence, we adopted definitions of the key concepts, while remaining fully aware that they were merely points of reference. In many countries, the reality is very complex: a mutual which offers a health plan might own and operate a clinic; a health co-op that provides health care could also deliver an important social care programme, etc. The key concepts are:

- Health Cooperative;
- Social Care Cooperative;
- Pharmacy Cooperative; and
- Mutual Health Organizations or insurance cooperatives; the mutual insurance branches of credit union organizations; and insurance companies owned by credit union organizations which offer health insurance products and/or manage health facilities like medical care centres.

After a few weeks of research, it became apparent that this framework required adjustment, while upholding the two central goals of the project, the improvement to health access and innovation. The adjustment was as follows: to consider how certain co-ops *other than health co-ops*, like savings and credit, agricultural, and even mining co-ops (in Bolivia) and mutuals, may engage directly in health issues. They not only offer services or products related to their core business, but provide health care with their own resources, i.e., they own and/or manage health facilities (like clinics and hospitals) and hire medical staff. They are strongly committed to improve access to health care, and may be at the forefront of innovation, no less! Some even offer a health plan. It was immediately self-evident that we had to include them in our research! It also explains the title of this report: *Better Health & Social Care*: *How are Co-ops & Mutuals Boosting Innovation & Access Worldwide?*

While the conceptual framework was being prepared, a team of researchers was hired based on their knowledge of the subject, their language ability (we processed information from eight different languages), and their links with specific regions of the world.

The strategy for collecting the data was simple.

The project commenced with desktop research. That meant using the Internet to locate websites and reference documents (e.g., research papers, government or NGO reports). Next we tried to find contacts who could help us to identify key resources in each of the countries referenced. Except when preparing case studies, requesting photos, or researching countries with a very limited number of co-ops, we tried to avoid contacting individual co-ops and to rely on aggregate data. The research would have required far more time and resources otherwise. **The data collection process has been a tremendous challenge for every member of the research team due to the lack of data, the difficulty in finding relevant data, long delayed replies from contacts (or no replies at all), inconsistent data, a lack of interest in the project, etc**. The information exchange process alone has been immensely time-consuming. Sometimes, after a few weeks or months of waiting, contact with our reference person evidently having been lost for reasons unknown, we had to start the research process all over again. All this took place under severe time constraints (January to September 2014). For these reasons, we had to remain very flexible when adapting our data collection grid. Necessarily, national cases have been included only for those countries for which sufficient information related to the central goals of the report was available.

Nevertheless, many individuals all over the world were generous in their assistance to this project. We have acknowledged the support received from each country, and for the project as a whole.

After the completion of each national case, we asked the members of our Steering Committee to act as second readers. Indeed, in some cases, people in key positions (co-op apex associations, civil servants responsible for the co-op sector, ICA regional staff) agreed to read and comment on the cases. Since English was the researchers' common language, in some cases the final step was to translate cases originally written in Spanish, Portuguese, or French into "the language of Shakespeare."

B. THE CONTENT

Since the health situation and the importance of public health spending varies significantly from one country to the next, seven key data were selected to introduce each national case and serve as a brief overview of the country's "state of health."

These key data fall into two sets: one related to the population and the other to health expenditure.

Population data:

- Total population
- Population median age (years)
- Population under 15 (%)
- Population over 60 (%)

Expenditure data:

- Total expenditure on health as a percentage of Gross Domestic Product
- General government expenditure on health as a percentage of total government expenditure
- Private expenditure on health as a percentage of total expenditure

We used the database of the WHO Global Health Observatory[186] which offers data from 2012 related to each of these indicators. 2012 is our data reference year. We have indicated instances in which the reference year differs.

The detailed definitions of these seven basic indicators can be found on the WHO website.[187]

BACKGROUND INFORMATION ON NATIONAL HEALTH FUNDING

How is it possible for a health co-op to combine a health insurance programme and a delivery facility, as does Group Health in the USA? Why does Kenya's Co-operative Insurance Company market its own very affordable health plan with basic health coverage, instead of the one designed by the State? We can't answer such questions without basic background information concerning the national health funding situation. Accordingly, in addition to the presentation of key health indicators, each national case is prefaced with an overview of its health funding situation. Annex 2 presents a simple typology of health funding.

CO-OPS & MUTUALS

For each country, we tried to collect information related to health and social care co-ops and dated as closely as possible to the reference year:

- Number of co-ops
- Types of co-op: User, Multistakeholder (more than one category of member), and Producer (including worker co-ops)
- Number of members: To compile information on different member categories was too complex. Therefore, we only recorded the total number of members.
- Number of staff: To compile information on the different staff categories was too complex. Therefore, this figure is the total number of employees without any specification as to the nature of their employment (part- or full-time).
- Number of users: In the case of health co-ops, the number of users may exceed the number of members for at least two reasons. In some cases, member status applies to families; in other words, all family members may use the co-op's services. In other cases, the health co-op welcomes patients who are not co-op members. It is assumed that the number of users is the number of *individual* users.
- Facilities: Because it was so difficult to arrive at a common definition of "facility," we welcomed the most basic information (e.g., clinic, health centre, hospital, etc.) and required no technical details.

As mentioned, we decided to include other co-ops and mutuals active in health and social care which own and/or manage facilities. In such cases, we used the following data:

- Total number of co-ops and/or mutuals
- Total number of users of the facilities annually
- Facilities – basic information only, e.g., clinic, health centre, hospital, etc. (Technical details were not required.)

In the matter of pharmacy co-ops, we tried to secure additional information especially as regards the types of co-op – first level, second level, or other. (See Operational Definitions, p. 5.)

In the matter of co-ops and mutuals which provide health plans, we decided to focus on those which do so in the absence of Universal Health Coverage and those mutuals which, in addition to a health plan, own and/or manage health facilities. Notwithstanding the cited instances of co-ops which offer complementary health plans, ours is not a comprehensive survey of that subject.

THE LEGAL DIMENSION

Not all countries have a general law on cooperatives. Some countries have both a general law and sectoral laws on cooperatives. In certain countries, such as Denmark and Ireland, cooperative organizations prosper without regulation under a law specific to them. However, no cooperative organizations are prospering in the complete absence of legislation applicable to them.[188]

Where there is a specific law on cooperatives at the national or state/provincial level,[189] or where regional legislation may apply, or where health legislation authorizes cooperatives to be active, data may be collected by public authorities or cooperative organizations or other entities. However, there is no guarantee that centralized and current data will be readily accessible. The lack of statistical information on cooperatives has been recognized by international and national authorities as well as by the movement itself. This lack of data is a serious problem in many countries[190] and one which was specifically identified as requiring attention during the International Year of Cooperatives 2012.

In countries where there is no law on cooperatives, cooperatives can and do exist. However, public authorities are not likely to collect any data about them. Here again, cooperative organizations (associations, federations, unions) may be a good source of information for those enterprises which operate as cooperatives. They may call themselves a cooperative but be registered under another legal framework. It is interesting to note that, until very recently, the very birthplace of the consumer cooperative (the UK) had no specific law for cooperatives. Instead they were registered under an array of other laws. In such cases, enterprises have been included which describe themselves as cooperatives or make reference to the Statement of Co-operative Identity[191] for their operations. In other cases, inclusion of organizations was at the discretion of the research team. For example, Group Health in the USA (a leading consumer-oriented health organization), and in Canada, the Saskatoon and Regina community clinics (which do not have a co-op legal status but describe themselves as co-ops and respect co-op principles) are all included in this report.

CASE STUDIES

These are an important output of this report – perhaps the most important! In each national case, we try to include a "case study": a short description of how a co-op or mutual is making major improvements in access to health care or notable innovations in that sector. We tried to identify key persons to help us to select these cases, but the availability of information was crucial. In other words, sometimes we were able to identify interesting cases, only to find relevant information was unavailable. The final decision for the selection of case studies was ours.

Unless otherwise noted, all references to money in this report are expressed first in terms of the American dollar (USD).

PICTURES

We did our best to make use only of photos which are in the public domain or which our information sources for the national cases made available. Unfortunately, only a few photos were readily available.

Annex 2: Basic Information related to Health Systems & their Funding Mechanisms

According to WHO,[192] there are five primary sources of financing or funding for health systems: general taxation from the State; social health insurance; voluntary or private health insurance; out-of-pocket payments; and other private expenditure (for instance, donations to charities). In the matter of provision, four major types of player get involved: public or para-public organizations, private for-profits, private not-for-profits, and individuals. There are about 200 countries on the planet and each makes its own set of arrangements with these five sources and four types of player in order to fund and provide health services. The place of public spending in total health expenditure could vary from 15% (as in some sub-Sahara countries) to 85% (as in Scandinavian countries). To take a different perspective, health expenditure could represent only 4.7% of GDP, as in Kenya and Venezuela, or as much as 17.9%, as in the USA!

It is crucial to keep in mind the organization of a health system's funding mechanism (and provision mechanism) in order to understand the potential place and role that membership-based organizations like co-ops and mutuals might occupy, as a funder (insurance) and/or as a provider. For instance, under the Beveridge model, a health plan provided by a co-op or mutual can only be complementary to the public plan. In the National Health Insurance model, since doctors are generally paid by the public authority, a health co-op would need to adapt their business model accordingly, by leasing space to the doctors, for instance.

It is not necessary to explain all national health systems in detail. That is not the purpose of this report. But it is useful to recapitulate here how T.R. Reid summarizes them in terms of four basic systems:[193]

Beveridge

Named after William Beveridge, the daring social reformer who designed Britain's National Health Service. In this system, health care is provided by government and financed by government, through tax payments.

Many, but not all, hospitals and clinics are owned by the government. Some doctors are government employees, but there are also private doctors who collect their fees from the government. These systems tend to have low costs per capita, because the government, as the sole payer, controls what doctors can do and what they can charge.

Countries using the Beveridge plan or variations on it include its birthplace, the United Kingdom, Spain, most of Scandinavia, and New Zealand. Cuba represents the extreme application of the Beveridge approach. It is probably the world's purest example of total government control.

Bismarck

Named after the Prussian Chancellor Otto von Bismarck, who invented the welfare state as part of the unification of Germany in the 19th century. It uses an insurance system (the insurers are called "sickness funds") usually financed jointly by employers and employees through payroll deductions.

Bismarck-type health insurance plans have to cover everybody, and they don't make a profit. Doctors and hospitals tend to be private in Bismarck countries; Japan, for example, has more private hospitals than the USA. Although this is a multi-payer model – Germany has about 240 different funds – tight regulation gives government much of the cost-control clout that the single-payer Beveridge Model provides.

The Bismarck model is found in Germany, of course, and France, Belgium, the Netherlands, Japan, Switzerland, and, to a degree, in Latin America.

National Health Insurance Model

This system has elements of both Beveridge and Bismarck. It uses private-sector providers, but payment comes from a government-run insurance program that every citizen pays into.

The single payer tends to have considerable market power to negotiate for lower prices. Canada's system, for example, has negotiated such low prices from pharmaceutical companies that Americans have spurned their own drug stores to buy pills north of the border. National Health Insurance plans also control costs by limiting the medical services they will pay for, or by making patients wait to be treated.

The classic NHI system is found in Canada, but some newly industrialized countries – Taiwan and South Korea, for example – have also adopted the NHI model.

Out-of-Pocket Model

Only the developed, industrialized countries – perhaps 40 in total – have established health care systems. Most of the nations on the planet are too poor and too disorganized to provide any kind of mass medical care. The basic rule in such countries is that the rich get medical care; the poor stay sick or die.

In rural regions of Africa, India, China, and South America, hundreds of millions of people go their whole lives without ever seeing a doctor. They may have access, though, to a village healer using home-brewed remedies that may or not be effective against disease.

In the poor world, patients can sometimes scratch together enough money to pay a doctor's bill; otherwise, they pay in potatoes or goat's milk or childcare or whatever else they may have to give. If they have nothing, they don't get medical care.

For the populations which have no health insurance, as in Cambodia or Burkina Faso or rural India, access to a doctor is available if you can pay the bill out-of-pocket at the time of treatment or if you're sick enough to be admitted to the emergency ward at the public hospital.

Annex 3: Health Cooperatives Around the World – Background Studies[194]

For 20 years, there have been few efforts to paint portraits of the world's health cooperatives. The following is a brief tour of the methods and objects of several earlier studies, each of which in its own way reflects the complexity of the subject.

In 1996, Comeau and Girard compiled 11 national portraits, each combining information about a national health system and the activity of health cooperatives (Comeau and Girard 1996a). This research paper, from the Chair coopération de Guy-Bernier at the Université du Québec à Montréal in Canada, is enriched with a reflection on the crisis of the welfare state and opportunities to develop health cooperatives in such a context. A summary has been published in *RECMA*, the French social economy review (Comeau and Girard 1996b).[195]

In 1997, after over two years of hard work, the United Nations published a global overview of cooperatives active in the health and social care sector in English, followed the next year by French and Spanish language versions. This is certainly the most comprehensive study on the subject to date (United Nations 1997). However, the aim of this study was not so much to present a comprehensive picture of health cooperatives, as to "... clearly define the preconditions for the further development of health and social services components of the international cooperative movement ...."

In addition, the report included a very detailed classification of cooperatives according to the importance which their mission attached to the health and social services sector and the nature of their membership. It included several insights into factors which can help or hinder the development of health cooperatives in the world. There was also an analysis of the impact of cooperatives on health systems. For example, a system based on a type of welfare state (funded from taxes), as in Canada and the United Kingdom, may be less conducive to the development of health cooperatives than a system with a predominantly private system (e.g., the United States). Unlike Comeau and Girard's research, this study made no systematic presentation of the health systems of each of the countries where health cooperatives were to be found.

In 1997, a publication on health cooperatives in seven Latin American countries, including a reflection on opportunities for doing business with such organizations, was published by ICA Americas with the support of the Canadian Co-operative Association, in Spanish with an English translation (Alianza Cooperativa Internacional, Américas 1997). In 2003, Nayar and Razum wrote an article which dealt with health cooperatives from a holistic point of view, but focused their analysis on examples of old health cooperatives in China and India (Nayar and Razum 2003).

In 2007, with the support of the International Health Co-operative Organization (IHCO) and multiple Canadian sponsors, the Institute of the Université de Sherbrooke for the study and research of co-ops

and mutuals (IRECUS) launched a project (coordinated by Girard) aimed at providing a global picture of health cooperatives (IRECUS 2014). Due to technical problems, the result was limited to the development of multilingual questionnaires (English, French, and Spanish), the production of five national cases, each combining an overview of the national health system and the activity of health cooperatives, and a text analysis (*Global Background and Trends from Health and Social Care Perspective*). The results were published in English and French. The case of Mali covered Mutual Health Organizations, while the rest concerned health cooperatives in Canada, the USA, Benin, and Uganda.

Since the beginning of the 1990s, international conferences on the subject of health cooperatives have been organized from time to time (often by IHCO members). These presented good opportunities to share information related to national cases. Although some current data was brought forward on these occasions, very little was available from a global perspective, since no study had updated the work of 1997.[196]

For many years, not to say decades, in response to the lack of data related to the importance of cooperatives and mutuals around the world, the International Co-operative Alliance (ICA) and other organizations supporting cooperatives have launched diverse research projects.[197] After the *Global300 Report*,[198] the most recent one has been the *World Co-operative Monitor*.[199] Partnered with the European Research Institute on Cooperatives and Social Enterprises (Euricse), the purpose of the *Monitor* "is to collect robust economic, organisational and social data about not only the top 300 co-operative and mutual organisations worldwide but also an expanded number of co-operatives in order to represent the co-operative sector in its organisational, regional and sectorial diversity." The latest version of the *Monitor* (2013) concerns the health and social care sector.[200] For it, data was collected for 53 co-operatives, located in 12 countries, and with a total turnover of $20.84 billion USD (2011). One figure (F11) shows the countries from which the data were collected and another (F12) the location of those cooperatives with an annual turnover of over $100 million USD. The report also presents a table with the top 10 largest cooperatives by turnover (totaling $15.25 billion USD) and another with the 10 largest co-operatives by turnover by GDP per capita.[201]

The situation is different with regard to Mutual Health Organizations. During a period of 10 years (1995-2005), with the involvement of various NGOs (especially a Belgian NGO) and the ILO STEP programme, many studies and research projects have been conducted from both a practice and a theoretical point of view. (Examples are Develtere and Fonteneau, 2002; ILO 2002; Universitas ILO 2002; and ILO 2007.)

Annex 4: Note on China & Health Co-ops[202]

In China, with the dismantling of the commune system in rural areas and the work units in urban areas in the early 1980s, the majority of Chinese people became uninsured. As a result of China's economic liberalization, the commercialized health care market has emerged, and the user-pay system has been introduced. This has made health care services and treatment unaffordable to many. For some time this has been regarded as one of the most severe of China's social problems.

China now has a mixed health care system of public and private ownership. China has "inherited a largely hospital-based delivery system managed through the Ministry of Health and local governments, supplemented by a vast cadre of village doctors and a newly developed system of grassroots providers in urban areas."[203] Although health care and social care services remain in large part publicly-owned, the private sector has developed rapidly in the sector of care provision. Ministry of Health statistics show that from 2005 to 2012, the number of public hospitals relative to the total number of hospitals in China has decreased from 82.8% to 57.8%, whereas that of private hospitals has increased from 17.2% to 42.2%. In 2012, the number of beds provided by private hospitals accounted for 14% of the total number of beds in hospitals, an increase of 8.1% over 2005.[204]

In the pursuit of high economic growth, Chinese leaders showed limited interest in the health care sector.[205] Like other Asian countries, "welfare development remains subordinate to economic growth. Compared with European countries, care is far from taken as a public responsibility in Asia and the Asian states remain far less involved in making provision for care."[206] It is widely believed that the severe acute respiratory syndrome (SARS) crisis in 2003 and its harmful impacts upon social stability and economic development awakened Chinese policymakers, driving them to re-assess the challenges facing China's health care system.[207] Since then, top Chinese officials have devoted a great deal of attention to health care reform. In 2009, a new health system reform plan was launched. It aims to achieve universal coverage of health care in China by 2020, which is expected to build on initiatives already underway with the expansion of population coverage under the Rural Co-operative Medical Scheme.[208]

Currently there are three main types of social insurance scheme:

- Urban Employees' Basic Medical Insurance system (UEBMI) (since 1998). This is to replace work-unit based coverage with risk pooling at the municipal level. In 2012, UEBMI covered 71.3% of the urban employed population and 37.2% of the total urban population. This is a compulsory type of insurance.
- Urban Residents' Basic Medical Insurance programme (URBMI) (since 2007). This has been designed for the rest of the urban population, not covered by the first type (students, retirees, other dependents, etc.). In 2012, URBMI covered 38.1% of the total urban population. This is a voluntary type of insurance.

- Rural Co-operative Medical Scheme (RCMS) (since 2003). This targets the rural population. In this system, the risk pooling is at the county level. In 2012, 90% of counties have implemented RCMS. This is a voluntary type of insurance. In 2012, RCMS covered 59.5% of the total population in China.

By the end of 2012, those three mainstream health insurance schemes together covered 99% of China's total population.

As a result of recent health system reforms, there is a significant decline in out-of-pocket spending as a share of the total health expenditure, from 52.2% in 2005 to 34.4% in 2012. In the meantime, along with the expansion of social health insurance, the ratio of social health expenditure and of government health expenditure to total health expenditure has increased steadily, from 29.9% and 17.9% in 2005 to 35.6% and 30.0% in 2012, respectively.[209] In the same period, total health expenditure as a share of GDP has risen from 4.68% to 5.36%.

The WHO definition of universal health coverage has three aspects, namely, equity in access to health services, quality of health services, and protection against financial risk.[210] As for some concrete criteria, Eggleston proposed that "a defensible definition of universal coverage including both breadth and depth of coverage might be as follows: more than 90% of the population has health insurance/coverage, and more than 60% of health care spending is through insurance or other risk pooling (i.e. out of pocket spending is 40% or lower)."[211] Indeed, based on these criteria, China has already achieved universal coverage.

Despite China's impressive health achievements, some significant problems persist, particularly in terms of population aging. To tackle these problems, unlike some of its Asian neighbours, China has not been able to benefit from a strong tradition of social movements. For the moment, health cooperatives, social cooperatives, and pharmacy cooperatives are basically absent in Chinese society.

Although since 2009 government reform documents "have called for 'bold and innovative' local experiments, including ownership restructuring,"[212] the current institutional environment for Chinese cooperatives and the health system in general have not encouraged such experiments.

The cooperative movement in China is suffering from a lack of legal and institutional supports. With only one cooperative law existing in the agricultural sector, the potential of cooperatives to expand into and act in other societal domains is very limited. With regard to the resistance of the health system in China, as Eggleston has explained, "the political stakes are high, the interest groups strong, the financial flows large, and the risk of mismanagement appear to outweigh the rewards from such bold reforms."[213]

As a final note, there are in China some grassroots initiatives for health promotion. For example, a group of elderly persons will come together to dance or to practice Tai-chi in a park or a public square. But that is more of an informal club than an institutionalized health organization.

Annex 5: Other Health Co-ops in the World

Palestine

The Beit Sahour Cooperative Society for Health Welfare[214] is an organization established in 1959 that seeks to develop health welfare systems based on cooperative principles, providing affordable, quality health care for residents of Bethlehem Governorate. The society operates out of the Shepherd's Field Hospital in Beit Sahour. It has a small surgical unit, an 18-bed maternity ward, an outpatient clinic, a small 24-hour emergency clinic, a laboratory, and a pharmacy.

Around 200 families or 1,000 people are members, paying a registration fee of approximately $135 USD annually and a $1.30 USD monthly fee for each member of the household. In return, families receive all clinical checkups for free and pay only 40% of the cost of laboratory services, surgery, and prescribed medicine. In fact, the society's health care package costs the average family 50% less than the private sector and many health care providers in the Governorate would charge. Additionally, contributions from community, national, and international donors enable the society to make its low-cost/high-quality health care services available to poor families.

Over the years, this co-op has received support from different organizations, including an NPO of the Catholic Church[215] and the Japanese government.[216] Several attempts were made to collect data from this co-op, without success.[217]

Iran

According to two research papers published in 2006 and 2012,[218] Iran's health co-ops originate in the conversion of existing public health centres. This process started in the region of East Azerbaijan, and reportedly at least nine cooperative health centres (CHCs) have been established to date. Each serves between 9,000 and 17,000 citizens.

Sri Lanka

Sri Lanka uses the notion of hospital cooperative societies to describe health co-ops. Despite many attempts to obtain detailed data from the Sri Lanka Consumers Co-operatives Societies Federation (Coopfed), we only received two data: six hospital cooperative societies have a total of 12,490 members. The data on the Federation's website are close, but not identical: it reports seven hospitals and 8,400 members.[219]

Annex 6: Legal Considerations regarding Health Cooperatives & MHOs in Western & Central Africa[220]

This section only concerns supranational regulations which apply in parts of western and central Africa. These regulations are pertinent to this report because of their potential to exercise a major impact on the future development of Health Mutual Organizations (MHOs) in these regions. Three main legal frameworks are to be considered:

- The OHADA Uniform Act relating to cooperative societies' Law
- The WAEMU Regulation concerning social mutuality
- The CIMA Insurance and Microinsurance Code

The OHADA (Organization for the Harmonization of Business Law in Africa) Uniform Act relating to cooperative societies' Law was adopted on December 15, 2010 and came into force on May 15, 2011. It is applicable in 17 states: Benin, Burkina Faso, Cameroon, Central Africa Republic, Chad, Comoros, Congo, Côte d'Ivoire, the Democratic Republic of Congo, Gabon, Guinea, Guinea-Bissau, Equatorial Guinea, Mali, Niger, Senegal, and Togo.

The draft Uniform Act was launched in March 2001, with the objective of regulating cooperatives and mutual societies. Many debates on the first draft act (2004) highlighted the difficulties, both legal and practical, raised by its broad scope, which gradually has been reduced. In fact, it has been decided to exclude mutual societies from the Act, and the special rules with respect to activities.

With this exclusion, there is no regulation for mutual societies in the OHADA zone, except for the eight member countries of the WAEMU.

In 2009, the WAEMU (West African Economic and Monetary Organization) adopted a Regulation on mutual health social organizations, applicable throughout its eight member countries: Benin, Burkina Faso, Côte d'Ivoire, Guinea Bissau, Mali, Niger, Senegal, and Togo.[221]

Shortly thereafter, the OHADA adopted the Uniform Act applicable to cooperatives. It is indeed curious that cooperatives are absent from the provision of health services to low-income populations in such countries as Cameroon, Burkina Faso, Guinea, or Senegal, when Article 5 of the OHADA Uniform Act permits them to operate in all areas. Could it be due to competition from MHOs?

MHOs arrived in Africa (mainly in francophone countries) in the 1990s. In those years, when the health sector experienced a crisis, most countries in western and central Africa received technical and financial support from European countries. This is probably how MHOs made their entry, on the basis of French experience.

But the factors behind the absence of cooperatives seem to be more legal in nature. Cooperatives are specifically prohibited from engaging in microinsurance, according to the provisions of CIMA (Inter-African Conference on Insurance Markets). CIMA is an international organization whose purpose is to harmonize Insurance Law in 14 countries: all the members of the WAEMU, plus Cameroon, Gabon, Chad, the Central African Republic, Congo, and Equatorial Guinea. Its Insurance Code recognizes only limited companies and mutual societies.

What then distinguishes MHOs from cooperatives? The main difference is the absence of equity in MHOs. They are organizations which integrate features both of the company and the association. In addition, MHOs seem to be limited to the activity of microinsurance, while cooperatives can invest in a greater variety of activities.[222]

Research shows that cooperatives and MHOs can build strong partnerships in the health domain. Cooperatives can provide services to MHOs and vice versa, so that one organization can contribute to the development of the other by providing services that the latter cannot perform directly.[223]

Annex 7: The Project Team

RESEARCH MEMBERS

Jean-Pierre Girard

An international expert in cooperatives, nonprofit organizations, and other types of collective enterprise, over the last 30 years Jean-Pierre Girard has undertaken a range of projects, combining consulting and academic activities, from the local to the international. In terms of consulting, he recently completed projects for the United Nations, the OECD, and Doctors Without Borders. He also makes presentations in many countries in South and Central America and Europe and has organized study tours to Japan. Academically, he leads research projects and teaches a variety of programmes in co-op management at universities in Québec and Africa.

In collaboration with others, Mr. Girard wrote the national cases for France, India, Canada (with Vanessa Hammond), and Italy (with Alleanza delle cooperative Italiane). He also wrote the report and led the project.

Maria Elena Chávez-Hertig

Maria Elena Chávez Hertig, a Canadian and Chilean national, is a cooperative specialist with over 30 years of experience. She has worked both for cooperative organizations and organizations supporting cooperatives as, among other positions, Coordinator and Chief of the Cooperative Branch at the International Labour Office (ILO), Deputy Director-General of the International Co-operative Alliance (ICA), Coordinator of the Committee for the Promotion and Advancement of Cooperatives (COPAC), and Office Manager of World Council of Credit Unions (WOCCU) in Geneva, Switzerland. Ms. Chávez Hertig is currently an international consultant living in Geneva, Switzerland.

Ms. Chávez Hertig researched and wrote the national cases for Mexico, Costa Rica, the Dominican Republic, El Salvador, Guatemala, Honduras, Nicaragua, Panama, Argentina, Bolivia, Brazil, Chile, Columbia, Ecuador, Paraguay, Peru, Uruguay, Venezuela, Portugal, and Spain.

Li Zhao

Li Zhao holds a PhD in Political and Social Science from the University of Leuven, Belgium. She has been a researcher at the Research Institute for Work and Society (HIVA) at KU Leuven and the Leuven Centre for Global Governance Studies. She has also been guest lecturer at the Living Stone Centre of Competence for Intercultural Entrepreneurship. She has authored and co-authored numerous academic articles and

recently co-edited the book, *Co-operative Innovations in China and the West* (Palgrave Macmillan, ISBN: 9781137277275). In China, she graduated from Tsinghua University with an MA in Public Management.

Ms. Zhao researched and wrote the national cases for India, Japan, Republic of Korea, Malaysia, Nepal, Singapore, Vietnam, Australia, and New Zealand.

Willy Tadjudje

Willy Tadjudje is an international consultant and a senior researcher. He holds a PhD from the University of Luxembourg. As a legal expert, he is a member of the newly established cooperative law committee of the International Co-operative Alliance. He is also a trainer and a temporary teacher at the Regional High School of Magistracy of the Organization for the Harmonization of Business Law in Africa (OHADA). He specializes in the legal and sociological aspects of social and solidarity economy organizations, microfinance, microinsurance, land management, corporate governance, etc.

Mr. Tadjudje researched and wrote the national cases for Benin, Burkina Faso, Burundi, Cameroon, Ghana, Guinea, Kenya, Morocco, Rwanda, Senegal, South Africa, Uganda, Greece, Poland, and Turkey.

Candice Mazzoleni

Candice Mazzoleni is a grad student at HEC Montréal where she studies sustainable development and social economy. She is also a graduate of the Institute of Political Studies in Paris.

Ms. Mazzoleni researched and wrote the national cases for Finland, Germany, Netherlands, Switzerland, UK, and the USA, and (in collaboration with Laëtitia Lethielleux, Mélissa Boudes, and Maryline Thenot) Belgium.

Laëtitia Lethielleux

Laëtitia Lethielleux is a lecturer in Management Science at the Université de Reims Champagne-Ardenne. Associate Professor of Economics and Management, a lawyer and doctor of Management Science, she is the author of numerous books on law and management. She is Head of the Master 2 Management of Social and Solidarity Economy Enterprises and the Reims Management School. A member of the REGARDS research laboratory, her research focuses primarily on issues of governance and support for employees and volunteers in times of organizational change.

With other members of the ESS, Ms. Lethielleux collaborated with Jean-Pierre Girard on the national case for France, and with Candice Mazzoleni on the national case for Belgium.

Mélissa Boudes

A graduate of the Sorbonne Graduate Business School in Paris (Master in Applied Organizational Research), for three years Mélissa Boudes has been a research and teaching assistant in the Social and Solidarity Economy Chair (ESS) at the Université de Reims. She organizes specialized ESS course modules, supports students in their professional development, and takes part in applied research projects jointly developed by researchers at the School of Business and the Université de Reims. She is currently engaged in a PhD in Management Science for Activity and Employment Cooperatives under the direction of Bernard Leca, at the Université Paris-Dauphine.

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Maryline Thénot

In addition to Masters in Taxation, Business Law, Finance, Strategy and Organizational Management, Maryline Thénot also holds a PhD in Management Sciences. She has over 15 years of professional experience as a legal and financial strategy consultant in an auditing firm and an international body. She joined the Rouen Management School in 1999 as a teacher before becoming Department Head of Finance, Taxation and Control. Her research focuses on organizational change, financial strategies, governance of international groups, the cooperative model, and industrial bio-economy.

With other members of the ESS, Ms. Thénot collaborated with Jean-Pierre Girard on the national case for France, and with Candice Mazzoleni on the national case for Belgium.

Don McNair

Active in community and cooperative economic development as an editor, illustrator, writer, designer, and publisher since 1985, Don McNair was responsible for the editing, layout, and proofing of this report and the volume of national cases. He lives in Vernon, British Columbia, Canada.

STEERING COMMITTEE MEMBERS

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Vanessa Hammond: Chair: Health Care Co-operatives Federation of Canada, Victoria, Canada

Daniel Roussel: Executive Director of the Insurance and Financial Services Development Centre, Québec, Canada

Michèle Saint-Pierre: Professor of Strategic Management of Organizations in the Health Sector, in the Department of Management, Faculty of Administrative Sciences at Laval University, Québec, Canada

Gabriella Sozanski: Founding Member and Board Secretary, Alliance for Health Promotion, Geneva, Switzerland

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Notes

Note: all Internet locations were verified September 5, 2014, unless otherwise indicated. Sources whose bibliographical information is listed in full in the Annex "Key References" (e.g., are cited in abbreviated ASA format. References for tables 1-3 are found on pp. 25-26.

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[3] WHO. 2013. "8th Global Conference on Health Promotion: Health in All Policies. Helsinki 2013." Webpage. Retrieved June 6, 2014 (http://www.healthpromotion2013.org/).

[4] Wilkinson, Richard G., and Kate Pickett. 2009. *The Spirit Level: Why More Equal Societies Almost Always Do Better*. London: Allen Lane.

[5] WHO. 2010. "Where Are We Now?" Pp. 3-17 in *The World Health Report: Health Systems Financing: The path to universal coverage*. (http://www.who.int/whr/2010/10_chap01_en.pdf).

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[8] As demonstrated in the well-known study, Arnstein, S.R. 1969. "A Ladder of Citizen Participation." *American Institute of Planners Journal* 35(4):216-224.

[9] European Research Institute on Cooperative and Social Enterprises (Euricse). Website. (http://www.euricse.eu/en).

[10] As explained in other parts of this report, such global health data as life expectancy or public health expenditure were easily obtained. Not so technical information, like the nature (e.g., the legal framework) of clinics, etc.

[11] WHO 2014a.

[12] The reader is invited to contact the project research leader for any additional information, or on any other matters relating to this research, at jpg282000@yahoo.ca

[13] The reader can also find a definition of cooperative identity at the following webpage: International Co-operative Alliance (ICA). 2014. "What's a co-op?" (http://ica.coop/fr/node/36).

[14] United Nations (UN). 1997. *Cooperative enterprise in the Health and Social Care Sectors: A Global Survey*. New York: United Nations Department for Policy Coordination and Sustainable Development.

[15] Note that the services could be also accessible to the member's dependents (family members) and, in certain cases, to the whole community.

[16] UN 1997:7.

[17] In light of a comment received from the CEO of the International Pharmaceutical Federation (FIP), it would be important to learn if the services of the pharmacy are for the population (customers) in general, or for internal purposes (hospitals or retirement homes).

[18] UN 1997:34-35.

[19] WHO. 2006. "Constitution of the World Health Organization." *Basic Documents*. 45th Edition, Supplement. Geneva. Retrieved June 6, 2014 (http://www.who.int/governance/eb/who_constitution_en.pdf). This WHO definition of health, like any other, is a social construction, under influence of biology and culture and, of course, is subject to change over the time. See: Morris, David B. 1998. *Illness and Culture in the Postmodern Age*. Berkeley: University of California Press. P. 241.

[20] WHO. 2004. *A Glossary of Terms for Community Health Care and Services for Older Persons*. Ageing and Health Technical Report Vol. 5. Kobe City, Japan: WHO Centre for Health Development. (http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf).

[21] See p. 5 for a definition of the term "health cooperative."

[22] "Western medicine" describes the treatment of medical conditions with medications by doctors, nurses, and other conventional health care providers who employ methods developed according to Western medical and scientific traditions. wiseGEEK. 2014. "What Is Western Medicine." Webpage. (http://www.wisegeek.org/what-is-western-medicine.htm).

[23] Joint Learning Network for Universal Health Coverage. 2014. Website. Retrieved June 6, 2014 (http://uhcforward.org/about/universal-health-coverage/basic-models).

[24] Such a contract generally identifies the population covered by the agreement, the type of service provided by the organization, and what is to be charged to the patient (and paid by insurance or OOP).

[25] In such cases, as occurs in Québec (Canada), for example, the GP is paid on a fee-for-service basis by the State and uses a part of this income to pay the lease.

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[27] In 1998 Chris Atim posited that the concept of Mutual Health Organization is equivalent to the French mutuelle de santé. Atim, Chris. 1998. "Contribution of Mutual Health Organizations to Financing, Delivery, and Access to Health Care: Ghana Case Study." International Labour Organization, STEP Programme. (http://www.ilo.org/dyn/infoecon/docs/473/F808578758/GHana%2021p1.pdf).

[28] BIT-ACOPAM-ANMC. 1996. *Mutuelles de santé en Afrique, guide pratique à l'usage des promoteurs, administrateurs et gérants*. Geneva: International Labour Office. P. 11.

[29] To be effective, the MHO needs to sign an agreement with the health provider. In some cases, members of the MHO have no choice of health professional; in other cases they can choose from a list. Finally, when the time arrives for a consultation, members can directly pay for the service and then be reimbursed. In other cases, the fee is charged to the MHO directly. Generally, MHO health plans exclude coverage for chronic illnesses, such as HIV-AIDS.

[30] With Suzdaltsev Evgeny, from the International Department of Centrosoyuz of Russia, April 10, 2014.

[31] As in the case of Oromia in Ethiopia. This co-op supports many projects aimed at the improvement of members or community well-being. Their activities include a health post which impacts up to 72,000 beneficiaries. See: Oromia Coffee Farmers Cooperative Union Limited Liability. 2012. "Infrastructures built from the fair trade premium." Webpage. (http://www.oromiacoffeeunion.org/LifeImproving.php).

[32] Most social cooperatives in Italy cap the number of their members. In other words, when the co-op reaches a certain point of development, it will assist the establishment of a new social cooperative, rather than grow any larger.

[33] Koperattivi Malta. 2014. "ME 2 Coop Ltd." Webpage. (http://cooperatives-malta.coop/me-2-coop-ltd/).

[34] One of the most significant sources of information in this regard was a 2009 presentation on pharmacy co-ops at the European level: Cooperatives Europe. 2009. "Mapping Exercise*:* Cooperatives working in the Pharmacy Sector in Europe." Presented at the European seminar "Cooperative enterprises in the pharmacy sector, opportunities and challenges," Rome, 30-31. Retrieved August 14, 2014 (http://static.correofarmaceutico.com/docs/2009/07/270709Informe_Cooperative_Europe.pdf).

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[36] Desjardins Group. 2014. "Physical, mental and financial health, a winning combination." Webpage. (http://www.desjardins.com/ca/co-opme/desjardins-difference/physical-financial-health/index.jsp).

[37] ILO - Microinsurance Innovation Facility. 2011. "Kénéya Sabatili (Insuring health) -- UTM." (http://www.microinsurancefacility.org/projects/lessons/keneya-sabatili-project-insuring-health).

[38]Unfortunately, no additional information could be found about either organization: Congo Forum. nd. "Sommaire." (http://www.congoforum.be/upldocs/BE%202713.doc.).

[39] There are many more examples. The reader is invited to refer to entries in Volume 2: National Cases for details on this subject.

[40] Collaboration santé internationale. 2014. "Actualités du CSI." Webpage. (http://www.csiquebec.org/).

[41] Based on communication with the director general of the organization, August 2014.

[42] IDA Foundation. 2014. "Making Quality Health Care Affordable." Webpage. (http://www.ida.nl/).

NB: references 43-159 (for tables 1-3) are located on pp. 25-26.

[160] All these examples are drawn from Volume 2: National Cases.

[161] See Article No. 5, "The people have the right and duty to participate individually and collectively in the planning and implementation of their health care," in WHO. 1978. "Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978." (http://www.who.int/publications/almaata_declaration_en.pdf).

[162] WHO. 2007. *People at the Centre of Health Care: Harmonizing mind and body, people and systems*. Geneva. (http://www.wpro.who.int/publications/PUB_139789290613169/en/).

[163] WHO. 2008. *The World Health Report 2008: Primary Health Care – Now More Than Ever*. Geneva. Retrieved September 2, 2014 (http://www.who.int/whr/2008/en/).

[164] WHO. 2014b. *Investing in the World's Health Organization: Taking steps towards a fully-funded Programme Budget 2014-2015*. Financing Dialogue /2. Retrieved September 2, 2014. (http://www.who.int/mediacentre/events/2013/financing-brochure-en.pdf).

[165] For instance, Umberson, Debra, and Jennifer Karas Montez. 2010. "Social Relationships and Health: A Flashpoint for Health Policy." *Journal of health and social behavior* 51(Suppl.):54-66. (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3150158/).

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[167] Gottret, P., and G. Schieber. 2006. *Health Financing Revisited: A Practitioner's Guide*. Washington D.C.: World Bank.

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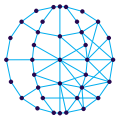

QUEBEC 2014 INTERNATIONAL SUMMIT OF COOPERATIVES

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Better Health & Social Care

How are Co-ops & Mutuals Boosting Innovation & Access Worldwide?

An international survey of co-ops and mutuals at work in the health and social care sector (CMHSC14)

Jean-Pierre Girard
Lead Researcher & Editor

Volume 2: National Cases

With the support of Confcooperative Federazionesanitá, La Fédération des coopératives de services à domicile et de santé du Québec, Desjardins Insurance, International Health Co-operative Organisation, the Chair in Social and Solidarity Economy, NEOMA Business School, Université de Reims Champagne-Ardenne

For the research framework, the analysis of the national cases, and other research components, including a description of the research team members, refer to *Better Health & Social Care.* Volume 1: Report.

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ARGENTINA

2014

HEALTH SYSTEM

The Argentine health system is composed of three sectors: public, social security (obras sociales), and private. The public sector includes national and provincial ministries as well as public hospitals and primary health care units which provide care to the uninsured population. Most of these are informal workers, the unemployed, and poor. It is estimated that the public sector provides care for 40% of the population. This sector is financed with taxes and payments by social security beneficiaries who use public health care facilities. The social security sector covers all workers in the formal economy and their families. Most organizations operate through contracts with private providers and are financed with the payroll contributions of employers and employees. This sector represents approximately 50% of the population. The private sector includes all private providers offering services to individuals, to beneficiaries of social security coverage, and to those with private health insurance, including prepaid medical plans. It provides services to 10% of the population.[1]

Although health care is universal, an estimated 15 million Argentines do not have access to it for reasons of distance, limited financial resources, or availability.[2]

Population (in thousands): 41,087

Population median age (years): 30.83

Population under 15 (%): 24.42

Population over 60 (%): 14.97

Total expenditure on health as a % of Gross Domestic Product: 8.5

General government expenditure on health as a % of total government expenditure: 22.5

Private expenditure on health as a % of total expenditure: 30.8

The cooperative movement in Argentina has a long history, with the first cooperative founded prior to 1900. Cooperatives are economically significant. They are responsible for 10% of GDP, draw together 10 million people, and are active in numerous sectors, including health care.[3] In 2006 more than 8,800 cooperatives were reported. The vast majority are worker cooperatives (59.9%), followed by public services (telephone, electricity, water, etc.); housing, consumer, and supply cooperatives together account for 10-15% of all cooperatives; credit cooperatives and agricultural cooperatives each account for 9% of the total. Medical and dental cooperatives account for only 0.6% of all cooperatives and 0.9% are involved in social assistance including social care. However, 2.2% of all cooperatives (195) reported being engaged in health activities as a primary or secondary function, indicating that cooperatives classified under other sectors are health care actors.

In Argentina mutuals play a larger role in health care than cooperatives do. The National Institute on Associations and Social Economy (Instituto Nacional de Asociativismo y Economía Social, INAES) which collects information on social economy organizations, reported that in 2006 over 1,000 cooperatives and mutuals provided health care services to 2.7 million Argentines. Over 18% of these organizations were cooperatives (195) and nearly 82% were mutuals (861). However, over 90% provided services to fewer than 5,000 people.[4]

HEALTH COOPERATIVES

Health cooperatives complement national health care services by providing low-cost primary care and engaging in health promotion, prevention, curative treatment, and rehabilitation. They provide a wide range of medical services, including but not limited to ambulatory care, dentistry, ophthalmology, and emergency care. They operate blood banks and ambulance services, and run pharmacies and laboratories. They provide nursing and home care, as well as discounts on health supplies, including pharmaceutical products. They also provide prepaid insurance coverage. The majority of services in 2006 were provided through partner health providers, although health cooperatives and mutuals do own and operate their own health facilities.

Service provision	Own facilities	Contracted services
Medical centres and offices	238	568
Hospitals and inpatient facilities	377	597
Pharmacies	111	577
Total	726	1,742

INAES reported that 59 medical and dental cooperatives existed in Argentina in 2006, but that 195 cooperatives were engaged in health activities as their primary or secondary activity.[5]

In 2011, a new law on prepaid insurance enterprises was adopted to regulate private insurers. Initially excluded from its application, ultimately cooperatives and mutuals were also covered. The law provides for equal treatment of for-profit enterprises and cooperatives and mutuals. Both are regulated by the Superintendent of Health Services (SSS) which sets rules on pricing, affiliations, and levels of coverage vis-à-vis the obligatory medical programme (Programa Médico Obligatorio, PMO*)* and financial reserve issues. The cooperative movement has been lobbying the government, claiming that current regulations do not recognize distinctive features of cooperatives and increase the burden upon health cooperatives (tax status), including the imposition of double regulation – reporting to the Superintendent of Health Services and to INAES. Moreover, the movement cautions that the lack of legal clarity with regard to health cooperatives and mutuals has led to a reduction in services, and can ultimately lead to the demise of the sector.[6] In March 2014, a draft resolution of the Chamber of Deputies (Cámara de Diputados de la Nación) requested a report on the impact of the new law. The report is to provide information on a number of entities providing health services. In addition, the report will reflect on the role that cooperatives and mutuals have been playing over the decades, providing health services throughout the country in accordance with a model whereby the members who pay for the service also participate in democratic decision-making.[7]

Health Cooperative and Mutual Data (2006)[8]

	Cooperatives	Mutuals	Total (cooperatives and mutuals)
Number	195 including 59 medical and dental cooperatives	861	1,056
Type	User and Producer	User and Producer	
Members			2.7 million
Services	Obligatory medical programme (Programa Médico Obligatorio)[9] • 39% total • 61% partial	• 19% total • 81% partial	Curative care, rehabilitation, (Ambulatory care, surgical and highly complex care, hospitalization, pharmacy with 60% of services related to general medicine.)
Facilities			377 hospitals, 238 clinics and medical centres, 111 pharmacies
Revenue[10] **ARS**	110,161,987	915,224,367	1,025,386,353
USD (2006 value)	$35.8 million	$298.1 million	$334 million

Case Study

The **Argentine Federation of Solidarity Health Entities** (Federación Argentina de Entidades de Salud Solidaria, FAESS) was created from a collaborative agreement between the Instituto Movilizador de Fondos Cooperativos (IMFC) and the Cooperative Confederation of the Republic of Argentina (Confederación Cooperativa de la Republica Argentina, COOPERAR) to bring together users and producers to develop a cooperative health service model. It currently brings together 66 member organizations, cooperatives, mutuals, and other entities.[11]

FAESS provides high-quality primary care services, treatment, and health education to its members and to clients at reasonable cost. It also engages in promoting cooperative awareness and participation. It does not just provide health services, but also preserves the principles of association and solidarity among its members, both users and producers.

With the support of local cooperatives and municipalities, it has been able to establish 10 primary health care centres.[12] These centres provide services to more than 14,000 people and have created over 100 jobs, including 60 for medical professionals.[13]

In 2012, FAESS reported that since 2000 it had also run over 20 health campaigns to address health risks.[14]

PHARMACY COOPERATIVES

Pharmacy cooperatives play a role in the production, purchase, and distribution of pharmaceuticals in Argentina. They have a long history, starting in 1886.[15] The oldest pharmacy cooperative is **Cooperativa Farmaceutica de Cordoba** Ltda., founded in 1926.[16] The

majority of pharmacy cooperatives, however, were founded in the late 1950s and early 1960s. In 1981 there were 46 pharmacy cooperatives with 6,440 member pharmacies.[17] According to INAES, 18 such cooperatives are currently active. They service nearly all the 12,000 pharmacies currently active in Argentina.[18]

Partial data on membership and employees was obtained as per the table below.

Name of cooperative	Member pharmacies	Employees
Cooperativa Farmacéutica de la Provincia de Buenos Aires (ACOFAR Farmacéutica)	850	169
Asociación de Propietarios de Farmacias Cooperativa de Provisión Limitada (ASOPROFARMA LTDA)[19]	1,500	
Cooperativa de propietarios de farmacias de Lomas de Zamora. de Provisión, Consumo, Edificación, Crédito, Servicios Asistenciales y Sociales (COFALOZA LTDA)	285	
Cooperativa Farmacéutica de Provisión y Consumo Alberdi Ltda (COFARAL LTDA)[20]	1,000	140
Cooperativa Farmacéutica Mendoza Ltda (COFARMEN LTDA)[21]	600	200
Cooperativa Farmacéutica Ltda (COFASA)[22]	400	
Cooperativa Farmacéutica del Litoral Ltda.		76

SOCIAL CARE COOPERATIVES

Social care cooperatives are in part covered by the data on health cooperatives whose service repertoire includes social care. In addition, cooperatives of health professionals in such areas as home care also fall under the category of health cooperatives.

There are however other cooperatives (particularly worker cooperatives of persons with disabilities) which provide opportunities for income generation and social inclusion. Government support for worker cooperative initiatives of all types is currently available under the "Argentina Trabaja" programme launched in 2009. It has already led to the establishment of more than 6,000 cooperatives. The movement has been critical of the programme, claiming that the majority of these cooperatives are not sustainable.[23] Nevertheless, the programme has led to the establishment of new cooperatives for disabled persons (e.g., Devoto, which brings together a group of young people in the province of Cordoba) and an elderly care cooperative[24] in the province of Salta in 2013.

INSURANCE COOPERATIVES

The health insurance cooperative **Sancor Seguros**, reported to have 3.14 million members in 2011, provides a range of insurance products through the Sancor Seguros Group in Argentina and in neighbouring Paraguay and Brazil. It holds 10% of the national insurance market.[25] It provides complementary health insurance, accident and occupational health insurance, and its life insurance plans include basic health care coverage.

In March 2014, Sancor Seguros launched Prevention Health (Prevención Salud), a new comprehensive health insurance product. Prevention Health offers a total of seven plans, ranging from an initial co-payment option, which guarantees all the benefits under the compulsory medical plan, to the most complete plan with premium coverage. One plan is specifically designed for young people 18-25 years in age, while another offers comprehensive corporate plans for employees.[26]

MUTUALS

In Argentina, the development of mutuals is linked to immigrants from Spain, Italy, Portugal, France, and Germany. They started the mutual aid organizations (socorros mutuos) which evolved into today's mutual associations. The first mutual was established in 1854 in Buenos Aires by French immigrants – l'Union et Secours Mutuels (La Unión de Socorros Mutuos). It is still in operation, providing both health services and social services.

Mutuals are regulated under Law 20.321 and supervised by INAES. It reports that there are 4,200 registered mutuals with a total of over five million members,[27] who benefit from a wide range of services. The majority provide multiple services, health care, consumer goods (including pharmaceuticals and health insurance), funeral services, as well as travel and recreational services, housing, and social services.

Mutuals are well organized, with a confederation that was founded in 1953 and today encompasses 30 mutual federations. There is also a federation of health mutuals, Federación Argentina de Mutuales de Salud (FAMSA). It was established in 1991 and has 33 members.[28]

In 2006 there were 861 mutuals specifically providing health services, and nearly 1,000 providing health and social care-related services (pharmacy, nursing, home care, ambulance services, etc.).

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AUSTRALIA[1]

2014

HEALTH SYSTEM

The Australian Government provides a basic universal health insurance called Medicare, a scheme established in 1984.[2] Private health insurance in Australia generally provides services not covered by Medicare or services provided in private hospitals. "While most Australians choose to be covered under Medicare only, many also choose to augment that coverage with private health insurance cover."[3]

In 2011-12, governments provided $90.9 billion USD (97.8 billion AUD) or 69.7% of total health expenditure in Australia. The contribution of the national government to that total was $55.3 billion USD (59.5 billion AUD, 42.4%) and state and territory governments contributed $35.6 billion USD (27.3%). Non-government funding sources (individuals, private health insurance, and other non-government sources) provided the remaining $39.2 billion USD (42.4 billion AUD, 30.3%).[4]

At the federal level, health expenditure by the Australian government increased steadily throughout the period from $25.8 billion USD (27.8 billion AUD) in 2001-02 to $55.3 billion USD (59.5 billion AUD) in 2011-12.[5] The ratio of health expenditure to revenue for the Australian government increased from 22.4% in 2001-02 to 26.4% in 2011-12. At the local level, during the same period, health expenditure by the state and local governments grew from $13.7 billion USD (14.7 billion AUD) to $35.6 billion USD (38.3 billion AUD), an average annual growth rate of 10.1% per year.[6] The ratio of health expenditure to revenue for the state and local governments rose from 16.4% to 24.5% in one decade.

Population (in thousands): 23,050

Population median age (years): 37.08

Population under 15 (%): 18.95

Population over 60 (%): 19.46

Total expenditure on health as a % of Gross Domestic Product: 9.1

General government expenditure on health as a % of total government expenditure: 17.8

Private expenditure on health as a % of total expenditure: 33.1

In 2013, 34 private health insurers were registered in Australia under the Private Health Insurance Act 2007 (PHI Act), including eight for-profit insurers and 26 not-for-profit insurers.[7] It is estimated that 31.6% of hospital treatment policyholders have coverage from a not-for-profit insurer.[8] Besides, not-for-profit insurers make up about 30% of the private health insurance industry, based on policies covered.

From 2001-02 to 2011-12, private health insurance funding per person increased on average between 1.6% and 4.0% each year in all states and territories, with Victoria having the fastest growth (4.0% per year) and the Northern Territory the slowest (1.6% per year).[9] During 2012 and 2013, the number of insured people in the private health insurance industry increased at a rate of 2.9%, and the insured population taking up private health insurance has expanded to 54.9% of the total population.

There are basically two types of private health insurance, namely, hospital policies and general treatment policies (also called ancillary or extras, covering such ancillary treatment as dental, physiotherapy, etc.). Most health insurers offer combined policies that provide a packaged cover for both hospital and general treatment services.[10] At the end of 2012-13, 47.0% of the Australian population was covered for hospital treatment by a private health insurance policy and 54.9% was covered by a general treatment policy. 85.5% of insured persons are insured for both hospital and general treatment policies.[11]

During 2012-13, the total cost of privately-insured services was covered by three main sources: benefits provided by private health insurance ($14.229 billion USD, 68.3%), benefits provided by Medicare ($2.209 billion USD, 10.6%), and payments by patients ($4.391 billion USD, 21.1%).[12]

HEALTH COOPERATIVES[13]

In Australia, there are currently two health cooperatives and 15 not-for-profit health mutual organizations with open access. In addition, it is estimated that there are 30 pharmacy cooperatives providing retail pharmacy stores, and nine cooperative hospitals, of which four are private hospitals and the remaining five are small public hospitals.[14]

The first Australian health cooperative, Westgate Health co-operative, emerged in 1980. It was initiated by a group of residents in the low-income area of South Kingsville/Spottswood, in Melbourne's West. Twenty years later, residents in a disadvantaged outer metropolitan area of Canberra launched a similar initiative, which by 2006 had developed into West Belconnen Health Co-operative Ltd. Since then it has changed its name to the National Health Co-operative.

Health Cooperative Data (as of June 2014)

Number of cooperatives	2
Types of co-operative	User
Number of members	＞32,000
Number of employees	105 Doctors and nurses: 58 Other health professionals: 10 Others: 37
Users	N/A
Services	Includes primary care, immunization, minor surgical procedures, dental care, allied health Illness/accident prevention (1) Wellness and health promotion (0) Treatment and cure (2) Rehabilitation (2)
Facilities	7 clinics
Annual turnover:	N/A

Case Study

The first Australian health cooperative, **Westgate Health co-operative**,[15] was initiated in 1980 by a group of residents of the low-income area of South Kingsville/Spottswood, in Melbourne's West. Their main motivation was concern over a lack of bulk-billing medical services in their neighbourhood. They were soon able to attract a general practitioner[16] and decided to develop their own health service. It is a registered community cooperative. For Westgate, the principle of cooperation is the organization philosophy. This refers to cooperation between patients and health professionals on the one hand, and on the other hand, cooperation in the governance and support of the organization between staff, management, and members.

Over the last 30 years, the organization has grown substantially. Up until 2013 there were over 8,000 members, and Westgate operated two centres, South Kingsville and Newport. The organization provides a wide range of health services by employing over 30 staff and doctors, as well as other practitioners of allied health (including psychology, physiotherapy, acupuncture, podiatry, diabetes education, mental health, and nutrition).

People in Westgate regard their organization as unique. In particular, they believe the cooperative model of operation makes it possible for the organization to provide user-owners with high-quality health care. For the same reason, they have recently carried out a patient survey with the purpose of improving the services provided. In 2012, the board also made a commitment to improve communication with its members. One year later, a new website had been launched, offering members personalized logins and a wider range of online services (such as online payments). By putting members first, Westgate has experienced a steady growth in membership. In 2013, an additional 406 members joined the organization, for a total of 8,112. It is also worth noting that Westgate offers four membership types: family concession (accounting for 13% of total members in 2013), family waged (35%), single concession (22%), and single waged (30%). Normally, Westgate members pay a one-off joining fee of $27.90 USD per family, then an annual fee of up to $46.50 USD per person or $83.70 USD per family.[17]

As members of Westgate, the clients can benefit from a wide range of personal supports, such as one free dental check-up per year, discounts on dental services and allied health services, bulk-billing for medical services, etc. Besides, they become able to engage in local community health issues and in strengthening community supports for healthy lifestyles. With the involvement of its members, Westgate supplies other services for community development from time to time, such as free transport, counselling, and a "casserole bank" for patients, particularly mothers.[18] In this way, they also can enjoy a sense of community ownership and control, which is another way to show the uniqueness of Westgate. As the first medical service of its kind in the country, Westgate was "crucial to the subsequent formation of Canberra's West Belconnen Health Co-operative and remains willing to support other communities looking to follow its example."[19]

As a non-profit organization, Westgate does not divide any surplus, which is used to develop the mission and services of the cooperative. Finally, it should be mentioned that Westgate receives no public funding. It relies on membership fees, bulk-billing rebates, and fees for service. Membership fees are further structured to optimize access to health services for low-income clients and members.

SOCIAL COOPERATIVES

Social cooperatives have been developing rapidly in Australia. Nowadays there are numerous social cooperatives providing a wide range of services and activities to their members or their communities, such as primary health care, home care, aged care, disability support services, and community support services.

One type of social cooperative peculiar to Australia is the aboriginal medical services cooperative. Since its emergence in the early 1970s, the first aboriginal medical service cooperative in Australia now has already more than 40 years of history. Although indigenous Australians have typically more health problems than non-indigenous Australians, 40 years ago it was recorded that they were poorly treated and the medical services available or open to them were rather limited. During the past four decades of development, Aboriginal Medical Service has been "joined by 200 aboriginal medical services throughout Australia."[20] They provide affordable and professional services to local indigenous communities, ranging from clinical and primary health care and home care to health promotion and community aged care. In many cases, they provide combined services. In this sense, they should also be regarded as multipurpose cooperatives.

Field of activity	Aboriginal medical services, primary health care, home care, aged care, disability support services, community support, etc.
Number of cooperatives	34
Type of cooperative	N/A
Number of members	N/A
Number of users	N/A
Annual turnover	N/A

Another type of social cooperative focuses on providing aged care or disability support. These organizations operate both in a classical and an innovative way of cooperation. One innovative example is Radio for the Print Handicapped Co-operative. Formally registered in 1979, this cooperative provides a radio reading service for people who cannot see, handle, or understand printed material. It provides its service 17 hours a day from seven stations around Australia (Melbourne, Canberra, Sydney, Brisbane, Adelaide, Perth, and Hobart). As part of this organization, Radio for the Print Handicapped of New South Wales has been broadcasting in Sydney since 1983. According to its website,[21] besides the print handicapped, people from a non-English speaking background are among the listeners.

Finally, although not classified as health cooperatives, some social cooperatives also specialize in providing medical and other health care services. Some examples are Sydney Medical Service Co-operative Ltd and Wollongong Medical Service Co-operative Ltd, which offer doctor home visits and/or treatment of acute illnesses after hours to their members and clients.

MUTUALS

In Australia, there were 26 registered not-for-profit insurers at the end of June 2013, including 15 with open access and 11 with restricted access.[22] It is estimated that 92.9% of hospital treatment policyholders in Australia have coverage provided by insurers with open access.[23]

SOURCES

[1] A more detailed version of this case is available upon request.
[2] Previously, another arrangement called "Medibank" was introduced in 1975 to provide universal funding for public hospital treatment and medical costs. It was abolished in 1978. See Private Health Insurance Administration Council (PHIAC). 2013a. "The Operations of Private Health Insurers Annual Report 2012-2013." Canberra: PHIAC. (http://phiac.gov.au/wp-content/uploads/2013/12/2012-13-accessible-pdf.pdf). P. 4.
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[5] AIHW 2013:15.
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[7] Not-for-profit insurers face a different tax environment, being exempt from company tax and retaining the GST-exempt status applying within the industry as a whole. But there are much stronger restrictions on the nature and type of investments that may be made by not-for-profit insurers. PHIAC. 2013b. "Competition in the Australian Private Health Insurance Market." Canberra: PHIAC. Research Paper 1. (http://phiac.gov.au/wp-content/uploads/2013/12/PHIAC_Research_Paper_No1-new-format.pdf). P. 31.
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[14] Information provided by Mr. Vern Hughes, Director of the Centre for Civil Society in Australia, http://www.civilsociety.org.au/Director.htm.)
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[17] Derby 2012.
[18] Derby 2012.
[19] Derby 2012.
[20] Derby, Mark. 2014. "The kinship tradition." International Co-op Alliance. (http://ica.coop/en/media/co-operative-stories/kinship-tradition).
[21] R2PH Mobile. 2014. Website. (http://2rphv2.gingerfever.com/index.php/faq/about-us/item/what-is-radio-2rph-3).
[22] In Australia, private health insurers can be registered as an open or restricted fund, and as a for-profit or not-for-profit fund. According to PHIAC (2013a:13), "An open access insurer allows anyone to join, whereas the products of a restricted access insurer are limited to people belonging to a particular group, which are usually employer, trade, industry, professional association or union based." The first for-profit private health insurers began operation in 1989 (PHIAC 2013b:30).
[23] PHIAC 2013a:13.

BELGIUM

2014

HEALTH SYSTEM[1]

The Belgian health system is mainly organized on two levels, federal and regional. Since 1980, part of the responsibility for health care policy has been devolved from the federal government to the regional governments. The federal government is responsible for the regulating and financing of the compulsory health insurance. The regional governments are responsible for health promotion.

The Belgian health system is based on the principles of equal access and freedom of choice, with a Bismarckian type of compulsory national health insurance. It covers the whole population and has a very broad benefits package. Compulsory health insurance is combined with a private system of health care delivery, based on independent medical practice, free choice of service provider, and predominantly fee-for-service payment. All individuals entitled to health insurance must join or register with a sickness fund.

Patients in Belgium participate in health care financing 1) via co-payments, for which the patient pays a fixed amount of the cost of a service, with the third-party payer covering the balance of the amount; and 2) via co-insurance, for which the patient pays a fixed proportion of the cost of a service and the third-party payer covers the remaining proportion. There are two systems of payment: 1) a reimbursement system, for which the patient pays the full costs of services and then obtains a refund for part of the expense from the sickness fund, which covers ambulatory care; and 2) a third-party payer system, for which the sickness fund directly pays the provider while the patient only pays the co-insurance or co-payment, which covers inpatient care and pharmaceuticals.

Population (in thousands): 11,060

Population median age (years): 41.41

Population under 15 (%): 16.88

Population over 60 (%): 23.81

Total expenditure on health as a $ of Gross Domestic Product: 10.8

General government expenditure on health as a % of total government expenditure: 15.0

Private expenditure on health as a % of total expenditure: 24.1

Health care in Belgium is sponsored by competing mutual health associations and is provided by a mixture of public and non-profit hospitals. The government pays each mutual health association depending upon the number of registered members. Most of the mutuals are historically affiliated to a political institution. However, there is no substantive difference between them as reimbursement rates are fixed by the Belgian government. Insurance funds do not cover 100% of the patient's bills. The typical reimbursement is between half to three-quarters of a typical doctor or specialist fee. Insured citizens have a standardized credit-cart style "SIS" card, which is mandatory in pharmacies and hospitals.

HEALTH CO-OPS

In Belgium, there is a strong cooperative movement. In 2011, the country had more than 26,000 cooperatives representing 5% of GDP. Most of the cooperative societies are found in the Walloon region. The province of Liege tops all Belgian provinces in terms of the number of cooperatives. Since the 1991 reform, the "cooperative society" legal form has variants: SCRL (limited liability) and SCRI (unlimited liability).

Belgium has many cooperative professions including doctors, specialists, dentists, etc. The cooperative form offers more flexibility on how to join and exit. Companies with a social purpose (SFS) also appeared in 1995. There were 31 SFSs in 2011. Three-quarters of SFSs are cooperatives. In the health sector the SFS are also present, as the example of the Entente Jolimontoise demonstrates (healthcare and welfare). (See Table 1, next page.) Even if SFSs are not registered under co-op law, the medical clinics ("maisons médicales") have a lot of similarities to co-ops.[2]

In Flanders, "the healthcare sector from a cooperative perspective is a virtually untapped market niche."[3] Private companies are the main actors in this area, where health care cooperatives are held in deep "suspicion."[4]

SOCIAL CARE CO-OPS

Social care cooperatives have emerged in the past years in Belgium, although few examples were found during this study. A nurse cooperative, "Soignon'Sympa," was identified. It provides care and domiciliary services and is a producer-based cooperative. (See Table 1, next page.)

Social care cooperatives are also found in the form of "intercommunals" (intercommunales). In Belgium, intercommunal organizations are cooperatives created by cities or institutions that collaborate in the management of public social services (e.g., water management). Ten intercommunal health and social care organizations were identified. All are multistakeholder cooperatives; both public and private entities sit on their boards. They manage hospitals and/or social and medical services.

For example, the Intercommunale de Santé Publique du Pays de Charleroi manages a public hospital, three clinics, a daycare centre, a nursery, and a youth centre. The Intercommunale Centre d'Accueil "Les Heures Claires" offers rehabilitation and social care services for elderly and handicapped people as well as for long-term and convalescent patients. The Association Intercommunale de Santé de la Basse-Sambre operates a hospital, a clinic, two long-term centres, a centre for drug addicts, and a social care centre. It also offers domiciliary and therapy services. The Intercommunale de Soins Spécialisés de Liège operates psychiatric and geriatric centres as well as centres for the elderly (long-term and retirement). The CHU Ambroise Paré operates four hospitals.

Two cooperatives in Flanders were also identified: Inclusie Invest and Biloba huis. Inclusie Invest is a cooperative that builds "custom living arrangements for people with disabilities."[5] Biloba huis is a cooperative project whose goal is to provide "housing for seniors and a caring living space for the residents"[6] and to prevent financial insecurity.[7]

Table 1: Health & Social Care Cooperatives

Name of cooperative	Type			Members	Employees					Types of service			
	User	Producer	Multistakeholder		NB	Doctors	Nurses	Other health prof	Others	Illness & accident prevention	Wellness & health promotion	Treatment and cure	Rehabilitation
Soignon'Sympa[8]		X		N/A	N/A		X			X	X	X	X
Intercommunale de Santé Publique du Pays de Charleroi[9]			X	N/A	N/A	X	X	X	X	X	X	X	X
Entraide Jolimontoise[10]			X	N/A	N/A	X	X	X	X	X	X	X	X
Intercommunale Centre d'Accueil "Les Heures Claires"[11]			X	N/A	N/A	X	X	X	X		X	X	X
Association Intercommunale de Santé de la Basse-Sambre[12]			X	N/A	N/A	X	X	X	X	X	X	X	X
Centre Intercommunal Universitaire Ambroise Paré (Société Intercommunale)[13]			X	N/A	1,810	260	X	X	X	X	X	X	X
Intercommunale de Soins Spécialisés de Liège (Société Intercommunale)[14]			X	N/A	N/A	X	X	X	X	X	X	X	X
Centre Hospitalier Régional de Huy[15]			X	N/A	N/A	X	X	X	X	X	X	X	X
Association Intercommunale Hospitalière du Sud-Hainaut et du Sud-Namurois[16]			X	N/A	N/A	X	X	X	X	X	X	X	X
Vivalia[17]			X	N/A	3,600	400	X	X	X	X	X	X	X
Intercommunale d'œuvres médico-sociales des arrondissements de Tournai-ATH-Mouscron			X	N/A	N/A		x	x	x	x	x	x	X
Inclusie Invest			X	N/A	N/A						X		x
Biloba huis			x	N/A	N/A					x	x		x

PHARMACY CO-OPS

Distribution of drugs is one of the pillars of the cooperative movement in Belgium. According to the federation OPHACO, cooperative pharmacies have a market share of about 20% in Belgium. Many of these cooperatives opted for the cooperative form, either under the legal framework of limited liability or Cooperative Society (SC). Febelco is the largest wholesale distributor of drugs in Belgium with a market share of over 35%. It has more than 2,500 clients.

HEALTH MUTUALS

Health mutuals are a key component of Belgium's health care system. They act as an interface between the National Social Security Institution (l'Institut National d'Assurance Maladie-Invalidité, INAMI) and citizens.[18] They also offer complementary health plans and social services like domiciliary care.

Health mutuals are organized in five national networks.[19] These networks operate multiple regional offices (from 6 to 19 regional mutuals in some cases). Collectively they have 12,864 employees[20] and 10,834,186 users. In addition to providing reimbursement, they offer complementary health plans as well as domiciliary and other care services. Some of them also offer social services, such as legal aid or support groups for youth. One mutual, Mutualité Socialiste du Brabant, also operates 14 medical clinics. These clinics served 609,465 users in 2013.[21]

Table 2: Top 10 Pharmacy Co-ops in Belgium[22]

Rank	Name	Legal status	Region
2	Febelco	SCRL	Flanders
12	Multipharma	SCRL	Capital Brussels
29	L'Economie Populaire (E.P.C)	SCRL	Walloon
32	ESCAPO	SCRL	Flanders
77	SCRL Royale des Pharmacies Populaires de Verviers et Arrondissement	SC	Walloon
84	MSF Supply[23]	SC	Capital Brussels
95	Vooruit Nr 1	SCRL	Flanders
100	Pharmacies du Peuple Réseau Solidaris	SCRL	Walloon
102	Pharma Santé-Réseau Solidaris	SCRL	Walloon
118	De Voorzorg	SCRL	Flanders

Table 3: Health Mutual Organizations

Name of cooperative	Number of mutuals[24]	Number of members (2013)	Number of employees	Brief description
Alliance nationale des mutualités chrétiennes/ Landsbond der christelijke mutualiteiten[25]	19 regional mutuals	4.543.819[26]	6,178	Provides complementary health plans and offers domiciliary services and health-related workshops.
Union nationale des mutualités neutres/ Landsbond van de neutrale ziekenfondsen[27]	7 regional mutuals	497.925	748	Provides complementary health plans and social and medical services (e.g., legal aid).
Union nationale des mutualités socialistes/ Nationaal verbond van socialistische mutualiteiten	11 regional mutuals[28]	3,111,616	N/A	Provides complementary health plans, domiciliary services, and social and legal services. One mutual (Mutualité Socialiste du Brabant) operates 14 medical clinics with different health professionals (general practitioner, ophthalmologist, dentist, etc.).[29]
Union nationale des mutualités libérales/ Landsbond van liberale mutualiteiten[30]	10 regional mutuals	575,798	N/A	Provides complementary health plans and offers domiciliary services, health-related workshops, and social services.
Union nationale des mutualités libres/ Landsbond van de onafhankelijke ziekenfondsen[31]	6 regional mutuals	2,105,028	N/A	Provides complementary health plans and offers care services and health-related workshops/support.

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BENIN[1]

2014

HEALTH SYSTEM

The data related to the health system in Benin poses some challenging issues linked with the question of accessibility to health services. In 2000, only 5% of the economically active population in Benin had health care coverage. Based on 2004 data, 52% of the total expenditure in health was by households and 76% of these expenses were for pharmaceuticals. Up to 37% of the population lives in poverty.

A 2014 report from the World Health Organization (WHO) states that, "A STEP study conducted in 2008 has clearly demonstrated that non communicable diseases are a real public health threat, but adequate policies and strategies to tackle the issue are still to be adapted and implemented in the country. Moreover, there "is an inequality between rural and urban areas as well as between the different poverty quintiles."[2]

In 2011, Benin launched a universal health coverage program under the name Régime d'assurance maladie universel (RAMU) with the support of many international financial and technical partners (PTF).[3] Nevertheless, "The development of the last triennial plan 2013-2015 has just been completed. Out of the 34 health zones, 30 are fully functional at the moment. Health coverage is quite high at 77%, although this rate covers inequity in the distribution of the health centres, rural areas being less provided with health services. On the other hand, despite the availability, the utilization rate is quite low at 44%."[4]

Population (in thousands): 10,051

Population median age (years): 18.3

Population under 15 (%): 42.95

Population over 60 (%): 4.54

Total expenditure on health as a % of Gross Domestic Product: 4.5

General government expenditure on health as a % of total government expenditure: 10.3

Private expenditure on health as a % of total expenditure: 48.5

HEALTH COOPERATIVES

Two bodies supporting health cooperatives have been identified.

The **Collectif des cliniques coopératives de santé du Bénin** (CCCB), founded in 1992 and comprising nine cooperative health clinics in six departments. All are producer-owned cooperatives, i.e., they are owned by doctors and nurses. Their intention is to provide comprehensive health care, including preventive health care and promotion activities. The cooperatives received start-up grants from both the United Nations Development Programme (UNDP) and WHO. Currently they employ 200 health care providers, who are also members of the cooperative. Approximately 50,000 people use its facilities every year.

The CCCB's main purpose is to act as a hub at which the member cooperatives can exchange experiences and resolve challenges. It is financed by the monthly fees of its member organizations. One of its main functions is to provide temporary administration of cooperatives which experience management difficulties. In addition, it serves as central point of contact between the cooperatives and the authorities. However, a study by the International Health Cooperative Organisation (IHCO) indicates that the engagement of the clinics with the CCCB is declining.

The government played an important role in the facilitation of cooperatives by establishing the legal framework for public-private cooperative partnership, mediating with health care professionals and signing agreements with such international organizations as the UNDP and the WHO. However, the IHCO study indicates that currently the CCCB and the authorities disagree regarding plans to enlarge and extend the project. Unfortunately, the study fails to explain why there is this disagreement.[5]

A programme of the **Cooperative Pan-African Conference** (CPC)[6] to promote Clinic Health Cooperatives (CHCs) has been implemented in Benin. A CHC is a private clinic founded by graduates of the health sector and other related sectors. It is a team of about a dozen people who organize themselves to provide quality services at affordable prices to lower-income populations. Generally, they are excluded from services of private health facilities and anxious to avoid the bad reception and poor quality of service available from the public sector.

The focus of the CHC is clinical: primary health care (preventive service, curative, and promotion). Specifically, it involves general medicine, maternal health (labour and consultation, pre- and postnatal), laboratory services, and social services. Depending on the needs of its customers, the CHC can provide the services of external specialists.

In 2014, there are nine CHCs in Benin with beneficiaries who number approximately 500. The annual turnover of a well-managed CHC may be in the order of $2,000-3,000 USD.

MUTUAL HEALTH ORGANIZATIONS[7]

In its 2009 Regulations the West African Economic and Monetary Union (WAEMU) defines the Mutual Health Organization (MHO) as a social group which, through contributions from its members, proposes to conduct in their interest and in the interest of their assigns an action of foresight, support, and solidarity for the prevention of social risks related to the person and to repair their consequences.

Data concerning MHOs in Benin have been collected from an interim (unpublished) report prepared by BlueSquare, a Belgian NGO.[8] In 2012, 308 MHOs were identified across the country. The following table gives the distribution of MHOs (all producer organizations) across the different departments of Benin. In addition, there are in total just over 108,000 MHO members in Benin, who have registered nearly 600,000 beneficiaries.

Department	Number of registered MHOs	Number of members	Number of beneficiaries
ALIBORI	46	7,125	27,045
ATACORA	36	9,352	26,869
ATLANTIQUE	26	11,787	54,353
BORGOU	31	15,515	256,122
COLLINES	60	12,791	81,339
COUFFO	18	3,716	6,612
DONGA	16	6,087	25,149
LITTORAL	1	8,040	14,568
MONO	22	12,246	44,947
OUEME	11	6,237	23,486
PLATEAU	3	2,131	2,605
ZOU	38	13,237	35,399
TOTAL	308	108,264	598,494

Coverage Rate

Based on the preliminary results of the 2013 general census of population and housing, MHOs in Benin cover about 6% of the total population. Coverage drops to 1.3 % if we take into account only those beneficiaries who are up to date with their monthly contributions.

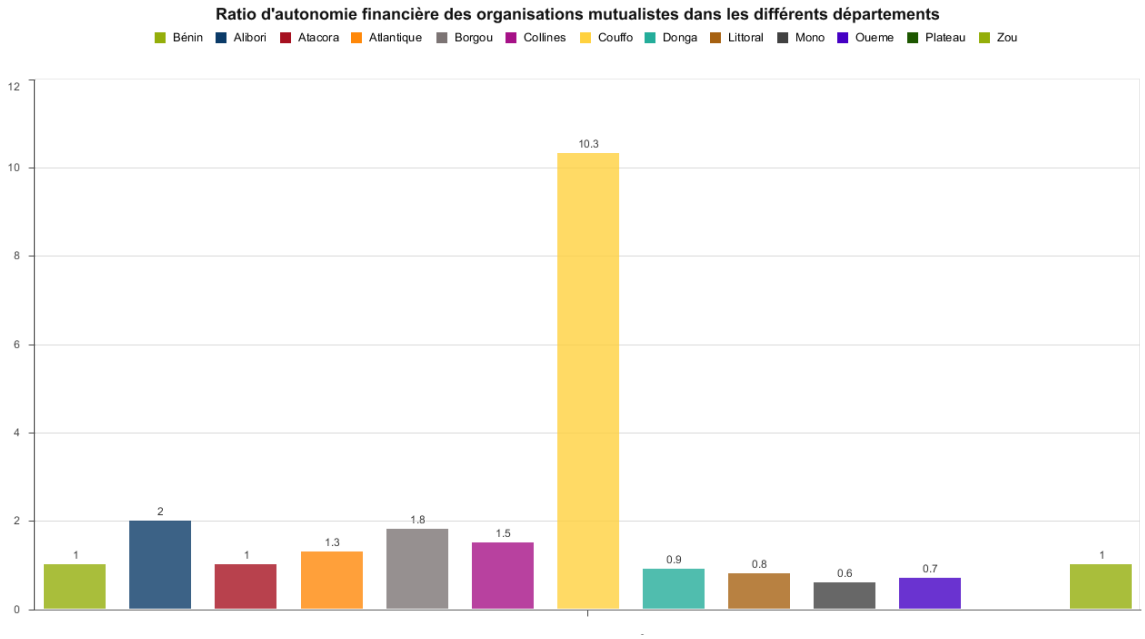
Maintaining continuous financial contributions from members remains a huge challenge in Benin. Indeed, it should be noted how small a number of beneficiaries had their dues paid-up in late 2012: about 125,000 (21%) had actually made their contribution. The following table shows the distribution of beneficiaries and paid-up beneficiaries across the country's various departments.

Department	Beneficiaries	Beneficiaries up to date with contributions	% beneficiaries up to date with contributions
ALIBORI	27,045	5,888	22%
ATACORA	26,869	13,291	49%
ATLANTIQUE	54,353	4,947	9%
BORGOU	256,122	21,459	8%
COLLINES	81,339	8,851	11%
COUFFO	6,612	618	9%
DONGA	25,149	21,034	84%
LITTORAL	14,568	9,760	67%
MONO	44,947	8,518	19%
OUEME	23,486	5,801	25%
PLATEAU	2,605	1,950	75%
ZOU	35,399	23,098	65%
TOTAL	598,494	125,215	21%

Financial Viability

Financial Autonomy Ratios are used to assess the ability of MHOs to fund their activities on the basis of the fees collected from their members. The ratio is calculated at 1 for the country as a whole (just consistent with WAEMU standards).[9] WAEMU recommends that this ratio should be greater than or equal to 1. The figure on the next page shows the ratios of financial viability per department.

However, MHOs also receive financial assistance from donors. The total amount of grants received in 2012 was approximately $180,000 USD. The table on the next page also shows the percentage of that total received in each of Benin's departments. Note that some MHOs have received no assistance while others have received a great deal.



Department	Total grants received (in USD)	Geographical Distribution of grants (%)
ALIBORI	1,505.89	0.83%
ATACORA	45,569.38	25.17%
ATLANTIQUE	3,810.60	2.10%
BORGOU	17,190.07	9.49%
COLLINES	5,267.74	2.91%
COUFFO	6,105.41	3.37%
DONGA	63,618.89	35.14%
LITTORAL		0.00%
MONO	16,975.68	9.38%
OUEME		0.00%
PLATEAU		0.00%
ZOU	21,022.29	11.61%
Total	$181,060.78	100.00%

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[7] For more details on MHOs in Benin, contact Mr. Koto Yérima Aboubacar, Coordinator Promusaf-Benin kotoyerimaa@yahoo.fr
[8] Blue Square. 2014. Website. Retrieved August 19, 2014 (http://www.bluesquare.org).
[9] See Annex 6 on this subject in Volume 1: Report.

BOLIVIA (Plurinational State of) 2014

The Bolivian constitution ensures access to universal and free health care. However, the health care system is organized into two main sectors, public and private, and does not cover the majority of the population. The public sector, i.e., the Ministry of Health, serves less than half the total population. The private sector provides services to 10% of the population and works primarily on the basis of direct out-of-pocket payments. About 30% of the population has access to health care that is offered by practitioners of traditional medicine in return for a fee.[1]

Bolivian labour law, applicable to all enterprises, allows the formation of cooperatives to provide medical and pharmacy services, obligatory and free dental services, childcare (obligatory for enterprises with more than 50 employees), child health care, recreation, education, and nutrition.[2] Cooperative legislation also specifically mentions health cooperatives and the ability to form cooperatives to address social needs.[3]

Cooperatives in a variety of sectors, including health, savings and credit, agriculture, and mining, facilitate access to health care. Cooperatives have been identified that provide health care, operate clinics and pharmacies, or offer health insurance or care for members, as well as loan products to defray health costs.

The largest number of cooperatives is found in the mining sector. In 2010 it was estimated that these represented 49% of the cooperative sector, followed by agricultural, transport, service, savings and credit, cooperatives active in other areas, and finally telecommunication cooperatives (about 1% of the movement). In terms of membership, the largest cooperatives are in the service sector. The most recent membership statistics indicate that 2.28 million people in Bolivia are members of a cooperative.[4]

Population (in thousands): 10,496

Population median age (years): 22.14

Population under 15 (%): 35.23

Population over 60 (%): 7.28

Total expenditure on health as a % of Gross Domestic Product: 5.8

General government expenditure on health as a % of total government expenditure: 9.5

Private expenditure on health as a % of total expenditure: 28.3

HEALTH COOPERATIVES

One health cooperative was identified, the Cooperativa de Salud Almed Ltda in Santa Cruz. No statistical data was found.

Case Study

Cooperativa de Salud Almed Ltda in Santa Cruz was founded in March 2003. It provides services through 73 doctors who have 39 medical specialties, including general medicine, cardiac, plastic, vascular and pediatric surgery, gynecology and obstetrics, pediatrics, oncology, neurology, otorhinolaryngology, rheumatology, radiology, traumatology, psychology, pulmonology, urology, nephrology, biochemistry, pathology, ophthalmology, orthodontic care, nutrition, nursing, and home care.

It offers preventive, curative, and rehabilitative care. It specializes in allergology, anaesthesiology gastroenterology and digestive care, cardiology, endocrinology, geriatrics, haematology and hemotherapy, medical hydrology, infectious diseases, sports, occupation, family and community medicine, internal, intensive and preventive medicine, nephrology, pulmonology, neurology, nutrition, medical and radiation oncology, paediatrics, psychiatry, rheumatology and rehabilitation. In addition to providing health care services, it operates a clinical laboratory.

The cooperative has formed alliances with clinics and pharmacies where members are provided with access at discounted rates.[5]

SAVINGS & CREDIT COOPERATIVES

The largest savings and credit cooperative in Bolivia, **Cooperativa de Ahorro y Crédito Jesús Nazareno Ltda**, has made health care a priority since its foundation in 1964. It has provided members with health care free of charge for nearly 40 years. Shortly after its foundation, its members had access to medical consultations with health professionals in three specialties and benefited from a 50% discount on pharmaceutical products. In 1989, it established it own pharmacy. It has operated a state-recognized clinic in Santa Cruz for over 10 years where members access general medical care as well

as paediatric, gynaecological, and orthodontic care at no cost. Today, it operates in total four medical centres including an infirmary and pharmacy, and serves more than 100,000 members.[6]

The Cooperativa de Ahorro y Crédito Abierta "San Martín de Porres" COSMart Ltda offers its members and their families health care through the Cooperativa de Salud Almed Ltda. In addition, it organizes health campaigns for the general public in the community of San Martín de Porres. Health professionals provide preventive care (checking sugar levels and blood pressure), provide basic health care, and undertake health promotion.[7]

OTHER COOPERATIVES

Other cooperatives facilitate or have facilitated access to health care.

For example, the multipurpose agricultural cooperative, Cooperativa Agropecuaria Integral San Juan de Yapacaní (CAISY), was founded over 50 years ago by Japanese immigrants. It provides health and accident insurance to the 103 members and employees and their families. Members can also access loans for exceptional health costs.[8]

In Oruro, the multipurpose mining cooperative, Cooperativa Multiactiva Corazón de Jesús, established a health centre. It is staffed by a doctor, an orthodontist, and two nurses to provide health care to members as a consequence of the poor treatment miners received in public health institutions.[9]

SOCIAL COOPERATIVES

Many of the social cooperatives are production cooperatives formed by vulnerable populations as a means of improving their economic and social situation. A majority of the social cooperatives identified were worker cooperatives in which employment was the key objective.

In 2005, an association to promote social cooperatives, Desarrollo de cooperativas sociales (DESCOOPSO), was founded to promote skills development and employment competencies for marginalized or vulnerable groups. Its members are five social cooperatives (production cooperatives) formed by individuals with disabilities and their families to create employment.

In addition, with the assistance of the Ministry of Labour, Employment, and Social Security, a number of new worker production cooperatives have been formed by persons with disabilities in order to provide employment. Since 2010 the Ministry has provided training in support of groups of persons with disabilities. In 2010, three new cooperatives (bakery, textile production, and handicraft) in the Oruro region were registered. Each was founded with 30 members.[10] In 2011, under the Ministry's programme to improve the productive capacity of persons with disabilities through training (Fortalecimiento con Capacitación y Producción a Personas con Discapacidad), 645 persons were offered skills and entrepreneurship training. This brought about the foundation of 11 cooperatives (handicraft, dressmaking/tailoring, bakery, and dairy processing) and three associations. The Ministry noted in 2013 that it would focus on promoting cooperatives of persons with disabilities in rural areas.[11]

MUTUALS

Although mutuals operate in Bolivia, none of those identified provide services in the area of health.

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BRAZIL

2014

HEALTH SYSTEM

The 1988 constitution of Brazil established free, universal health care. The Unified Health System (Sistema Único de Saúde, SUS), responsible for the stewardship of both the public and private health systems, was tasked with decentralizing health policy down to the level of the state and municipality, with municipalities responsible for managing and providing primary health care services. States would assist in setting policy goals and provide technical and financial assistance. Municipal health secretariats were the primary entities responsible for planning, managing, and administering most aspects of health care. Most federal hospital and ambulatory health services were transferred to both state and municipal secretariats, which had to staff hospitals, contract out services to the private sector, and provide community outreach services. Today, the majority of municipally-run public hospitals tend to be small facilities, with larger hospitals operated by the states, and the largest teaching hospitals operated by the federal government.[1] Approximately 80% of the population receives care through the public system and 20% opt for private care.[2]

Private providers can provide "supplementary" health care and can be contracted by the state as recognized operators of primary care. Private providers are classified as follows: benefits management organization, health maintenance organization (HMO), private health insurer, dental group, self health-insured, medical cooperative, dental cooperative, and non-profit health insurer.[3]

Population (in thousands): 199,000

Population median age (years): 29.89

Population under 15 (%): 24.56

Population over 60 (%): 10.81

Total expenditure on health as a % of Gross Domestic Product: 9.3

General government expenditure on health as a % of total government expenditure: 7.6

Private expenditure on health as a % of total expenditure: 53.6

Cooperatives are significant providers of health care in Brazil. In 2012, of 6,587 cooperatives in Brazil, 848 were health cooperatives, providing services to at least 21.7 million users or 32.2% of the private insurance market.[4] It is reported to be one of the fastest growing cooperative sectors.

HEALTH COOPERATIVES

Health cooperatives in Brazil are significant private sector actors in what is called supplementary or complementary health care. They are active in providing medical, dental, psychological, nursing, physiotherapy, speech therapy, and health insurance. There are user, user-producer, and producer cooperatives as well as cooperatives which have set up other legal forms to assist in the delivery of health care, particularly in the insurance field.

The Organization of Brazilian Cooperatives (OCB) collects annual statistical data on cooperatives. Its data encompass every type of cooperative which is involved in the health care sector. It therefore tracks not only medical and dental cooperatives, but a wide range of other cooperatives active in the sector, including social care cooperatives made up of health professionals and consumer cooperatives which provide access to pharmaceuticals. In 2012, OCB reported that Brazil had 848 health cooperatives.

The **UNIMED** Health Cooperative System is the largest cooperative health care provider in Brazil. Initially involved in providing health care, it grew to meet the needs of members and users. Now its network of diverse legal entities supplies both insurance and financial services. UNIMED comprises 354 cooperatives and a membership of 110,000 doctors, covering 83% of the country. It owns 108 general hospitals and numerous other health facilities and contracts with over 3,000 health facilities. It provides services to 19.6 million people. (See further information on UNIMED in the "Case Study.")

Also considered health cooperatives are the USIMED consumer cooperatives. Their membership consists of users of UNIMED medical services: UNIMED members (health professionals) and those covered by UNIMED health plans. USIMEDs provide a wide range of services, including provision of health supplies, equipment, and pharmaceuticals at discounted prices. Founded in 1993, USIMEDs are user and producer cooperatives.

There are 118 dentist cooperatives, many of which are members of the Cooperative Society of Dental Services, UNIODONTO. UNIODONTO is the national federation of dentist cooperatives and the leader of dental health services in Brazil. It was established in 1972 by 37 dentists as a worker cooperative to eliminate intermediaries for dental care, offer quality and affordable service, to enable access to dental care, and to create fair and quality employment. Today its network of dentists provides a wide range of dental health plans to individuals and enterprises in every part of the country.[5] In 2010, the UNIDONTO system comprised more than 20,000 dentists and provided services to 2.3 million users.[6] In 2012, the OCB reported that Brazil's 118 dentist cooperatives provided services to 3.4 million users.[7]

Uniodonto Curitiba was founded as a worker cooperative in 1984 by 27 dentists. Today it counts 1,110 members and is the largest cooperative of dental care services in the state of Paraná. It has five offices in Curitiba and operates offices in the nearby towns of Campo Mourao, Cascavel, Guarapuava, Paranagua, Sao Mateus do Sul and União da Vitória. It also has five mobile units (odontomóveis), each equipped with a dental office for consultations and prevention service. The cooperative has 210 employees and serves more than 400,000 people.[8]

Psychologists have also turned to the cooperative form to organize. For example, UNIPSICO is a cooperative of psychologists active at the national level. It is present in 25 cities in Brazil and has provided mental health services to more than 200,000 people.[9] It is joined by numerous other cooperative enterprises which are organized as worker or producer cooperatives.

There are also cooperatives of other health workers, including those active in nursing. These cooperatives are contracted by health facilities and by individuals to provide home care, for newborns and the elderly, for example. OCB statistics classify them as health care cooperatives although they could also fall under the category of social care cooperatives.

Health Cooperative Data (2012)

Number of cooperatives[10]	848 in total, including • 322 medical cooperatives • 118 dentist cooperatives • 408 psychologist and other user cooperatives
Types of cooperative	User, Producer, User/Producer
Number of members[11]	296,547
Number of employees[12]	77,066
Users	• 32% of the private health insurance market • 18.3 million users of medical cooperatives • 3.4 million users of dentist cooperative services
Facilities[13]	UNIMED only (2013) • 107 General hospitals • 11 Day hospitals • 189 Emergency units • 74 Laboratories • 88 Diagnostic centres • 120 Pharmacies • 8,345 Hospital beds
Services offered[14]	Outpatient, hospitalization, preventive medicine, support services for diagnosis and therapy, emergency care
Annual Turnover[15]	• $15 billion USD (33.9 billion BRL) for medical cooperatives • $237 million USD (530.9 million BRL) for dentist cooperatives
Source of revenue	Payment for services

Case Study

UNIMED is the largest health care network in Brazil, active in 83% of the national territory. It is also the largest health cooperative system in the world. UNIMED currently brings together 354 medical (doctor) cooperatives and provides services to more than 19 million people. It delivers health services and serves 32% of the market for complementary health insurance.

UNIMED = 354 cooperatives	
1	National confederation– Unimed do Brasil
1	Regional confederation
1	Central - Central Nacional Unimed – providing national health insurance plans
32	Federations (state, interstate, and intra state)
319	Primary cooperatives
	304 UNIMED cooperatives act as health plan providers, representing 28% of private sector operators

The UNIMED system began in 1967 with the founding of UNIMED Santos (São Paulo) by Dr. Edmundo Castillo. Its foundation was a reaction to the emergence of the first health care companies created by lawyers, businessmen, and medical groups. According to Dr. Castillo, doctors did not to want to see the "commodification" of health care. They wanted its delivery to be based on a set of ethics and respect for users, whereby doctors could practice their profession with respect for human values and


UNIMED-Rio's new 'green' hospital

be fairly paid.[16] Within 18 months, more than 43 cooperatives were formed in eight states. As the movement grew, it consolidated into a 3-tier cooperative system made up of local societies that belong to regional/state federations and to a national confederation, UNIMED of Brazil. As it grew, UNIMED also developed a financial and insurance arm – UNICRED and USIMED and a number of other subsidiaries which take various legal forms (including an insurance company, an insurance broker, and a non-profit institution, UNIMED Participações) and are controlled by their member cooperatives in support of health care activities.

With regard to health facilities, UNIMED owns and operates 107 general hospitals, 11 day hospitals, 189 emergency units, 74 laboratories, 88 diagnostic centres, 120 pharmacies, and 8,345 hospital beds. It provides outpatient care, hospitalization, preventive medicine, support services for diagnosis and therapy, and emergency care. Revenues from its health plan operations amount to $15 billion USD (33.9 billion BRL) with $12 billion USD (28 billion BRL) returned to cooperative and service providers.[17]

Today UNIMED employs 75,000 people, and created 5,725 jobs in 2012 alone. It brings together 109,900 members and serves 19.6 million people who report high levels of satisfaction. For the 21st consecutive year, according to the national survey undertaken by Datafolha Institute, UNIMED is the most trusted brand for health insurance.[18]

Unimed Rondônia was founded in 1983 in Porto Velho (RO) by 28 doctors. Today it has 2,940 members, 406 employees, and serves 36,300 people. The cooperative has enabled health

professionals to exercise their professions freely based on ethical principles and has improved their livelihoods. Initially, doctors attended to patients in borrowed rooms and rented properties. Ten years later, they opened their first offices, and in 1996 built their first hospital. Today, Unimed Rondônia brings together seven additional hospitals, 14 laboratories, 69 specialized clinics, and 11 diagnostic and imaging centres, with 269 physicians and 270 staff members.

Financial health and quality of service are guaranteed by sustained investment in measures which promote business professionalism and modernize patient care. Unimed Rondônia

constantly encourages personal and professional growth on the part of its employees. The idea is to keep the team motivated and committed to the goals of the cooperative.[19]

SOCIAL CARE COOPERATIVES

In accordance with OCB classification, the data provided above identifies cooperatives which are made up of health professionals as "health cooperatives." However, the OCB also has a specific category for what it calls "special" cooperatives, some of which could be considered "social care cooperatives." Members of special cooperatives are persons with mental, physical, or sensorial disabilities; former convicts or those who have been given alternative sentences; drug users; and adolescents in vulnerable situations. These cooperatives have the objective of creating employment, generating income, and promoting social inclusion.[20]

Social Care Cooperative Data (2011)[21]

Number of cooperatives	9
Number of members	393

MUTUALS

The National Regulatory Agency for Private Health Insurance and Plans (ANS) does not recognize "mutuals" as supplementary health providers.

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BURKINA FASO

2014

HEALTH SYSTEM

In Burkina Faso, the public social protection scheme covers less than 10% of the total population, primarily workers in the formal sector, public and private. The rest of the population (many of them poor and vulnerable people) enjoys no form of social protection. They are mainly people employed in the informal and rural sectors.

To meet their basic needs, households organize to ensure their own health management and in time themselves assume responsibility for other types of risk and social concern. Many organizations based on solidarity, mutual aid, and democracy have been created to provide populations with forms of social protection not covered by the social security system. In Burkina Faso, the most successful organizations of this type are the Mutual Health Organizations (MHOs).

Population (in thousands): 16,460

Population median age (years): 17.01

Population under 15 (%): 45.66

Population over 60 (%): 3.88

Total expenditure on health as a % of Gross Domestic Product: 6.2

General government expenditure on health as a % of total government expenditure: 11.9

Private expenditure on health as a % of total expenditure: 45.7

MUTUAL HEALTH ORGANIZATIONS

In its 2009 regulations, the West African Economic and Monetary Union (WAEMU)[1] defined the MHO as a social group which, through contributions from its members, proposes to conduct in their interest and in the interest of their assigns, an action of foresight, support, and solidarity for the prevention of social risks related to the person and to repair their consequences.

MHOs have been active in Burkina Faso since its independence. Indeed, the first MHO, the Mutual of Customs of Upper Volta, was established in 1963. But it was after 1991 that the movement really began to expand and diversify, in accordance with the principles of the Bamako Initiative (1987)[2] and with the support of NGOs and technical and financial partners.[3]

Nowadays, Burkina Faso counts many MHOs. Their most common types of membership are family mode (nearly 53%) followed by individual mode (30.8 %). The majority of MHOs (86%) charge an insurance fee of less than $1 USD (500 FCFA) per month. But fees in the range of $4-10 USD (2,000-5,000 FCFA) are becoming more commonplace.

The main reasons for membership in MHOs are financial access to care, quality health services, and geographical accessibility of health centres. The benefit package offered by MHOs primarily concerns primary care services (although some urban MHOs are covering all levels of health care). In general, these services include the management of ambulatory care, medical care, and evacuations. The support from MHOs to their beneficiaries is generally 80% of the cost of service. But certain MHOs cover only 70%, while a minority covers 100%.

The last inventory of social mutuals (July 2013) counted 188 active MHOs with 103,373 members and 256,015 beneficiaries. Among these MHOs, 105 (56%) are standard organizations, 38 (18%) are professional organizations, 22 (10.7%) are systems cost-sharing, 9 (8%) are prepayment systems, and 2 are solidarity funds, representing 2% of MHOs in Burkina Faso.

Government Promotion of MHOs[4]

The development of MHOs is on the agenda of the Government of Burkina Faso. In recent years, it decided to extend social protection to all strata of the population. Indeed, MHOs are listed in the National Policy for Social Protection, which itself is part of Axis II of the Strategy for Accelerated Growth and Sustainable Development, "Human Capital and Consolidation of Social Protection." On account of the government's decision to introduce universal health insurance (2008), and to facilitate its deployment for the benefit of the entire national population, it was decided to build upon the experience and know-how of MHOs in reaching populations in the informal and agricultural sectors.

MHOs will be delegated responsibility to play roles in mobilization and social control. To this end, community MHOs will

be created in all towns in Burkina Faso, as well as unions of MHOs in each region, and a federation of MHO unions at the national level.

The creation of professional MHOs will also be promoted in various sectors. To do this, it will be essential to establish a close relationship between the system of universal health insurance and the development of MHOs, which involves the creation of an institutional and legal environment.

CASE STUDY

Burkina Faso, one of the poorest countries in the word, has chosen as a strategic priority the reduction of poverty in the population. This struggle involves, among other tasks, the establishment and proper functioning of a system of social protection. Among these social protection benefits, coverage of health needs is a central priority. Indeed, coverage of health needs has a substantial impact on household resources and on the economy in general.[5]

In Burkina Faso, 38.35% of total health expenditure is borne by households. (According to WHO, 100 million people fall below the poverty line when they are forced to pay for their health care.[6]) The country's current Autonomous Pension Fund provides retirement benefits, disability, death, and more recently, accident insurance for civil servants, the military, the judiciary, as well as contractors of the Public Service. The National Social Security Fund is governed by Law No. 015-2006, enacted May 11, 2006, to establish a social security scheme applicable to employees. Both plans cover the formal sector and do not take into account disease.

Through the Office of Workers' Health (OWH) the government also developed health services for workers in private and para-public services. This structure provides two types of service: curative care and annual medical examinations. In terms of curative care, up to 80% of the cost of services to employees is covered in OWH facilities, with or without a cap, depending on the company. OWH has infirmaries and a clinic in Ouagadougou which offers all outpatient services. However, weaknesses in the technical facilities and inadequate staffing currently do not permit the practice of Occupational Medicine. OWH tends to deviate from its primary mission by providing health services at fees comparable to those charged by private hospitals.

To overcome shortcomings in the coverage of health care costs by OWH and the state budget, mechanisms for solidarity funds with a health component were developed within companies and in public and semi-public services. Until recently, such mechanisms were not available in the education sector, particularly in primary schools. Recognizing the importance of access to health care for the welfare of its members, the national union of primary school teachers (public and private) in Burkina Faso (SNEAB) made contact with the Mutuelle Générale de l'Education Nationale of France in 2013.

This action was taken at a time when the political climate was favourable. At the national level, the National Social Protection Policy was adopted in September 2013. Since 2008, the government has been thinking about the establishment of universal health insurance (AMU[7]) for all. The role of MHOs in the deployment of this health insurance will enable the families of rural, informal, and formal workers to benefit from the packages offered by the AMU scheme.

For the informal sector, the establishment of communal MHOs, regional unions, and a national federation of MHOs is envisioned.

The establishment of an MHO by and for education professionals, and public awareness of the issues of social protection, can have another important impact: the education sector is in a position to become a transmitter of knowledge and expertise on the issues of health and social protection. This applies to children and youth through education programmes on health and social protection and prevention activities. But it is also true for whole communities which can develop solidarity tools in the context of national policy. Professional education could play a role in the training and support of other audiences as well.

The MHO for teachers will be implemented with and for 40,000 primary school teachers in the public and private sectors, as well as the administrative and support staff of the Burkina Faso Ministry of Basic Education. The MHO also benefits the families of these education professionals, which in turn will benefit the wider communities in which these families live. More broadly, through education and awareness of social protection measures, and the support that educators can bring to other local MHOs, the project may have a significant impact on entire communities.

This initiative is also of interest because it is part of a national expansion of the welfare system. If Burkina Faso maintains its focus on this issue, in several years the government may well go one step further and implement universal coverage, based at the local level and specifically for the informal sector, which accounts for nearly 90% of the population.

The project's success depends on the support and participation of public authorities, including the ministries of Social Affairs, Public Service, and Finance. This institutional support should also be financial, because without seed funds, it will be difficult to create MHOs.

The awareness of the Ministry of Education of the connection between quality of education and the health care of education professionals must be maintained over the course of the project. It must be accompanied by a willingness to make education and prevention in health matters a priority, not only for teachers but also for educational programmes. If civil society and government join forces to transmit values, principles, and good practices in health and social protection to future generations, a major driver for the future development of the country will have been established. It is equally important that international actors and partner countries join the effort through training, support, and funding.

Currently, the project is following its normal course. The MHO for Burkina Faso's teachers will soon be implemented.[8]

SOURCES

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BURUNDI

2014

HEALTH SYSTEM

Burundi's mechanism of insurance covered only 17.9 % of the population in 2012-2013, according to a "Survey on Demography and Health" carried out across the country as part of a government programme for social protection.[1] Delivery of health insurance occurred through several means: the Medical Assistance Card (CAM),[2] the Public Service Mutual Health Organization (MFP), community MHOs, and certificates of indigence. It may however have increased slightly since the survey was completed, due to government efforts to promote CAM enrollment.

According to the Burundi Ministry of Public Health and the Fight Against AIDS, 23% of the population are currently CAM members. However, future growth in membership could be discouraged by long waits for the reimbursement of health service expenditures. According to a second survey in 2012-2013, the CAM suffers from weaknesses in design and implementation.

The CAM is a bold initiative to extend Medicare beyond the formal sector to the mass of the people dependent on family agriculture. But its introduction in 2012 without preliminary technical studies seems to have put the efficiency and sustainability of the entire mechanism at risk. Evidently, the annual membership fee of $1.96 USD (3,000 BIF) per household was not determined based on a calculation of the cost of services, the ability of households to pay, and/or the potential level of public subsidy.

Population (in thousands): 9,850

Population median age (years): 17.64

Population under 15 (%): 44.2

Population over 60 (%): 3.87

Total expenditure on health as a % of Gross Domestic Product: 8.1

General government expenditure on health as a % of total government expenditure: 13.7

Private expenditure on health as a % of total expenditure: 40.5

As a result, the CAM is underfunded. This is the reason for the long delays for reimbursement and the accumulation of debts by health units. Furthermore, the MFP, which provides health insurance to public sector employees, covers a small fraction of the population (3.4%). The same goes for community MHOs. Their coverage rate is also extremely low: a mere 1.3% of the population.

MUTUAL HEALTH ORGANIZATIONS

Despite the government's decision to subsidize 100% of the cost of health care for pregnant mothers and for children under five, access to health care for Burundi's rural population in general and the most vulnerable remains low. According to data provided by the Strategic Framework for Growth and the Fight Against Poverty (CSLP), 17.4 % of patients do not have financial access to health care, while 82% of patients in rural areas are forced to borrow or sell part of their property to pay their treatment. The government plans to solve this problem with the introduction of MHOs[3] in the rural sector in accordance with the policy of the Department of Public Health and the CSLP.

The National Policy on Social Protection designs MHOs based on family membership. Every householder would pay a single fee for dependents to a maximum of six people. The family premium per 6-person household would be around $6.48 USD (10,000 BIF). This amount would cover benefits only. Support from the government and its development partners would cover the additional dues. These supports may total at least $3.24 USD (5,000 BIF). The World Health Organization (WHO) estimates that the cost of primary health care in Burundi is about $2.00 USD per capita per year. The desired outcome is 100% adherence of the rural population to community MHOs in accordance with the "Burundi Vision 2025."[4]

Civil society has already taken steps in this direction; for example, the MHOs initiated in the Catholic diocese of Gitega and Muyinga. The producer associations grouped under the National Confederation of Associations of Coffee Producers (CNAC-Murimarusangi) have an MHO and are supported by the Association for the Support of Integral Development and Solidarity in the Hills (ADISCO). Another initiative is that of the Union for Co-operation and Development (UCODE) which established MHOs in the provinces of Ngozi, Kirundo, Muyinga, and Kayanza with funds provided by the NGO Louvain Coopération. Other MHOs are those supervised by SOS Médecin in certain parts of rural Bujumbura,

those of the Family to Defeat AIDS (FVS), and those framed by MEMISA Belgium and Health Net TPO.

Studies conducted by CORDAID Health Plus and Health Net TPO show that people deeply appreciate MHOs. With their membership cards, they are no longer forced to sell their land or crops for treatment. Some of them testify that before becoming MHO members, they were unhealthy because they repeatedly took incomplete cures for lack of means or they resorted to street drugs. MHOs have allowed them to heal properly, receiving full doses of the proper pharmaceuticals.[5]

Poverty in Burundi continues to increase. The decline in the price of coffee (the main source of income for most people) and the decline in agricultural production due to the fragmentation of land ownership are all factors that make people struggle to pay their contributions regularly or to renew their memberships. Complementary services were established to improve people's ability to contribute. These include microcredit in support of activities that enable a household to generate more income.[6]

Case Study

Burundi is recovering gradually from more than a decade of civil war. This prolonged crisis has weakened the economy, destroyed the social fabric, and reduced the population. According to a 2012 UNDP report, more than 70% of Burundians live below the poverty line on less than $1 USD per day.[7]

Under these conditions, access to basic needs (food, education, quality health care, etc.) has become a real challenge.

Fortunately, for more than two years, initiatives have been taken, especially in the field of health, to alleviate the suffering of the population. In 2006, the government decreed free care for children under five and for pregnant mothers. At the same time, existing farmer organizations decided to invest collectively in the establishment of MHOs in order to improve access to quality care.

Coffee producers were among the first to take this kind of initiative. More than 100,000 families live directly from the sale of coffee (nearly 800,000 people, 10% of the population). Their associative movement dates back to the 1990s.

At the national level, the various associations of coffee producers are topped by the National Confederation of Associations of Coffee Producers, CNAC.[8] For several years, the movement has enjoyed coaching from Inades/Formation/Burundi. In the aftermath of the war, however, this organization had no expertise to help coffee producers to develop a mutual health insurance scheme. The associations instead had to call for support from a specialized organization, **ADISCO** (Support for Integral Development and Solidarity in the Hills).[9] Over the past year or more the project has evolved favourably. It has already set up a dozen MHOs across the country. "Today we are at 13.6% of households but our goal is that at least 40% will adhere to a mutual health insurance scheme initiated around each coffee washing station," said Déogratias Nawaz, coordinator of the association.

The producers remain the pillars of each MHO. ADISCO helps only in training, monitoring, and control, and by providing governance documents. In its design phase, each MHO is indeed totally driven by coffee producers. They undertake the management, under the watchful eye of ADISCO.

To access the benefits of a mutual health insurance scheme, each family is requested to pay an annual contribution of $8.70 USD (13,500 BIF). "It is an amount affordable for all but realistic for a family of six people; beyond that, a household must add $1.62 USD (2,500 BIF) per additional person. If they are not eligible for the free care available for pregnant mothers and children under five, the contribution would amount to $18.20 USD (28,000 BIF)," explains Déo Nawaz. Once a household enrolls in the mutual health system, each family member is entitled to all the care available at a public health centre with a co-payment of 20% (or 40% in centres run by the Catholic Church) to a maximum of $19.50 USD (30,000 BIF).

To this point, the system seems to be safe and very promising. However, to prepare for any eventuality, provision has been made to initiate a guarantee fund to reimburse hospitals (if a MHO were to close its doors, for example). "For each member, support starts after two months of observation. Each new MHO offers its services after reaching a membership of 250. With a membership of 600, each MHO should be self-sustaining, which should happen in five years," concludes Déo Nawaz.

MUSCABU (Mutual Health Organization of Coffee Producers of Burundi) is considered the most important programme for the promotion of access to social protection in Burundi. By August 2012 it had managed to enroll 14,830 household members (31% of the members of coffee producer associations) and 79,896 beneficiaries. However, its revenues are unpredictable. Coffee producers are subject to cyclical instability due to the "vagaries of climate," with perverse repercussions on revenue projections.

Like its predecessor, the project is run both by the CNAC and ADISCO. While the first 3-year phase of the mutual health insurance scheme (2008-2010) launched a movement with 26 MHOs, five unions, and a national federation, the second phase (2011-2013)

aims to strengthen the partners, the MHOs, and their networks in terms of their vision, their competence, their network affiliations, and their resources. The CNAC is responsible for activities complementary to MHOs, while ADISCO is responsible for the mutuality component as well as the coordination of the programme.

As for the MHOs themselves, the programme is at the crossroads. There are certain mutual associations (+/-17) which have definitively taken off due to strong leadership which can adapt to difficult situations. Others continue to rely on ADISCO and CNAC. The challenge for the programme is to strengthen both those which have demonstrated dynamism, and those which still need assistance.

Up to 2013, MHOs have treated 45,000 people. These included 1,693 cases of hospitalization and nearly 700 serious cases which could have irreversibly impoverished a household. MHOs have responded well to this situation by stepping up controls and by increasing the levels of contribution.

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CAMEROON

2014

HEALTH SYSTEM

Three social security schemes exist in Cameroon:

- The system for civil servants and managed by a fund of the national Ministry of Finance.
- The system for private sector workers and government agents managed by the National Social Security Fund (Caisse nationale de la prévoyance sociale, CNPS). Social security in Cameroon covers nine types of universal social protection (sickness, old age pension, sick leave, unemployment, addiction, family benefits, etc.).[1] The State fully guarantees protection of employees against accidents and occupational diseases.
- Social insurance (including MHOs) for populations in the informal sector and rural areas, who still suffer from the lack of any law promoting their development and sustainability. The informal sector involves almost 90% of the population and its actors need access to social protection. This is why the promotion of MHOs over time has become a necessity.

Following the 1987 Bamako Initiative,[2] the Council of Ministers responsible for health in Cameroon and several African countries took measures inter alia to promote mutual health insurance as an alternative approach to the problem of cost recovery in the health system. In 1990, the law of association was voted by the parliament. In 1996, the constitution was revised to bring about integrated decentralization: the establishment of regions alongside municipalities. In 2004, the framework law on decentralization was adopted and Cameroon received support for the process.

Population (in thousands) total: 21,700

Population median age (years): 18.18

Population proportion under 15 (%): 43.08

Population proportion over 60 (%): 4.89

Total expenditure on health as a percentage of Gross Domestic Product: 5.1

General government expenditure on health as a % of total government expenditure: 8.5

Private expenditure on health as a % of total expenditure: 66.5

Until the present, mutual health organizations (MHOs) have been operating under the legal status of associations due to the absence of a special legal framework. They also have been creating endogenous relationships with local municipalities.

Reform of social security is underway in Cameroon with a strong orientation to the strategy of risk-pooling. Indeed, the Health Sector Strategy (HSS) adopted in July 2002 includes the promotion and development of risk-pooling as a priority.

A national Strategic Plan for the promotion and development of MHOs was adopted during the National Forum in February 2006. This Strategic Plan targets MHO coverage of at least 40% of the population by 2015. It is within this framework that any mutual health development initiative must be conducted in Cameroon.

Many initiatives already have been taken to implement a legal framework for MHOs: the Mutuality Code (Ministry of Labor and Social Security), framework legislation (Ministry of Public Health), etc. Thus, the State has a multitude of possible choices for a law that would govern the MHOs.

More and more players are interested in the promotion of MHOs in Cameroon. In addition to a platform comprising 30 civil society and cooperative actors, there is a "Task Force" established by ministerial decree for the implementation of the strategic plan. A 2013 inventory by PROMUSCAM (chaired by SAILD)[3] found that only 2% of the population of Cameroon was covered by MHOs.

THE CONTEXT OF MUTUAL HEALTH ORGANIZATIONS IN CAMEROON[4]

Mutual health insurance (microhealth insurance) is managed by the same people who created it for two purposes: to cope jointly with the financial difficulties of access to quality health care; and to contribute to the improvement of the quality of care in the community. MHO management and operations are similar to those of cooperatives.

It may be worth noting that MHOs are increasing in number in Cameroon, from 101 in 2006 to 158 in 2009 (56%). Since then another 20 new MHOs have emerged in the country.

Some Examples of Mutual Health in Cameroon

The Western Regional MHO Network: Created in 2007, this network counts 30 MHOs organized into unions at the health district level. In their early years, most received guidance from SAILD AWARE-RH/USAID[5] with the support of EED-Bonn[6] then from WSM[7] in the years 2007-2013. The network integrates all the local MHOs. The network has an advocacy mandate carried out by means of regular meetings at which health and development actors as well as resource persons can exchange information and advice. The network also manages a guarantee fund and assists MHOs when they experience cash flow difficulties. MHO unions work to support health care at a second level: inter-mutuality, data centralization, and management consulting with mutual basic health support. These apexes are financed by a portion of the fees collected by the MHOs at the base.

At the base, MHOs collect contributions from members for the delivery of an agreed package of health services at approved health facilities (clinics, hospitals, dispensaries, etc.) in case of disease.[8] The oldest MHO network dates to 2004. The majority of its MHOs were established between 2005 and 2010. A Strategy for the Promotion of Viable MHOs in the western region of Cameroon includes forging connections between MHOs and local MFIs (Micro Finance Institutions). The MHO signs an agreement in which it commits to apply seed money from the MFI to the health credit and to secure repayment. The MFI also makes, manages, and secures loans to MHOs.

Mutual Health Kumbo: This MHO is an initiative of the municipality of Kumbo in collaboration with GIZ.[9] This MHO has a total of 22,181 members, or 19% coverage of the target population. Since 2004, it has delivered health care to 19,617 people for a total of $393,542 USD (189,828,969 FCFA). MHO members who have already benefited from these services are unanimous that their health has improved considerably due to the quality of service, the speed, and the opportunity to go to health facilities at the first sign of illness.

Mutual Health of N'gaoundere: This MHO was set up by the residents of N'Gaoundéré in 2007 with the support of AWARE-RH /USAID, UNICEF, EED –Bonn, and SAILD. It covers the health district of N'Gaoundéré and works closely with its integrated health centres and hospitals under the supervision of the Adamawa Regional Delegation of Public Health. The MHO provides benefits based on annual contributions of $4.89 USD (2400 FCFA) per beneficiary. The services offered by the health insurance scheme include ambulatory assistance to health facilities for a maximum of $101.88 USD (50,000 FCFA) per consultation, hospitalization, or surgery. The main risks are those related to disease, birth, surgery, and epidemic.

CONCLUSION

Despite the delay of the Cameroonian government in adopting a legal and institutional framework for MHOs, the will of the State to promote MHOs is clear: two ministries – the Ministry of Public Health and the Ministry of Labor and Social Security – are involved in the process.

Sub-regional integration increasingly has become a reality in central Africa, and may be extended to other countries in the area. In addition, the Cameroonian government has embarked on a process of decentralization. Their goal is to increase the accountability of municipalities and communities in the shaping, implementation, and management of their own development.

The role of civil society is increasingly recognized, both nationally and regionally. Moreover, PROMUSCAM, with the support of PASOC (Support Programme for the Structuring of the Civil Society) has made an urgent plea for the establishment of health insurance for all in Cameroon. This requires integration of the following measures:

- Establishment of an interim national technical assistance body to support the promotion and development of MHOs.
- Implementation of comprehensive health coverage through the promotion and development of MHOs. Other sectors will progressively assume more responsibility in this regard.
- Support MHO funding streams by the following mechanisms:
  - Take a percentage on phone calls, on money transfers, on mobile phone usage, and require that communication operators reinvest 10% of their turnover in social protection (MHOs).
  - Take a percentage of forestry licence fees.
  - Take a percentage of the VAT on the consumption of alcohol and tobacco.
- Harmonization of the various ongoing health-funding initiatives, like Project "Health Check."
- Apply common performance indicators to the promotion of MHOs.

SOURCES

[1] Decree No. 2000/692 of September 13, 2000 lays down the procedure by which employees exercise the right to health.
[2] Launched in 1987 by the WHO and UNICEF, the Bamako Initiative sought to ensure universal access to quality primary health care. It had three principles: that patients contribute to the sustainability of service through payment of a fee; that access to better medicine, especially generic pharmaceuticals, is essential; and participation of community members in the governance of health care centres. See p. 383 of Churchill, Craig Farren. 2006. *Protecting the Poor: A Microinsurance Compendium*. Vol. 1. International Labour Organization.
[3] Services d'Appui aux Initiatives Locales de Développement (Support Services for Local Development Initiatives is an NGO based in Cameroon. Website: (http://www.saild.org).
[4] The data was collected with the assistance of PROMUSCAM (Programme d'Appui aux mutuelles de santé au Cameroun/Support Programme for Mutual Health Organizations in Cameroon).
[5] Action for West Africa Region, Reproductive Health conducted by the United Stated Assistance to Foreign Countries.
[6] Evangelischer Entwicklungsdienst (Church Development Service). This association of German Protestant Churches supports the development work of churches and other Christian and secular organizations through financial contributions, personnel involvement, scholarships, and consulting.
[7] World Solidarity/Solidarité mondiale is the NGO of the Christian Workers Movement in Belgium. It works mainly with social movements in the global North and South that pursue decent work, social protection, and job creation for workers.
[8] The content of the package is usually negotiated between the MHO and its members according to their levels of contribution. The conditions are generally summarized in the by-laws of MHOs.
[9] The Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH/German Corporation for International Cooperation assists the German government in the field of international cooperation by providing demand-driven, tailor-made technical services for sustainable development.

CANADA[1]

2014

Paramedic cooperators attend to an accident. Photo: Philippe Serafino

HEALTH SYSTEM

The second largest country in the world, Canada adopted a universal health coverage scheme in the mid-1950s. It was based, at least conceptually, on the United Kingdom's experience. In the main, the system is publicly financed with services provided through private (for-profit and not-for-profit) and public bodies. Based on provincial and territorial jurisdictions, there are 13 single-payer, universal systems for "medically required" services, mostly hospital and physician services defined as insured services under the federal Canada Health Act.[2] It maintains that all residents of the country are eligible to receive insured services free at the point of delivery. However, the financing, administration, delivery modes, and range of public health care services are different in each province and territory. Over the past years many initiatives have been taken to improve the control of First Nations (the indigenous population) over local and regional health systems and resources.[3]

The main source of health care financing in Canada is taxation by the provincial, territorial, and federal governments (70% of total health expenditure). Private financing (30%) is split between out-of-pocket payments and private health insurance, including plans offered by co-ops and mutuals. The remaining expenditures come from social insurance funds, mainly for health benefits through workers compensation and charitable donations.

Population (in thousands): 34,838

Population median age (years): 39.99

Population under 15 (%): 16.37

Population over 60 (%): 20.82

Total expenditure on health as a % of Gross Domestic Product: 10.9

General government expenditure on health as a % of total government expenditure: 17.4

Private expenditure on health as a % of total expenditure: 30

General practitioners (family physicians) serve as the patient's first point of contact with the health system. Physicians generally work independently on a fee-for-service basis except for a minority who work on a salaried basis, for instance in some community health centres (including some health cooperatives and public clinics).

Almost all secondary, tertiary, and emergency care, including the majority of specialized ambulatory care and elective surgery services, is offered within hospitals. Primary care is left to clinics owned by physicians, pharmacies, or community-based organizations, including cooperatives. Both public and private (for-profit and not-for-profit) organizations own and operate long-term care facilities, nursing homes, and similar institutions across Canada.

Even if the Canadian health system has been successful in maintaining a high level of population health, the future is rife with challenges. Among them, the increase in health care expenditure, especially for pharmaceuticals, lengthy wait times, and shortages of health care human resources. Moreover, the population is aging so the need for health services will increase over the coming years. In some provinces, the health system cost is close to 50% of the government's entire programme spending. So there is pressure to make the system more efficient and to introduce more private or community involvement.

HEALTH CO-OPERATIVES

The development of health co-ops in Canada is closely linked to the establishment of the universal health care system.

In Canada, the first universal health coverage, known as Medicare, was implemented in the province of Saskatchewan in 1962. In response, the provincial association of doctors went on strike to denounce what they called a "socialist takeover of the medical profession." By contrast, doctors who disagreed with this position and citizens sympathetic to Medicare decided to organize community-based health centres. Over time they managed to secure recognition from the Ministry of Health and received appropriate funding on a multi-year basis.[4] They also set up the Community Health Co-operative Federation. In 2014, the Saskatoon and Regina community clinics are among the largest health co-ops in Canada. In 1972, Saskatchewan's community health clinics served as models for the NorWest Co-op Community Health Centre when it was established in one of the poorest areas of Winnipeg, capital of the neighbouring province of Manitoba. Over time, NorWest too has become one of the leading health co-ops in the country.

Saint-Étienne-des-Grès, a village of 3,600 in Québec, learned in 1992 that its doctors were going to retire. For two years, the community tried without success to convince doctors to open a clinic. Finally, the citizens decided to form a co-op. They prepared a business plan and financial strategy (the membership's subscription of social and privilege shares was an important component), then built a clinic and advertised for professional tenants, including doctors, a dental surgeon, and a psychologist. Support from the municipality and the local Desjardins credit union were crucial to the venture. The Coopérative de santé Les Grès started operations in 1995, the first health co-op of the post-universal health coverage period. A major inspiration to other communities in a Québec searching for practical solutions to the family doctor shortage, Les Grès itself has never stopped innovating. Since 1995 it has created a long-term care residence, extended the main building, and opened a satellite clinic.[5]

Over the next 18 years, more than 54 health co-ops were founded in Québec, of which 37 are still active. Most operate a health clinic.

Since 2008, the presence of a Health Co-op Federation in Quebec, **La Fédération des coopératives de services à domicile et de santé du Québec** (FCSDSQ) has been very advantageous for the development of health co-ops in this francophone province. It main goals are to:

- ensure the promotion and development of cooperatives in the sectors of home care and health.
- facilitate the exchange of information and expertise and take concerted action on joint projects.
- protect, defend, and promote the interests of the entire network and each of its members.
- offer and provide technical and professional assistance in organizing and promoting the services of funding, training, and other support needs.
- support members in improving the quality of services and the development of employment.

In many parts of Québec in the 1980s, paramedics strove to improve their working conditions, training, and public recognition of their profession, and to offer better services to the public. In the years 1988-1990, with the help of unions, five paramedic worker co-ops were established, followed by three more shortly thereafter. Finally, in 2005, these paramedic co-ops combined into a federation, la Fédération des coopératives de paramédics du Québec.

Apart from what was achieved in Saskatchewan and Manitoba during the 1960s, the development of health co-ops has not benefited from major resources nor from an equivalent model. Nevertheless, in most provinces, projects initiated by communities or co-op developers have benefited from the support of provincial or regional associations of cooperatives.[6]

After several years of discussion between health co-op leaders outside Québec, and thanks to support from The Co-operators insurance co-op and the Canadian Co-operative Association, the **Health Care Co-operative Federation of Canada** (HCCFC)[7] was incorporated in 2011. Its aims are to:

- serve health co-ops across Canada (except in Québec).
- raise public awareness of the benefits which health co-ops create for their members and their communities.
- facilitate the sharing of information and resources among members.
- provide information at all levels (from municipal to federal, and internationally) about the achievements and potential of the sector.

As a satellite to the 2012 International Summit of Cooperatives, an International Forum on Health Co-operatives was organized in Lévis, Québec in that year. It was to serve as a basis for collaboration between the FCSDSQ and the HCCFC with the recognition of the International Health Co-operative Organisation (IHCO). Study tours to health co-ops in Japan were organized for Canadian health co-ops in 2007 and 2010. The very innovative idea of HANS Kai (a small group health promotion and prevention programme) was brought to Canada and is now being implemented by health cooperatives in six provinces. (See the NorWest case study, below.)

Funding of Health Cooperatives

The funding base of health co-ops is not the same in all parts of Canada. At least two funding models could be clearly identified. The Community Health Centres in Saskatchewan and Manitoba benefit from formal recognition by their provincial Ministries of Health as primary health centres for designated populations. Through contracts with their District Health Boards, they annually receive an amount (as high as $9.2 million USD or 10 million CAD) for their services. With such funding, the Saskatoon Community Clinic can employ more than 160 full-time staff. These service agreements with the public health authority generally represent close to 80-85% of the whole income of the co-op. As the doctors on salary, they can spend as much time as necessary with each patient.

The funding model developed in Québec, starting with Les Grès health co-op in 1995, is very different. There, the revenue came mainly from the rental of space to health professionals. The doctors could be user-members (by leasing space) or support-members. In addition to the requirement that each member purchase a share, many health cooperatives in Québec have also required the payment of an annual fee. Such annual fees primarily serve to cover the management cost of a cooperative. Sometimes, health co-ops bill for services which are outside public health coverage, but the charges are lower than those of private, for-profit clinics.

In 2012, because of the growing importance of health co-ops in Québec and some issues regarding business practices, the Québec government appointed a health cooperative working group. Its report, released in 2013, included six recommendations.[8] The FCSDSQ committed itself to all the recommendations and works to maintain ongoing communication with the Health Ministry. The doctors at six health co-ops have also won Health Ministry recognition as family medicine groups (GMF): groups of family physicians who work closely with other health professionals, enabling customers/patients to get easier access to medical care. Each doctor takes care of her/his own patients, who are registered with this doctor, but all physicians in the GMF have access to all medical records. Thus, a person who urgently needs an appointment can be seen by any available doctor in the GMF. The Ministry of Health pays the GMF a certain amount to cover such responsibilities.[9]

Health Cooperative Services

The funding situation has a big impact on the business model which each co-op applies, i.e., the services which it decides to offer. For example, Saskatchewan's community clinics put much emphasis on preventive and health promotion programmes, targeting the lives of people who are most at risk, including children, youth, Aboriginals, disabled persons, and seniors. They also are greatly concerned about the effects of poverty on health and environmental issues.

In Québec, during the first years, the main focus of health co-ops was to improve access to health professionals in rural areas. But a recent survey of FCSDSQ members shows that 56% of their members have developed different activities related to health promotion, such as health days, health information booths, health fairs, walking clubs, or HANS Kai groups.

Of course, the service repertoire of health co-ops around Canada is much more diversified than these two examples.

- In Edmonton (Alberta), the Multicultural Health Brokers Co-operative, a worker cooperative,[10] provides perinatal education, childhood development support for multicultural families, support for isolated seniors of immigrant and refugee background, and translation services.
- Health Connex,[11] a consumer co-op in Nova Scotia, provides online tools that enable patients to manage their own health care information. The organization also provides patients with self-managed Personal Health Records, connects patients with

compatible communities of support, facilitates online communication with health care providers, and offers online educational opportunities.
- The Ontario Chinese Medicine and Acupuncture Co-operative Inc. promotes alternative health care.
- In six provinces co-ops are engaged in mental health or psychosocial rehabilitation and recovery. TeamWerks Co-operative in Thunder Bay (northern Ontario) operates a very innovative programme: survivors of mental illness and addiction gain supported employment in enterprises ranging from a coffee house and shredding services to an agricultural and food security program.[12]
- Co-op Atlantic sponsors a health and wellness co-op for its employees.
- Coop santé Espace-Temps in Montreal works with a young autistic clients. Health Cooperative SABSA in Québec City has a nurse practitioner, but no doctor. The Nurses' Union provided funding for the start-up of the project.
- The Victoria Health Co-op in British Columbia, with a membership of 450, serves 5,000 patients and provides a range of outreach services to the wider community.

Health Care Cooperatives Data

As in many other countries, unfortunately, there is no simple, single, and up-to-date database regarding health co-ops in Canada. For the purpose of this report, we combined data coming from diverse sources and from diverse reference years.[13]

Number of cooperatives	73[14]
Types of cooperative	Consumer: 25 Multistakeholder: 35 Producers (including worker co-ops): 8
Number of members	88,128[15]
Number of employees	1,452[16]
Number of doctors	150[17]
Users	Over 178,000[18]
Facilities	36[19]
Services offered	Illness prevention Wellness and health promotion Treatment and cure Rehabilitation
Annual turnover	$120 million USD (131 million CAD)[20]
Assets	$63 million USD (68 million CAD)[21]

CASE STUDIES

NorWest Co-op Community Health[22]

NorWest Co-op Community Health Centre focuses on engaging the community in cooperative health and wellness. NorWest has served the Inkster community in northwest Winnipeg, Manitoba, since 1972. As the only health care cooperative in Manitoba, NorWest works with its patients and clients, its neighbourhood resource centres, other health care providers, and its partners to offer a variety of programmes and services. The team delivers community-based services and programmes in the following: primary health care; health promotion and chronic disease supports; community development; immigrant settlement services; parent-child coalition; a wide variety of counselling and support services; two early learning and childcare centres; and a brand new Community Food Centre. Eligible individuals across the city can access services in the areas of family violence, immigrant and refugee matters, substance abuse during pregnancy, nursing foot care, and Aboriginal health outreach.

In 2010 NorWest introduced the HANS Kai (Group Meeting) programme to Canada, having seen its phenomenal success in Japan. In this programme, each peer group supports its members in monitoring their personal wellness indicators. (It gets much better results than when people rely just on their own motivation!) Approximately 15 peer-led HANS Kai have been operating in Winnipeg for over three years. NorWest is also developing HANS Kai tools for teens and young adults. A further innovation currently underway is research into how care for the spirit may be integrated with its work as a Community Health Centre. NorWest developed this programme in close collaboration with Coop Santé Robert Cliche in Québec. Working with other HCCFC members, NorWest is now working on a programme to help teens identify and avoid risky activities that could harm their physical and mental health.

Access NorWest opened in April 2013 and now houses three organizations: NorWest Co-op, the Winnipeg Regional Health Authority, and Manitoba Child and Family Services. Access NorWest is the only access centre in Winnipeg to have three organizations under one roof. In the first year it saw an increase of 1,700 clients in primary care.

NorWest Co-op has 500 members and an active board of directors of 13 people, many of whom have been committed to the organization for years.

La coopérative des techniciens ambulanciers du Québec (CTAQ)[23]

Founded in 1988, this cooperative has become one of the three largest in Québec in this sector. Close to 400 employees and a fleet of 26 ambulances serve the metropolitan region of Québec, the region of Charlevoix, as well as Chicoutimi-Jonquière borough in the city of Saguenay. With an annual increase in calls of about 5%, the CTAQ projects an increase of 30% in the number of ambulances and staff by 2024. Current volume is estimated to be 140 calls per day.

This is why the cooperative has been building a new facility, equipped with leading edge technology, in Québec City. The estimated price tag is nearly $4.5 million USD or 5 million CAD. Specialized engineers were engaged to design an optimal space. Thus, for maintenance, ambulances will no longer have to back into the garage, but will enter through one door and go out the other. What's more, with these new facilities, the cooperative has secured the approval of one of Québec's two leading ambulance distributors to carry out the installation and maintenance of equipment in vehicle interiors.

The staff lounge is comfortably furnished and equipped with TVs. To care for the health of members, the cooperative pays a maximum of $457 USD (500 CAD) per year per member to enable them to take part in physical activity programs.

SOCIAL CARE COOPERATIVES

Over the years, many co-ops have been created across the country, offering a wide variety of services to address the problems faced by the disabled, First Nations, seniors, immigrants, and other vulnerable groups. One of the most impressive originated in Québec in 1996. At a socio-economic summit of politicians, business people, union leaders, and civil society representatives a singular project was hatched: the creation of a network of social economy enterprises in home services (SEEHS). This network would offer its services (including housekeeping and meal preparation) primarily to seniors to help them stay as long as possible in their homes rather than move into a seniors' residence.

The program began the next year and in a very short time more than 100 SEEHS had been implemented. Since then, SEEHS have gradually developed a service offering assistance with daily living. Several SEEHS also offer respite services and surveillance presence to support caregivers, and provide services for residents of retirement homes. Still more can be expected to offer such services, subject to the availability of financial resources.

How is the service funded? Mainly from the government but always with customer participation. There are two types of subsidy for the service:

- basic financial assistance of $3.66 USD (4 CAD) per hour of services rendered is granted to any eligible person, regardless of family income.
- variable financial assistance of $.55-$8.23 USD (0.60-9.00 CAD) for each hour of service rendered may be granted over and above the basic financial assistance. The level of assistance is determined on the basis of an eligible person's family income and family situation.[24]

The balance is paid by the user. The per hour rate charged by the SEEHS ranges from $14.64 to $18.30 USD (16-20 CAD). SEEHS include 55 charities and 47 cooperatives (35 multistakeholder co-ops and 12 consumer co-ops), and a total of 6,700 full-time staff. Annually they do 5.6 million hours of service for 90,000 citizens (70% of them over 65 years old).

Social Care Cooperatives Data

Number of cooperatives	58[25]
Types of cooperative	Consumer: 18 Multistakeholder: 37 Producer (including worker cooperatives): 3
Number of members	40,000[26]
Number of employees	3,000[27]
Users	40,000[28]
Services offered	Housekeeping, nursing, foot care, personal care (assistance with medication, free in-home assessments, dietary needs, assistance with everyday living); companionship and respite (socialization, walks, and exercise); homemaking (meal preparation)
Annual turnover	$54.8 million USD (60 million CAD)[29]
Assets	$22.8 million USD (25 million CAD)[30]

CASE STUDY

La Coopérative de solidarité de services à domicile du Royaume du Saguenay[31]

Since 1997, a network of hundreds of home care social enterprises has been offering services primarily to Québec's seniors so that they can stay in their homes as long as possible. Although housekeeping, meal preparation, and similar tasks underpin the work, sometimes personal care is required to meet the needs of customers. Therefore, the region's public health network entered into an

agreement with the Coopérative de solidarité de services à domicile du Royaume du Saguenay that would extend its support services to such basic matters of personal care as transfers, bathing, etc.

In addition, since 2009 the cooperative has been supplying personnel management, cafeteria service, and overall care to seven long-term seniors' residences. It is also the owner of one of these residences: Pension Sainte-Famille, which has 29 units, including eight intermediate spaces for people awaiting placement in nursing homes. Since 2000, the cooperative also has partnered with the municipal housing office and the CSSS (Public Health Regional Centre) to carry out 24-7 monitoring in six other seniors' homes, each accommodating nine persons with physical disabilities.

Four elements are at the heart of the success story of this cooperative:

- **Listening to the growing needs of members**. Since its inception, the organization has been in tune with the changing needs of its members and has adapted its services accordingly.
- **Collaboration with public health authorities**. Operating on the territory of two CSSSs, the co-operative was able to reach service agreements with both.
- **Investment in training**. The Cooperative has invested in training to enable employees to diversify their skills. For example, in addition to household tasks, employees can learn to give a bath to an elderly person. In turn, nursing assistants are shown how to train employees to do these tasks.
- **Additional work opportunities for employees**. By developing a custom assignment service, the cooperative enables employees to work overtime in addition to their regular schedule. Thus, some have a combined annual salary of nearly $45,749 USD (50,000 CAD).

This cooperative is located in the Jonquière and Chicoutimi borough of the city of Saguenay, population 125,000. Currently (2014), the Coopérative de solidarité de services à domicile du Royaume du Saguenay is the largest of its kind in Canada. It has 6,500 members and 260 employees who provide 300,000 hours of service on an annual basis, and generate a turnover of more than US $6.8 million (7.5 million CAD).

PHARMACY COOPERATIVES

In Canada, there are no retail, wholesale, or other kinds of co-op pharmacy. However, some retail consumer co-ops, federated in the western provinces and (through Co-op Atlantic) in the east, offer pharmacy services. In Co-op Atlantic, they are associated with The Medicine Shoppe.[32]

Saskatoon Community Clinic includes a pharmacy that tries to keep the price of drugs as low as possible by promoting generic products and providing education to the users. They invest the surplus in health promotion.

MUTUALS & CO-OP HEALTH INSURANCE

The universal system of health insurance in place in Canada, as explained earlier, offers coverage for "medically required" services. That means that public spending annually represents about 70% of the total expenditure on health. This situation leaves space for health insurance products supplementary to the public coverage. Many types of cooperative enterprise offer a variety of kinds of health insurance, including financial co-ops (like the biggest single credit union in Canada, Vancity),[33] mutuals, and others.

For instance, the first financial co-op group in Canada, Desjardins Group, offers four kinds of health insurance:[34]

- Disability insurance (to secure income in case of accident or illness)
- Critical illness insurance (for recovery after a serious illness, like cancer or a stroke)
- Long-term care insurance (if there is a loss of independence because of a serious illness)
- Health care insurance (for health care expenses not covered under government plans, like dental care or alternative medicine)

In addition to its critical illness plan, The Co-operators Group Limited, a Canadian-owned cooperative, offers its Best Doctors programme. It gives access to a global network of over 50,000 doctors who are at the top of their profession. They can provide confirmation of a diagnosis and narrow down the search for a specialist. Even while offering their products (like health and disability insurance) to the general public, La Capitale Financial Group[35] offers special rebates for those who work for Québec's public service.[36]

Prescription drugs present another opportunity. In Québec, it is compulsory for individuals to have such a plan (1997).[37] Therefore, SSQ Financial Group[38] offers prescription drug insurance to businesses and associations.[39]

SOURCES

[1] Special thanks to the Fédération des coopératives de services à domicile et de santé du Québec and Gabrielle Bourgault-Brunelle for providing up-to-date and detailed data. The first section of this case is mostly based on Girard, Jean-Pierre, and Geneviève Bussière. 2007. *Health Co-ops Around the World: Canada*. International Health Co-operative Organisation. Retrieved August 3, 2014 (http://www.usherbrooke.ca/irecus/fileadmin/sites/irecus/documents/ihco_jean pierre_girard/coops_world_anglais/canada_anglais.pdf).

[2] Justice Laws Website. 2014. "Canada Health Act (R.S.C., 1985, c. C-6)." Government of Canada. Retrieved August 3, 2014 (http://laws-lois.justice.gc.ca/eng/acts/C-6/).

[3] Allaire, J.-F., Larouche, C., and Jean-Pierre Girard. 2011. "Health Systems in the Great Canadian North." Report submitted to the Co-op Secretariat, Government of Canada. Unpublished.

[4] A must-read on this subject is Marchildon, Gregory P., and Catherine Leviten-Reid, eds. 2012. *Privilege & Policy: A History of Community Clinics in Saskatchewan*. Revised edition. Regina: University of Regina, CPRC Press.

[5] Girard, Jean-Pierre. 2006. *Notre système de santé autrement : L'engagement citoyen par les coopératives*. Montréal, BLG.

[6] For example, the British Columbia Co-operatives Association, the Newfoundland and Labrador Federation of Cooperatives, the Ontario Cooperative Association, the Coopératives de développement régional-Acadie (New Brunswick), and Conseil Québécois de la coopération et de la mutualité (Québec).

[7] Health Care Co-operatives Federation of Canada. 2014. Website. Retrieved August 3, 2014 (http://www.healthcoopscanada.coop).

[8] Roy, Pierre, Brunet, Paul G. et al. 2013. "Rapport du Groupe de travail sur les coopératives de santé." Ministère de la Santé et des Services sociaux. Retrieved August 3, 2014 (http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2013/13-720-01W.pdf).

[9] Québec: Portail santé mieux-être. 2014. "Groupe de médecine de famille (GMF)." Government of Québec. Webpage. Retrieved August 3, 2014 (http://sante.gouv.qc.ca/systeme-sante-en-bref/groupe-de-medecine-de-famille-gmf/).

[10] Multicultural Health Brokers Cooperative. 2014. Website. Retrieved August 3, 2014 (http://mchb.org/).

[11] Health Connex. 2014. Website. Retrieved August 3, 2014 (https://healthconnex.ca/).

[12] TeamWerks Co-op. 2014. Website. Retrieved August 3, 2014 (http://teamwerks.ca/directory/about/index.html#).

[13] Industry Canada (IC), responsible for co-ops at the federal level, provided 2010 data for health clinics, co-ops, and other health services co-ops (outside Québec). The HCCFC provided two sources of data, a 2012 file with basic information about health and home care co-ops across the country (except in Québec) and the results of a survey conducted among their members February-March 2014. (The data categories are not the same as those used by Industry Canada.) The FCSDSQ and FCPQ provided May 2014 data for health co-ops and paramedic co-ops in Québec. The latter is a mix of data: some relates to all of Québec's health and paramedic co-ops and some only to their members.

[14] This number is certainly higher as of August 2014. The results from the partial data to which we had access was as follows: based on FCSDSQ data for health co-ops, 37 (May 2014); on FCPQ data for paramedic co-ops, 8 (May 2014); and on an extract from a 2010 IC survey on co-ops in Canada (outside Québec) inclusive of health clinics, 10, plus other types of co-op in the health sector, 18 (excluding 1 home care co-op).

[15] Based on 2010 data from IC, 28 health co-ops outside Québec (27,128); 2014 data from FCSDSQ, 36 health co-ops in Québec (60,000) and from FCPQ, 5 paramedic co-ops (1,000). *Note: any co-op that provides services covered by the Canada Health Act, serves many more patients than the number of members indicates.*

[16] Canada (2010), outside Québec = 452; Québec (2014), health co-ops (excluding general practitioners and clerical staff) = 50; Québec (2014) paramedics = 1,350.

[17] Only for health co-ops in Québec.

[18] 2014 reference. Only for health co-ops which are members of the FCSDSQ.

[19] No data available for Canada (out of Québec). 2014 data from FCSDSQ = 36 health co-ops in Québec. Some of these co-ops, besides the main clinics, also have points of service.

[20] Based on 2010 data from IC, 28 health co-ops outside Québec (26,262,204); 2014 data from FCSDSQ, 36 health co-ops in Québec (5,000,000) and FCPQ, 5 paramedic co-ops (100,000,000). In the latter case, note that the greater part of this income came from a contract with the Québec Health Ministry and its regional public health agency.

[21] Based on 2010 data from IC, 28 health co-ops outside Québec (18,710,115); 2014 data from FCPQ, 5 paramedic co-ops (50,000,000).

[22] This case study was supplied by NorWest Co-op Community Health Co-op.

[23] Interview with Jocelyn Grondin, advisor, Fédération des coopératives de paramédics du Québec, May 30, 2014.

[24] Régie de l'assurance maladie Québec. 2014. "Domestic help." Webpage. Retrieved August 3, 2014 (http://www.ramq.gouv.qc.ca/en/citizens/aid-programs/domestic-help/Pages/domestic-help.aspx).

[25] Data: 47 from FCSDSQ for Québec (2013); 11 from HCCFC (2012) for the rest of Canada.

[26] Data for Québec only (2013), 35 multistakeholders. Most are user-member, others are worker and support-member.

[27] This is an approximation, only for Québec and based on data for all SEEHs involved in home care.

[28] Idem.

[29] Data only for members of FCSDSQ (2013).

[30] Idem.

[31] Interviews with Lynda Bélanger, the Executive Director of Coopérative de solidarité de services à domicile du Royaume du Saguenay, May 23 and June 5, 2014.

[32] The Medicine Shoppe Pharmacy. 2014. Website. Retrieved August 3, 2014 (http://www.medicineshoppe.ca/).

[33] Vancity. 2014. Website. Vancouver City Savings Credit Union. Retrieved August 3, 2014 (https://www.vancity.com/).

[34] Desjardins. 2014. "Assurance santé et invalidité". Webpage. Retrieved August 3, 2014 (http://www.desjardins.com/ca/personal/insurance/life-health-insurance/health-disability-insurance/index.jsp).

[35] The Group is owned by La Capitale Civil Service Mutual, a mutual with close to 240,000 members working in the public and para-public sectors.

[36] La Capitale Financial Group. 2014. "Health and Disability Insurance." Webpage. Retrieved August 3, 2014 (http://www.lacapitale.com/en/individuals/insurances/health-disability-insurance).

[37] Régie de l'assurance maladie Québec. 2014. "Citizens: Prescription Drug Insurance." Webpage. Retrieved August 3, 2014 (http://www.ramq.gouv.qc.ca/en/citizens/prescription-drug-insurance/Pages/prescription-drug-insurance.aspx).

[38] The group is partly owned by a mutual, SSQ mutuelle de gestion.

[39] SSQ Financial Group. 2014. "Prescription Drug Insurance." Webpage. Retrieved August 3, 2014 (https://ssq.ca/businesses-associations/insurance/group-insurance/prescription-drug-insurance).

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2014

HEALTH SYSTEM

Chile's health system is composed of mandatory health insurance that can be either public or private. Public insurance is offered through a single non-profit provider, the National Health Fund (FONASA). Private insurance can be purchased from 13 for-profit or not-for-profit private health insurance institutions known as ISAPREs (Instituciones de Salud Previsional) of which six are open to all and seven are restricted to personnel of a particular company or institution. Both FONASA and ISAPREs receive 7% of the worker's remuneration. That covers basic primary care, emergency care, and targeted health problems.[2] The basic coverage is laid out by the Explicit Health Guarantees Plan (Garantías Explícitas de Salud, AUGE-GES) which assures universal health coverage and a medical benefits package consisting of a prioritized list of diagnoses and treatments (80 items in 2013).[3] Those unable to pay health care are covered by FONASA through direct payments by the State.[4] Co-payments may be made under both systems depending on the care required and the health plan.

Population (in thousands) total: 17,465

Population median age (years): 32.76

Population under 15 (%): 21.38

Population over 60 (%): 13.8

Total expenditure on health as a % of Gross Domestic Product: 7.2

General government expenditure on health as a % of total government expenditure: 15.2

Private expenditure on health as a % of total expenditure: 51.4

Cooperatives have a long history in Chile, with the first consumer cooperatives founded in 1887. According to the Department of Cooperatives of the Ministry of Economy, Development and Tourism (DECOOP), there were 1,324 active cooperatives in Chile on December 31, 2013.[5] Cooperatives are regulated by a general cooperative law which describes different types of cooperative and provides examples of their sectors of activity, including consumer, service, worker, electricity, agriculture, fishery, savings and credit, and housing.[6] It also describes cooperatives with regard to their impact on the economy, introducing the concept of "cooperatives of economic importance." These are defined as savings and credit cooperatives, housing cooperatives with open membership, and those whose capital exceeds approx. $2 million USD (50,000 Unidades de Fomento)[7] or have more than 500 members.[8] It makes no specific mention to health or social cooperatives, but does not limit the sectors of activity in which cooperatives can operate.

Up until 2003-2004, one health cooperative, Cooperativa de Servicios de Protección Medica Particular (Promepart) was one of the ISAPREs. It provided services to over 120,000 people nationwide. It ceased operations due to alleged financial mismanagement, inability to provide the increased services required to be an ISAPRE at competitive prices, and the increased capital requirements.

Today, cooperatives do not provide obligatory health coverage. However, they do provide pharmaceutical services and complementary health insurance and services through public and private health care providers. Cooperatives are also involved in social care.

Mutuals are also recognized health care providers and manage 80% of the obligatory accident and occupational health insurance and services market.

HEALTH COOPERATIVES

The Department of Cooperatives of the Ministry of Economy, Development and Tourism (DECOOP) defines health cooperatives as those cooperatives which provide health care of all kinds. Under this definition, DECOOP reports that there are no health cooperatives in Chile.

DECOOP does however identify an additional six cooperatives that provide health-related services – one pharmacy cooperative and five cooperatives offering complementary health insurance and services. Those providing complementary insurance also offer members services through accredited health care providers with whom they have service contacts. They are listed below in order of date of foundation. The pharmacy cooperative is listed in a separate section of this case.

Cooperativa de Servicios Villa de Vida Natural Manuel Lezaeta Acharan Limitada (COVINAT), a service cooperative founded December 19, 1965 as a naturopathic medicine cooperative. Its centre offers medical services, such as acupuncture, hydrotherapy, pelotherapy, and massage treatments, as well as nutritional and other educational programmes aimed at maintaining or recovering health.[9]

Cooperativa de Servicios Medicos Limitada (SERMECOOP), a service cooperative, was founded November 27, 1967.[10] It provides complementary health services to more than 45,000 beneficiaries (members and their families) throughout the country. It aims to assist members and their families in accessing the best of the public and private health services available (medical and emergency dental care) and operates a complementary health plan.

Cooperativa de Servicios de Salud de los Educadores de Chile y Afines Limitada (ISAEDUCOOP), was founded February 14, 1992. It has 3,000 members and family beneficiaries. Like SERMECOOP, ISAEDUCOOP aims to assist members (teachers) and their families in accessing the best of the public and private health services available and operates a complementary health plan. It contracts with entities providing health services and administers the contributions that members make to cover co-payments for the following: hospitalizations, births, or surgeries; purchase orders for medical care (bonds), medical programmes, payment of prescriptions, purchases of optical lenses; dental treatment, dental emergencies; ambulance or other services.

Cooperativa Nacional de Salud Solidaria Limitada (National Cooperative of Health Solidarity) was established in 1994. Its purpose is the development of systems of mutual aid among its members, facilitating access to comprehensive services, community and family health care.

Cooperativa de Servicios y Beneficios de Salud de los Trabajadores de Chile Limitada. SERTRACOOP was established in 2011 to provide services, health and other benefits to protect and improve the quality of life and health of members and beneficiaries.

Health Cooperative Data (2013)

DECOOP provided the following data on the cooperatives identified, as of 2013:

Number of cooperatives	5 User cooperatives
Number of members	29,902 (12,818 women, 17,084 men)
Number of employees	88
Annual Turnover	$11,610,350 USD

Case Study

SERMECOOP assists members and their families in accessing the best of the public and private health services available from public and private providers (medical and emergency dental care) and operates a complementary health plan. It contracts with health providers (private medical clinics, dental clinics, laboratories, opticians, pharmacies, hearing aid providers and the national reimbursement system I-Med)[11] to reduce the costs of health services. It also offers health education and organizes health promotional activities. Among its partner organizations are financial institutions offering health care loans, optional life and disaster or catastrophic insurance plans.[12]

SERMECOOP was established in 1967. The Sodimac cooperative and its workers wanted to improve the well-being of workers through the creation of a workers' welfare fund. Sodimac at the time was a consumer-retail cooperative specializing in construction materials. It dissolved in the 1980s due to bankruptcy. The enterprise re-emerged in 1982 as a private company, Sodimac S.A.

SERMECOOP initially managed a solidarity fund. It was a pioneer in making medical services available to all members while reducing out-of-pocket expenses. After the dissolution of Sodimac Cooperative, it continued to provide services to Sodimac S.A. and in 2001 expanded its service offerings to other enterprises.

In 2007 it signed an agreement with the Health Authority of Chile (Superintendencia de Salud) to provide information and guidance to members and to the general public on their rights and obligations with regard to health.[13]

Today, it provides services to 30,000 workers and 45,000 beneficiaries (members and their families from 100 enterprises and municipalities). Its services differ from for-profit actors as follows:

Item	SERMECOOP	For-profit industry actor
Pre-existing conditions	Accepts	Does not accept
Age	No limit	Limits
Waiting period	None	Yes
Deductibles	None	Yes
Dental plan	Integrated	Separate plan
I-Med[14]	Included at no cost	Optional at a cost
Advice/orientation	Yes	No
Contraceptives	Yes	No
Laser eye surgery	Yes (no minimum diopters)	Yes (minimum diopters)
Newborns	Coverage as of day 0	Coverage as of 15 days
Profits	Not-for-Profit	For-profit

SERMECOOP's head office is in Santiago. To achieve national coverage it has established branch offices in Viña del Mar and Concepción in 2002, in la Florida in 2006, Puerto Montt in 2008 and Antofagasta in 2013.

PHARMACY COOPERATIVES

DECOOP identified one pharmacy cooperative, Cooperativa de Servicios de Salud y Medicamentos Limitada (FARMACOOP), established in 2009. Its objectives are to provide access to affordable medicines and laboratory clinics, promote healthy living, and promote entrepreneurial activities and work opportunities for the elderly, persons with disabilities, and other vulnerable groups.

According to DECOOP, the cooperative is not currently active in the market due to a lack of member capital for the initial investment. FARMACOOP has confirmed that the founder group, a group of seniors, is still in the process of setting up the cooperative. It has not yet been able to open its first pharmacy or to seek new members, given the country's difficult financial situation.[15] It is currently seeking information, advice, and financial support to help initiate operations.

OTHER COOPERATIVES

The retail-consumer and savings cooperative set up by the police force, Cooperativa de Consumos y de Ahorros Carabineros de Chile Ltda (COOPERCARAB), provides members with a wide range of consumer goods, including pharmaceutical and optical products. Created on July 13, 1934 to meet the needs of the police force for basic goods, it is the oldest and largest cooperative. In 2013 it had 75,216 members and in 2012 reported sales of $66,276,736 USD. It has branches in Chile's major cities: Santiago, Iquique, Antofagasta, Valparaíso, Concepción, Temuco, and Puerto Montt.

COOPERCARAB offers pharmaceutical and optical products to its members for 20% less than the market price. The cooperative handles sales service within its retail centres to control costs. It does not lease space to providers, but runs the business itself.

SOCIAL COOPERATIVES

DECOOP defines social cooperatives as those providing services for vulnerable populations, including persons with disabilities and the elderly. By this definition, only one cooperative is active, **Cooperativa de Trabajo para personas con Discapacidad, los Emprendedores de los Vilos**.

This worker cooperative was founded in 2012 with the objective of creating job opportunities for people with disabilities through entrepreneurship, skills development, and occupational inclusion. The cooperative is engaged in the banqueting and catering industry and more specifically in food production, and packaging, venue rentals, facilities, event, and staff management. It has 26 worker-members, 15 women and 11 men.

It is also worthy of note that the National Disability Fund (Fondo Nacional de Discapacidad, FONADIS) provides financial support for initiatives in self-employment and microenterprise development for or by persons with disabilities. The Fund makes specific reference to support for cooperative development, thus providing opportunities for other cooperatives to form.

MUTUALS

In 1968 the legal code was amended to make obligatory the protection of workers from accidents and occupational disease (Seguro Social contra Riesgos de Accidentes del Trabajo y Enfermedades Profesionales). Mutuals that protected workers from accident and health-related misfortunes predated this law, however.

Currently there are three mutuals and one state provider, Instituto de Seguro Laboral (ISL). All provide obligatory accident and occupational health insurance and health care services in addition to other social protection services and accident prevention training.

The three mutuals manage 80% of the 5.5 million obligatory accident and occupational health insurance policies. They provide preventive, curative, and rehabilitative care to workers as well as compensation in the form of subsidies, allowances, and annuities for loss of earning due to accident or professional illness.[16] The mutuals providing health services are:

- **Instituto de Seguridad del Trabajo** (IST), the first employers' mutual in Chile. It was created in December 1957 by the Industrial Association of Valparaíso y Aconcagua (Asociación de Industriales de Valparaíso y Aconcagua, ASIVA). In 2012, IST held 12% of the mutual market, serving over 550,000 workers.[17]
- **La Asociación Chilena de Seguridad** (ACHS) created June 26, 1958 (Decreto N° 3.029) and associated with the industrial workers association, Sociedad de Fomento Fabril (SOFOFA). In 2013 it had approximately 2.4 million members.[18]
- **Mutual de Seguridad CChC**, created in 1966 by the Chilean Chamber of Construction (Cámara Chilena de la Construcción). In 2012, it had 1.7 million members.[19]

Their service offerings are available to individual salaried workers, to enterprises through group plans, and to self-employed workers. Mutuals provide their services through networks and their own health care installations across the country as well as through other health care providers with whom they have partnered.

Mutual Data (2013)[20]

Number of mutuals	3
Number of members	4.4 million
Number of employees	N/A
Users	N/A
Facilities	3 hospitals, 53 clinics, 153 polyclinics providing a total 1,014 beds
Services offered	Preventive, curative, rehabilitative care, including emergency medical transport (ambulance, helicopter), surgery, dental, orthopaedic care, ophthalmology, cardiology, hearing specialists, etc.

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COLOMBIA

2014

HEALTH SYSTEM

The 1991 constitution of Colombia entitles all Colombians to social protection. The 1993 "Law 100" established a national obligatory health insurance. It consists of two schemes which as of April 30, 2014 covered 43,184,337 or 96% of the population.[1] The "contributory" scheme covers formal workers and is financed by employers and employee contributions. Their services are provided through 21 Health Promotion Entities (Entidades Promotoras de Salud, EPS). The "subsidized" scheme covers informal workers, the unemployed, and those not otherwise covered. It is financed primarily by national and local taxes and serviced currently by 39 entities. The EPS contract for services is made with Service Provision Institutions (Instituciones Prestadoras de Servicios, IPS) which number approximately 30,000 authorized hospitals, labs, clinics, doctors', and dental clinics.[2] Cooperatives are found among the EPSs and IPSs.

In 2011, the government began a review of the operations and finances of a number of health service promoters and providers (EPSs, and more recently IPSs) following allegations of collusion. A number of the entities were sanctioned and fined, including some cooperatives.

Overall, the cooperative movement is both economically and socially important in Colombia. Cooperatives are among the top 100 enterprises in Colombia in terms of turnover. In 2012, the Confederation of Cooperatives of Colombia (Confederación de Cooperativas de Colombia, CONFECOOP) reported that 5.5 million people or 11.9% of the population were members of 6,421 active cooperatives. CONFECOOP further estimates that cooperatives have an impact on over 16.3 million people or 35.7% of the population. Cooperatives are significant economic actors with a combined turnover of approximately $15.2 billion USD (26,900 trillion COP). According to CONFECOOP they contribute approximately 4.1% of GDP.[3]

Population (in thousands): 47,704

Population median age (years): 27.4

Population under 15 (%): 28.03

Population over 60 (%): 9.19

Total expenditure on health as a % of Gross Domestic Product: 6.8

General government expenditure on health as a % of total government expenditure: 18.5

Private expenditure on health as a % of total expenditure: 24.2

Health and social care cooperatives account for 7.1% of all cooperatives and 2% of cooperative membership. They provide access to health and social care services to over 12.1 million people.

Cooperatives in Colombia 2012[4]

Sector	Number	Members	Employees
Financial	1,643	4,272,846	68,629
Transport, communication, others	660	79,840	23,718
Retail trade	605	525,780	23,255
Health and social services	457	112,997	106,570
Agriculture, fisheries, livestock, forestry	401	31,518	21,574
Industrial/Manufacturing	147	25,144	18,220
Other	2,508	492,955	250,868
Total	6,421	5,541,080	512,834

Source: CONFECOOP. Desempeño Sector Cooperativo Colombiano 2012

Together cooperatives and mutuals provide health coverage to 18 million people in Colombia.

HEALTH & SOCIAL CARE COOPERATIVES

Cooperatives are significant actors in the provision of health services in Colombia. According to CONFECOOP, the majority (85.7%) are producer (worker) cooperatives, but there are user and user/producer cooperatives as well. They are involved in health and social care delivery, but also in the provision of prepaid insurance. As mentioned above, some are authorized providers in the obligatory health system (for the contributory and subsidized schemes), others provide services to the latter or complementary care not covered by the obligatory health plan. The EPSs provide insurance and services through contracted health providers (IPSs), deliver health services in their own facilities, and produce, purchase, and distribute pharmaceuticals. Cooperative IPSs provide general and highly-specialized medical services (for example, oncology,

anaesthesiology, urology, gastroenterology), dental care, ophthalmology, physical therapy and rehabilitation, hospitalization, pharmacy, home care, and ambulance services.

In 2012, CONFECOOP estimated that 457 cooperatives were engaged in health and social care activities, a 5.9% increase over 2011. They were active in 25 of Colombia's 32 departments. These include cooperatives that are EPSs in the contributory scheme. They provide services to 38% of the 20.08 million contributory scheme affiliates, and 20% of the 22.7 million subsidized scheme affiliates, for a grand total of 28.1% of those covered by national obligatory health insurance.

Contributory	Affiliates
E.P.S. Saludcoop	4,011,677
Coomeva E.P.S. S.A.	2,904,894
Cafesalud E.P.S. S.A. (owned by Saludcoop)	693,215
Subtotal	7,609,786
Subsidized	
Cooperativa de Salud y Desarrollo Integral Zona Sur Oriental de Cartagena Ltda. Coosalud E.S.S.	1,611,106
Entidad Cooperativa Sol. de Salud del Norte de Soacha Ecoopsos	297,334
Cooperativa de Salud Comunitaria-Comparta	1,623,297
CAFESALUD E.P.S. S.A. (owned by Saludcoop)	1,010,914
Subtotal	4,542,651
TOTAL	12,152,437

Source: Miniserio de Salud y Proteccion Sociale. Sistema Integral de Proteccion Social (SISPRO)[5]

Just over 69.9% of the 457 cooperatives are microenterprises. They account for 23.1% of the sector's turnover, 65.5% of its members, and 62.4% of its employees. Approximately 33% of health and social care cooperatives are small enterprises, 3.9% are medium enterprises, and 1.1% (five) are large enterprises. The large enterprises generate 76.9% of turnover in the sector and bring together 34.4% of members and 37.8% of employees. They have registered negative surpluses of $22,100 USD (41.699 million COP), however.

Health and social cooperatives as a group are responsible for approximately 20.6% of cooperative turnover. Inpatient health services provide the largest part of revenue in the sector, 78.3%. Social services account for 10.5%, while other medical services account for 9.5%.

In 2012, health and social care cooperatives had a combined membership of 112,997 or 2% of all cooperative members in Colombia. Of the cooperatives active in health and social care, 436 provided sex-disaggregated data indicating that 39.2% of members were men, and 60.8% were women.

With regard to employment, the sector provided jobs to 34,412 persons. However, since the majority of health and social care cooperatives are worker cooperatives (392 out of 467), an additional 67,158 worker-members should also be included as employees. Thus the sector provided employment to 106,570 people in total.

Health and social cooperatives had revenues of $2.9 million USD (5.6 billion COP) in 2012, an increase of 10.8% over the previous year. It accounted for 20.8% of revenues of the cooperative movement. However, the sector continued to register losses of $21,069 USD (39.754 million COP) in 2012, a decrease over the previous year's $27,458 USD (51.809 million COP).[6]

Two of the largest health cooperatives are **Saludoop** and **Coomeva**. Following the investigations related to the allegations of collusion, and more recent reviews of EPS and IPS operations, both Saludoop and Coomeva have had to make structural changes. Saludcoop provides 20% of services to the contributory scheme and through its group owns numerous IPSs. The government intervened in 2011, which gave rise to rumours regarding its eventual liquidation. Given its importance in the market, Saludoop will undergo reforms and continue to operate, but will remain under government supervision until May 2015.[7] The impact which the ongoing review of the overall health system will have on current promoters and providers of health care remains unclear.

Health & Social Care Cooperative Data

Number of cooperatives	457
Types of cooperative	User, Producer, User/Producer
Members	112,997
Employees	106,570 of which 67,158 are worker-members
Users	12,152,437 (figure based on users of service providers of both the contributory and subsidized schemes)
Services	Integral health services – emergency care, general and specialized medicine, surgical and outpatient hospital care, obstetrics, dental care, health promotion and prevention, curative treatments, diagnostic imaging, laboratories and rehabilitation services, home care, prepaid health insurance
Facilities	N/A
Sources of revenue	Direct transfers, payments for services

PHARMACY COOPERATIVES

Pharmacy cooperatives are strong in Colombia. They produce pharmaceuticals in their laboratories, engage in bulk purchasing and distribution, and provide marketing support, technical assistance, credit, and insurance. No aggregated information on pharmacy cooperatives was identified.

One of the largest pharmacy chains in the country is a cooperative, **Cooperativa Nacional de Droguistas Detallistas** (COPIDROGAS). Founded in 1969, it currently has 3,900 members with 5,200 pharmacies and has outlets in 31 of the 32 departments. COPIDROGAS reported a turnover of $777 million USD in 2013, up from $673 million USD in 2012. It ranked as Colombia's second largest cooperative in terms of turnover in 2012[8] and in 2014 was ranked Number 58 in size relative to Colombian enterprises over all.[9] In April 2014, it announced that it was engaging in a new branding campaign with a new logo and name. Its pharmacies will now be known as "Farmacenters."[10]

Another important pharmacy cooperative that engages in the production and distribution of pharmaceuticals is Coaspharma. It had a turnover in 2013 of $51 million USD (92.417 billion COP) of which 45% are attributed to exports in the Latin America region.[11]

Other cooperative pharmacies are Cooperativa Epsifarma (part of the Saludcoop Group) and Cooperativa Multiactiva de Produccion Distribucion y Servicios Farmadisa (COODEMCU).

INSURANCE COOPERATIVES

Insurance cooperatives provide complementary insurance plans for accidents, occupational health, and complementary medical and dental care.

For example, **La Equidad Seguros** provides a complementary health insurance plan for "high cost illnesses" ("enfermedades de alto costo") which covers the cost of treatments not included under the obligatory national health plan. La Equidad also provides occupational health insurance to enterprises. It is ranked nineteenth among 26 insurance companies in Colombia and twelfth in terms of cooperative turnover for its life insurance group. The cooperative insurer Aseguradora Solidaria de Colombia (Seguros UCONAL) also provides dental plans to its members. It is the fifth largest cooperative in terms of turnover in Colombia.

OTHER COOPERATIVES

According to CONFECOOP, the majority of cooperatives from all sectors support health care initiatives for members and employees but also for the communities which they serve. Of 373 cooperatives which provided information about their social programmes, CONFECOOP reports that 5.4% of resources (nearly $5 million USD) went to support health activities.[12]

In addition, cooperatives provide specific benefits, including complementary insurance at discounted rates or reimbursement of medical bills for treatments not covered under the national obligatory health plan. For example, the savings and credit cooperative **Fincomercio Cooperativa de Ahorro y Crédito** offers members beneficial rates on prepaid complementary health insurance made available through a number of providers, including cooperative and other private institutions.[13] Cooperativa de Ahorro y Crédito (CREAFAM) reimburses medical bills for members in good standing.[14]

MUTUALS

In 2012, 231 mutuals were active in Colombia. They had 175,013 members and a turnover of $1.3 million USD (2.4 billion COP).[15] These provide a series of services including retirement plans and access to health care.

Five mutuals that are health promotion entities (EPSs) under the subsidized health scheme were identified. They serve 5.7 million affiliates.

Name	Affiliates	Employees
Empresa Mutual para el Desarrollo Integral de la Salud E.S.S. EMDISALUD ESS	464,747	
Asociación Mutual La Esperanza ASMET Salud E.S.S.	1,590,499	40,000[16]
Asociación Mutual Barrios Unidos de Quibdó E.S.S.	839,023	
Asociación Mutual Empresa Solidaria de Salud de Nariño E.S.S. EMSSANAR E.S.S.	1,699,476	
Asociación Mutual SER Empresa Solidaria de Salud ESS	1,123,366	11,380[17]
TOTAL	5,717,111	

Source: Miniserio de Salud y Proteccion Sociale. Sistema Integral de Proteccion Social (SISPRO)[18]

Like cooperatives, mutuals which are EPSs or IPSs are under investigation in the government's ongoing review of the health systems.

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COSTA RICA[1]

2014

HEALTH SYSTEM

Universal health coverage is available to residents through the national health care system. In 1973, the health care system underwent reform. Its administrators – the Ministry of Health and the Costa Rican Social Security Institute (Caja Costarricense de Seguro Social or CCSS) – established a model by which medical services could be contracted out to both public and private entities, including cooperatives, with the CCSS regulating the provided services and setting quality standards and evaluation mechanisms. The law (Article 3 of Law No. 5345) includes specific mention that the contracting of health services to cooperatives is to be preferred.[2]

According to the IV[th] National Cooperative Census (2012) published by the National Institute for the Promotion of Cooperatives (Instituto Nacional de Formento Cooperativo INFOCOOP), 399,000 people now receive health care services through health cooperatives – 8.3% of the population.[3] In May 2013, representatives of health cooperatives reported that they provide services to a greater number: approximately 450,000 people.[4] The Census identified six health and social care cooperatives.[5]

However, INFOCOOP also reported that over 8.8% of the services provided by all types of cooperative contribute to health and social care activities. Savings and credit cooperatives provide loans for health care services and health insurance products. One example is COOPENAE, the largest savings and credit cooperative in Costa Rica. It not only operates an insurance arm offering health and accident insurance among other forms of insurance, but is also founder of a private insurer, Aseguradora del Istmo ADISA[6] which currently holds 7.9% of the accident and health insurance market.[7] Also worthy of mention is the National Salt Producers Cooperative COONAPROSAL (Cooperativa Nacional de Productores de Sal R.L.). By bringing together salt producers in the 1970s it "proved vital for implementing the salt iodization policy," and thus contributed to improved health in the population.[8]

Some mutuals also provide loans for health care to their members or advance life insurance benefits to those with serious illnesses. There are no insurance cooperatives providing health coverage.

Population (in thousands): 4,805

Population median age (years): 29.29

Population under 15 (%): 23.94

Population over 60 (%): 10.15

Total expenditure on health as a % of Gross Domestic Product: 10.1

General government expenditure on health as a % of total government expenditure: 27.7

Private expenditure on health as a % of total expenditure: 25.4

HEALTH COOPERATIVES

Health cooperatives emerged in 1988 due to discontent with national health care services in outpatient clinics. Cooperatives can be and are contracted by the CCSS as service providers for a set, renewable period. These cooperatives were founded in accordance with general cooperative law and are registered as per their membership model. Health and social cooperatives fall into the following categories: worker (autogestionada), consumer services (traditional), or multistakeholder (co-gestionada). They are considered a strategic arm of social security.

The role of cooperatives in the provision of health care services primarily involves being contracted by CCSS to manage clinics or other health service providers in specific geographic regions and to provide a series of health care services. Cooperatives are therefore involved in managing primary health centres or EBAIS (Equipos Básicos de Atención Integral en Salud), as well as providing private hospital, medical care, and dentistry services. Contracted service delivery cooperatives provide health care services under the same conditions and for the same fees as the public sector does. The CCSS finances the costs. Services provided are integrated health care and include general ambulatory care and specialized medicine, emergency care, minor surgery, dentistry, pharmacy, laboratory, radiology, social care, verification of entitlement and affiliation, patient transportation, support services to physicians, mixed medical care services, and preventive primary care activities, such as vaccinations, prenatal care, etc.

Currently there are four major health cooperatives. COOPESALUD (Cooperativa Autogestionaria de Servicios Integrales

de Salud RL) was established in 1987 and began operations in 1988 as a worker cooperative. It was followed by another worker cooperative, COOPESAIN (Cooperativa Autogestionaria de Servidores para la Salud Integral R.L.) in 1990. COOPESANA (Cooperativa Cogestionaria de Salud de Santa Ana R.L.) was founded in 1993 as a multistakeholder cooperative (the members being workers and other cooperative societies). Finally, COOPESIBA (Cooperativa Autogestionaria de Servicios Integrales de Salud de Barva R.L.) is a worker cooperative founded in 1999. A health cooperative consortium also exists, CONSALUD. It brings together two health cooperatives – COOPESALUD and COOPESAIN – with a third cooperative, the National Federation of Agricultural and Worker Cooperatives FECOOPA (Federación Nacional de Cooperativas Agropecuarias y de Autogestión R.L.). CONSALUD owns and manages a hospital, Hospital Cooperativo San Carlos Borromeo, which provides both primary and complementary care.[9]

Studies on the efficiency and quality of health care provided through cooperatives have confirmed that the model has been successful and financially efficient.

Health Cooperative Data

Number of cooperatives	4
Types of cooperative	3 Producer – 1 MS
Number of members	N/A
Number of employees[10]	Total: 1,017 (Data for all cooperatives not available. See Table 1, p. 49.)
Users	399,000[11] (2012) to 450,000[12] (2013)
Installations	175 care centres and 4 clinics/hospitals[13] (2013)
Services offered (2008)[14]	Orthodontia 80% Medical laboratories and diagnostic services 80% Medical care installations 80% Medical services 60% Private hospitals 20% Pharmacy 20%
Annual turnover	N/A
Source of revenue	Transfers and other

Case Study

Over 20 years in operation, **Cooperativa Cogestionaria de Salud de Santa Ana** (COOPESANA R.L.) is a multistakeholder cooperative. Its members are health professionals and technicians working with the cooperative, as well as users organized in 11 community groups, including the municipal government. COOPESANA was established in July 1992 and began operations in August 1993.

The cooperative was founded to make health care in the area of Santa Ana more accessible, in particular to persons with modest incomes, to reduce travel time, and to address the problems of long wait times at the nearest clinics. It was initially contracted to provide health services to 11 EBAIS in the Santa Ana area, serving approximately 40,000 people. Its initial services included primary care, emergency services, orthodontia, social services, gynaecology, paediatrics, and internal medicine. In 2002 the cooperative expanded its area of coverage to include the regions of San Francisco de Dos Ríos and San Antonio de Desamparados with eight additional EBAIS serving more than 30,000 people. In 2011 it won a competitive bid to provide services to the region of Escazú, adding 16 EBAIS serving 60,000 people. Today, it has contracts to provide health and social services to 35 EBAIS serving over 143,000 people.[15]

COOPESANA offers integrated health services – internal medicine, emergency medical attention, psychiatric and orthodontic care, laboratory and pharmacy services, social services, home care, nutritional guidance, nursing care, physical therapy, and others.

Unlike the other health cooperatives, COOPESANA R.L. owns its buildings and equipment. The others lease them from CCSS.

In 2011, COOPESANA reported that it had invested over $2.7 million USD (over 1,421,000,000 CRC) in the Cantón of Santa Ana since operations began in 1993.[16]

SOCIAL COOPERATIVES

Cooperative social care is essentially provided by health cooperatives with a few other cooperatives which focus on a specific target group or service. The review of cooperatives active in social care revealed that Costa Rica has five cooperatives formed by and for people with physical and mental disabilities, namely COOPEAPAD (Cooperativa Autogestionaria de Personas Activas con Discapacidad R.L.), COOPECIVEL (Cooperativa Nacional de Ciegos y Discapacitados Vendedores de Lotería y Servicios Múltiples R.L.), COOPRESCO (Cooperativa Prevocacional al Servicio de la Comunidad R.L.), COOPESI (Cooperativa de Servicios Múltiples de los usuarios/as de los servicios del Hospital Nacional Psiquiátrico R.L.), and Coopesuperación (Cooperativa Autogesionaria de Personas con Discapacidad Fisica Permanente R.L.).[17] These cooperatives provide employment opportunities to people with disabilities as a means of facilitating social integration or reinsertion in society through employment, training, and counselling. They take

the form of worker and service cooperatives and are active in recycling, the sale of lottery tickets, small livestock breeding, handicraft, garden nurseries, fertilizer production, hydroponics, and providing staff for a telephone helpline.

Other cooperatives identified offer ambulance and pre- and post-hospital transport services, home care and family care services (Cooperativa de Servicios en Asististencia Emergencias Medicas Cooperativas R.L., COOPEASEMEC). There is also a daycare cooperative set up by employees of the State-owned holding company of electric energy generation and telephony (Cooperativa de Servicios de Guardería de los Empleados del Grupo ICE COOPESEICE R.L.).

The data collected refers only to those cooperatives specifically cited. Since INFOCOOP reported that 8.8% of all cooperatives provide health and social care services, it is likely that other cooperatives whose primary functions are not health and social care are also active in this service area. Similarly, it is likely that social care is one of the services provided by some of the multiservice cooperatives.

Social Cooperative Data

Number of cooperatives	7
Types of cooperative	4 Producer, 3 User
Number of members	N/A
Number of employees	N/A (See Table 2, p. 49.)
Users	N/A
Installations	175 care centres and 4 clinics/hospitals[18] (2013)
Services offered	Illness prevention, wellness and health promotion, treatment and cure, rehabilitation
Annual turnover	N/A
Source of revenue	N/A

Case Study

Patients of the National Psychiatric Hospital formed their own cooperative in 2012 for an inclusive development of people with mental disabilities. Registered as multiservice cooperative, **COOPESI** engages in occupational therapy and forms part of a day hospital rehabilitation programme that promotes comprehensive care for people with mental illness. Its main function is to provide training, counselling, and skills development to enable members to become economically active.

Members are those who, following successful treatment, are ready to reintegrate into society. With an initial membership of 51, today the cooperative counts 62 members who suffer from schizophrenia, affective disorders, or organic psychosis. Of these, 48% are over 40 years of age, 64% are literate, 47% have secondary education, and 47% live in shelters and with family. They are united under the motto of "sí se puede" or "yes, we can."

The cooperative was established to address the lack of opportunities for patients once their treatments are completed. The cooperative provides both microentrepreneurship training and continued support with an interdisciplinary team of professionals in psychiatry, psychology, social work, pharmacy, health care, occupational therapy, and nursing. The initial focus of occupational workshops will be on growing and selling ornamental plants, hydroponic vegetables, organic fertilizer production, and butterflies.[19]

MUTUALS

A number of mutuals in Costa Rica provide financial products for individuals and enterprises: savings and loans, a series of insurance products (life, accident, funeral, home, etc.), and/or pension plans. Of those identified, the **Sociedad de Seguros de Vida del Magisterio Nacional**, which provides insurance coverage to 25% of the Costa Rican population,[20] provides the following: health loans; payments of 50% of life insurance policies to members diagnosed with serious illness; and access to subsidies to members who are dealing with specific long-term illnesses, such as Alzheimer's, AIDS, arthritis, cancer, diabetes, epilepsy, glaucoma, heart disease, lupus, paraplegia, Parkinsonism, etc.[21]

Table 1: Health Cooperatives

Name of cooperative	COOPSALUD[22]	COOPESIBA	COOPESAIN[23]	COOPESANA[24]
Type				
User				
Producer	X	X	X	
Multistakeholder				X
Members	300			42 worker members and 11 associations[25]
Employees	365	162	170[26]	320
Doctors	91[27]	31		
Nurses		22		
Other Health Prof	295	59		
Others	55	50		
Users[28]	174,257	61,553	48,158	143,000
Installations	2 private clinics+1 hospital + ?EBAIS	15 EBAIS	12 EBAIS	35 EBAIS
Types of service				
Illness & accident prevention	X	X	X	X
Wellness & health promotion	X	X	X	X
Treatment and cure	X	X	X	X
Rehabilitation	X	X	X	X

Table 2: Social Cooperatives

Name of cooperative	COOPEASEMEC[29]	COOPESI[30]	Coopesuperacion[31]	COOPRESCO[32]	COOPECIVEL[33]
Type					
User				X	
Producer	X	X	X		X
Multistakeholder					
Members	5	62	67	29	60
Employees					
Doctors					
Nurses					
Other Health Prof					
Others	5				
Users					
Facilities		1			
Types of service					
Illness & accident prevention	X				
Wellness & health promotion	X	X			
Treatment and cure	X				
Rehabilitation		X	X	X	X

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DOMINICAN REPUBLIC 2014

HEALTH SYSTEM

A new health care system was put in place in 2001 that guarantees universal health care.[1] To achieve coverage, health care services are delivered by both public and private providers, including non-profits and non-governmental organizations which provide critical services not covered by the public and the for-profit private sectors. The health system is financed through a both a contributory scheme (financed by employers) and subsidized scheme (coverage ensured by public financing). A 2009 study reported that 54% of the population was not covered by the contributory scheme and continued to access public health care provided by the Ministry of Health or covered their own medical expenses by resorting to private institutions.[2]

Legislation exists which recognizes health cooperatives. They are defined as being organized by consumers of medical and pharmaceutical services for health maintenance and disease prevention. However, other cooperatives (in particular savings and credit cooperatives and multipurpose cooperatives) are also active in supporting and providing health and social care services. Insurance cooperatives also engage in health promotion with education campaigns.

Cooperatives provide medical services by the following means: they run clinics with general, orthodontic and ophthalmologic care; they operate pharmacies or have agreements to provide members with discounted rates on pharmaceuticals; and they offer financial products (loans) to facilitate access to both health care and pharmaceuticals.

Health professionals also have formed savings and credit cooperatives and multiservice cooperatives.

The 2012 cooperative census found that there were 685 cooperative societies with 1,305,632 members active in 14 sectors: agriculture, consumer, marketing, health, insurance, transport, housing, savings and credit, mining, fisheries, industrial, energy, tourism, and forestry.[3]

Population (in thousands): 10,277

Population median age (years): 25.53

Population under 15 (%): 30.53

Population over 60 (%): 8.97

Total expenditure on health as a % of Gross Domestic Product: 5.4

General government expenditure on health as a % of total government expenditure: 14.3

Private expenditure on health as a % of total expenditure: 49.1

HEALTH COOPERATIVES

According to Articles 117-121 of the regulation for the application of the cooperative law of 1964,[4] health cooperatives are organized by consumers of medical and pharmaceutical services for health maintenance and disease prevention. They can operate at the local, regional, and national level, providing services in hospitals or clinics, and can outsource professional services. A minimum of 15 members and approximately $1,250 USD (50,000 DOP) in capital is required to register a health cooperative.[5]

In 2010, there were five active health cooperatives operating in two of the largest cities of the country, namely Santo Domingo and Santiago. They brought together 23,740 members and a total of approximately $15 million USD (599,744,642 DOP) in assets.[6]

PHARMACY COOPERATIVES

Cooperatives figure on a list published by the General Directorate of Drugs and Pharmaceuticals (Dirección General de Drogas y Farmacias) of the Ministry of Health, which authorizes pharmacy operations. The list has no effective date and does not include the full name of entities, which makes it difficult to identify all cooperatives authorized to provide pharmacy services. However, at least eight multiple service and savings and credit cooperatives are included.[7] Among those which could be identified were Cooperativa San José, Cooperativa Nacional de Servicios Múltiples de los Maestros (COOPNAMA), Cooperativa Vega Real, Cooperativa de Servicios Múltiples del Personal del Banco de Reservas de la República Dominicana, Cooperativa de Ahorro y Crédito, and Servicios Múltiples de los Empleados del Ministerio de Agricultura (Seacoop) Inc. (See "Savings & Credit Cooperatives," below.)

SAVINGS & CREDIT COOPERATIVES

The saving and credit cooperative sector is the second largest cooperative sector. There are 111 societies which focus solely on savings and credit, while 25 offer multiple services in addition to savings and credit services.[8]

The financial services offered include loans for health care. These take the form of specific loan plans for health care or a variety of types of "emergency" loan.

In keeping with their origins, cooperatives founded by health professionals provide credit to support professional development and improved services with regard to health care. They offer specific loan products for the purchase of medical equipment or for attending medical conventions, in addition to other financial products. This is the case for example for Cooperativa Médica de Santiago de Servicios Múltiples, Inc. (CoopMedica),[9] Cooperativa San José,[10] and Cooperativa de Servicios Múltiples de Profesionales de la Enfermeria (COOPROENF),[11] all of which primarily offer services to health professionals.

Other savings and credit cooperatives provide medical care services:

- The largest cooperative in Dominican Republic, **Cooperativa Nacional de Servicios Múltiples de los Maestros** (COOPNAMA) was founded in 1971 as a savings and credit cooperative for teachers in the public sector. It opened up its membership to include staff of the Ministry of Education and related institutions as well as its own employees. As it did so, it also assumed a multiservice role to cater to the needs of 130,000 members.[12] It introduced health care services and credit lines to facilitate access to pharmaceuticals and eye care (Opticoop).[13] COOPNAMA runs pharmacies at three of its branch locations.
- **Cooperativa Vega Real** has over 70,000 members, a medical department, and a medical and dental clinic as well as pharmacy.[14] It provides medical referrals to enable consultation with health specialists in partner institutions and provides members with credit lines (up to five times the value of member shares) for the purchase of pharmaceuticals.[15] It also involved in health promotion. For example, in early 2014, it held seminars on family health, cancer, and sexually transmitted diseases.[16] In 2012 it provided health care services to more than 50,000 people.[17]
- **Cooperativa de Ahorro y Créditos y Servicios Múltiples de los Empleados de la Oficina Nacional de la Propriedad Industrial** (COOP-ONAPI) provides medical and pharmacy services as well as health insurance to the employees of the National Office of Industrial Property.[18]

SOCIAL COOPERATIVES

The government of the Dominican Republic is a signatory of the United Nations Convention on the Rights of Persons with Disabilities and its optional Protocol in 2009. Article 27 (f) of the Convention, Work and Employment, calls on governments to "promote opportunities for self-employment, entrepreneurship, the development of cooperatives and starting one's own business" for persons with disabilities. However, no cooperatives of disabled persons were identified and national cooperative statistics do not include social cooperatives as a cooperative sector or type.

OTHER COOPERATIVES

Cooperatives in other sectors also provide health care-related services. For example, the service and production cooperative, Cooperativa de Servicios Múltiples y Producción de Trabajadores de la Falconbridge Dominicana (Coofalcondo), provides pharmacy services to its 6200+ members.[19]

INSURANCE COOPERATIVES

Cooperativa Nacional de Seguros (CoopSeguros), an insurance cooperative, is currently involved in health promotion. Although it does not yet offer health insurance, it does offer life and non-life insurance. Initially supported by international donors, CoopSeguros initiated an HIV/AIDS education programme. Through its member cooperatives, it provided information on HIV/AIDS prevention and reached 350,000 people. The programme has continued through a partnership with local organizations.[20]

MUTUALS

One mutual insurance company is authorized to operate by the governmental regulatory authorities, CUNA Mutual Insurance Society Dominicana, S.A., a subsidiary of CUNA Mutual Group of the United States. It provides life and other insurance products, but does not carry health insurance.[21]

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ECUADOR[1]

2014

HEALTH SYSTEM

The health system of Ecuador consists of a public and private sector. The public sector comprises the Ministry of Health (Ministerio de Salud Pública), the Ministry of Economic and Social Inclusion (Ministerio de Inclusión Económica y Social), municipal health services, and social security institutions (Instituto Ecuatoriano de Seguridad Social, Instituto de Seguridad Social de las Fuerzas Armadas e Instituto de Seguridad Social de la Policía Nacional). The Ministry of Health provides health care services to the entire population. The Ministry of Economic and Social Inclusion and municipalities have programmes and health facilities which also provide care for the uninsured population. The social security institutions cover those who are employed and affiliated through employee contributions. The private sector includes for-profit entities (hospitals, clinics, dispensaries, clinics, pharmacies, and prepaid "medicine" companies[2]) and non-profit organizations – civil society and social service organizations. Private insurance and prepaid health cover about 3% of the total population (middle- and high-income households). In addition, there are at least 10,000 private physicians' offices in the major cities, generally equipped with basic infrastructure and technology, at which medical services are available for direct payment (out-of-pocket).[3]

Population (in thousands): 15,492

Population median age (years): 25.83

Population under 15 (%): 30.29

Population over 60 (%): 9.21

Total expenditure on health as a % of Gross Domestic Product: 6.4

General government expenditure on health as a % of total government expenditure: 7.1

Private expenditure on health as a % of total expenditure: 55.2

According to the government authority regulating cooperatives, the Superintendency of Popular and Solidarity Economy (Superintendencia de Economía Popular y Solidaria, SEPS), cooperatives and associations are involved in providing health and social services in Ecuador. Both are governed by legislation that defines their forms and activities. Mutuals are not a recognized form of organization.

The law governing cooperatives, the Law on the Social and Solidarity Economy of 2011,[4] recognizes cooperatives of the following types: production, consumer, housing, savings and credit, and service. It also notes that service cooperatives may be active in a variety of sectors and specifically cites that these can include (but are not restricted to) transport, independent retailers/sales, and education and health, and take different forms including that of the worker cooperative. The law further allows cooperatives to provide multiple services to members to satisfy their economic and social needs.

HEALTH & SOCIAL COOPERATIVES

According to the SEPS Registry, two cooperatives and 25 associations were active in health and social services as of March 31, 2014.[5] It reports that information on these entities is limited to only the number of organizations active in the health and social services sector, the number of members, and assets.

Although not a cooperative itself, **Cruz Blanca** (a private company providing prepaid health insurance) is owned by the health cooperative Saludcoop Group of Colombia. Cruz Blanca has more than 25,000 users and operates a clinic in Quito, a medical centre in Guayaquil, and medical office in Santo Domingo.[6]

Health & Social Cooperative Data (2014)

Number of cooperatives	2
Types of cooperative	N/A
Number of members	196
Number of employees	N/A
Users	N/A
Facilities	N/A
Services offered	N/A
Annual turnover	N/A
Source of revenue	N/A

SAVINGS & CREDIT COOPERATIVES

The savings and credit cooperative sector, which accounts for 14% (over 800) of all cooperatives,[7] has a role in providing and facilitating access to health care. It markets a range of financial products to make health care affordable, as well as offering medical services to its members and to the communities in which cooperatives are based.

A number of savings and credit cooperatives provide financial products, including loans and medical/dental insurance. Others provide medical and dental care at no cost in their own installations or during "health days" where members and the community can consult health professionals, obtain medicines free of charge, or receive vouchers to access medical care. Still others have entered into strategic alliances with private health providers for discounted rates for hospitalization, pharmaceuticals, and medical attention.

Consider the following examples.

- **Cooperativa de Ahorro y Crédito "Pablo Muñoz Vega"** provides medical, orthodontic and laboratory services to a membership of over 60,000. The services are available free of charge to all members who in this way save a minimum of $5 USD per month.[8] Founded in 1964 in Tulcán, it has gained considerable prestige by providing a range of microfinance products to meet the needs of its members in the northern part of the country.[9]
- **Cooperativa de Ahorro y Crédito La Merced** was established in 1964. It currently operates through 16 branch offices in four provinces. In 2010, it partnered with the Health Network "Latino Clínica." With the network membership ID in hand, La Merced's 40,000 members can access such health services as a pre-approved hospital credit up to $1,500 USD, free ambulance transfers to network emergency clinics, special discounts for laboratory services, pharmacy, hospital, and emergency care services.[10]
- **Cooperativa de Ahorro y Crédito CoopProgreso** offers members a health plan for a monthly fee of $1.25 USD per month that entitles them to basic and specialist medical and orthodontic care with coverage for pharmaceuticals. As part of its social responsibility mandate, CoopProgreso runs a Health and Wellness Programme. In addition to running health promotion campaigns, this Programme organizes medical, ophthalmological, and orthodontic brigades that undertake ad hoc visits to provide members, employees, and community members with free basic health care. It also supports campaigns against domestic violence.[11]

INSURANCE

The savings and credit cooperative movement also established an insurance company, **CoopSeguros**, which provides health insurance products.

Established in 1969, CoopSeguros offers insurance products to the general public with a specific product line for cooperatives and financial cooperatives. Three life insurance policies are available, one of which includes health insurance and property insurance. The health insurance benefits include health care costs in case of accident, free medical, dental check-ups, and pharmaceutical services. These are available to policyholders and their immediate families (spouses and children) through the CoopSeguros network of providers. CoopSeguros offers other insurance policies to the general public (individuals and enterprises), including a specific health insurance policy for those over 60 years of age.[12]

However, CoopSeguros is not the sole insurance company servicing the savings and credit cooperative sector. Savings and credit cooperatives source their insurance products to a number of private insurers based on competitive offers. Two of the major insurance companies in Ecuador report that they provide life, accident, and health insurance coverage to savings and credit cooperatives, namely Emprendedores & Asociados (E&A Brokers)[13] and Long Life Seguros S.A.[14]

MUTUALS

No mutuals providing health care were identified.

SOURCES

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EL SALVADOR

2014


Photo: Shicali Cerámica

HEALTH SYSTEM

Health care is delivered by the public health sector, social insurance and to a lesser degree, the private sector. The private sector is composed primarily of non-profit organizations in major cities. These organizations offer services in the private market and sell services to the social security system (Instituto Salvadoreño de Bienestar Magisterial ISBM and Instituto Salvadoreño del Seguro Social ISSS). Non-profit organizations (NGOs, churches and others) operate mainly in rural El Salvador.[1]

Despite the fact that no-cost public health services have been provided by the Ministry of Health since 2009, the InterAmerican Development Bank estimates that nearly half the population does have access to health care, with the poor and informal economy workers particularly impacted.[2]

Cooperatives have a recognized role in promoting social welfare. For example, although cooperative legislation does not specifically recognize health or social cooperatives as cooperative sectors, the 1988 Health Code does specifically include reference to the role of cooperatives, calling on the Ministry of Health to

> "Mobilize, guide, stimulate and coordinate the activities of component parts of the community to form social groups whose aims include improving community or group well-being, such as welfare boards, mothers' clubs, youth clubs, children's groups, community workshops, mutual aid activities, cooperatives and other welfare institutions." (article 47 ch)

Population (in thousands): 6,297

Population median age (years): 23.78

Population under 15 (%): 30.62

Population over 60 (%): 9.64

Total expenditure on health as a % of Gross Domestic Product: 6.7

General government expenditure on health as a % of total government expenditure: 14.5

Private expenditure on health as a % of total expenditure: 37.2

More specifically, cooperatives are playing an important role in improving access to health care, particularly by providing microinsurance products through a wholly-owned insurance company established by the savings and credit cooperative movement, Asociacion Cooperativa de Servicios de Seguros Futuro, A.C de Responsabilidad Limitada (Seguros Futuro).

Cooperatives attributed to other sectors (particularly savings and credit cooperatives), and those which provide multiple services, also support health care professionals by enabling bulk purchasing, marketing and access to financial services, as well as access to pharmaceuticals.

Social care is also provided through cooperatives. Albeit only one artisanal production cooperative was identified, providing employment and a wide range of services to people with disabilities.

In March 2013, the Salvadoran Institute for the Promotion of Cooperatives (Instituto Salvadoreño de Fomento Cooperativo INSAFOCOOP) reported that, of 792 cooperatives in El Salvador, the majority are savings and credit, supply and transport cooperatives. The bulk of cooperatives are found in the capital city and paracentral region. Cooperatives counted 242,822 individuals as members.[3]

HEALTH COOPERATIVES

In El Salvador, the cooperative regulator categorizes cooperatives by their main area of activity, namely professional services, supply, and savings and credit cooperatives. It does not have a category for health or social care. As mentioned above, cooperatives that support health professionals or provide health care provide multiple services.

Two cooperatives which were identified are described as "professional services cooperatives" (anaesthesiologists and ophthalmologists) and include purchasing and supply activities.

Name of cooperative	Members		
	Men	Women	Total
Asociacion Cooperativa de Servicios Profesionales, Aprovisionamiento y Comercializacion de Medicos Anesteciologos (ACOMEDA de R.L.)[4]	22	7	29
Asociacion Cooperativa de Aprovision-amiento, Comercializacion, Ahorro y Credito de Medicos Oftalmologos de el Salvador (ASOCOOF, DE R.L.)[5]	16	10	26
Total members	38	17	55

OTHER CO-OPS

Savings & Credit Cooperatives

Savings and credit cooperatives are the largest cooperative sector, representing 44% of all cooperatives (351 societies with over 230,000 members). They play a role in health care as they are often multiservice cooperatives.

Some have been formed by health professionals to provide financial services exclusively, as was the case of the Asociación Cooperativa de Ahorro, Crédito de Empleados de Salud de Occidente de RL (ACACESPSA). Others are multiservice cooperatives whose primary functions are financial services, but combined with other activities in the health services field, such as the distribution of pharmaceuticals. (See below.) Still others are primarily financial services cooperatives that provide specific loan products to cover health care costs or have partnerships with health care providers for discounted rates on health care services. This, for example, is the case of the savings and credit cooperative of the medical college, Asociación Cooperativa de Ahorro y Crédito del Colegio Médico de El Salvador RL COMEDICA. It provides discounts at partner clinics, dentists, ophthalmologists, oncology centres, pharmacies, providers of medical equipment, insurance, emergency and home care providers, etc.

- The Federation of Savings and Credit Cooperatives (FEDECACES) has also played a role in making health care insurance available since 1994 and since 1996 through a cooperative insurer. (See "Insurance Cooperatives," below). Today, FEDECACES members act as delivery channels for cooperative insurance, including health insurance. FEDECACES has 32 member savings and credit cooperatives with 184,814 members and 97 branches.

Pharmacy Cooperatives

Two cooperatives whose primary activity is savings and credit are also involved in the supply and marketing of pharmaceuticals.

Name of cooperative	Members		
	Men	Women	Total
Asociacion Cooperativa de Ahorro, Credito y Consumo Farmaceutica Salvadoreña, de Responsabilidad Limitada COFARSAL[6]	29	46	75
Asociacion Cooperativa de Ahorro, Credito, Consumo y Aprovisionamiento de Quimicos y Farmaceuticos, de Responsabilidad Limitada Autorizado COQUIFAR[7]	30	47	77
Total members	59	93	152

Insurance Cooperatives

In 1994 the Federation of Savings and Credit Cooperatives (FEDECACES) established an insurance department to provide insurance products to members. In 1996, it established an insurance cooperative, **Asociacion Cooperativa de Servicios de Seguros Futuro**, A.C de R.L. (Seguros Futuro), to provide a range of insurance products. These include health (surgical) and life insurance, as well as non-life products (auto, home, theft, accident, funeral, remittance and repatriation, etc.). The insurance products are delivered through the network of FEDCACES member savings and credit cooperatives. Seguros Futuro has established 37 service centres in savings and credit cooperative branches throughout the country. In 2011, Seguros Futuro held 5% of the insurance market with more than 65,000 insured nationwide.[8]

Seguros Futuro offers several plans for surgical insurance with three levels of coverage: basic, standard, and superior. A catalogue provides information on the level of reimbursement for each of the 200 recognized interventions. Policyholders can freely choose the hospital or medical centre for the intervention, knowing in advance the amount that they will receive to cover the costs. The policy also includes coverage of a maximum of $130 USD for pre-surgical exams.[9]

Seguros Futuro is also developing a new microinsurance product to improve health insurance coverage. It submitted a project to the InterAmerican Development Bank (IDB) through FOMIN (Multilateral Investment Fund) to increase the supply of basic health microinsurance for low-income populations, particularly women. The project, **Microseguros de Salud en El Salvador**, was approved in May 2012 and initiated activities in the same year. Within the scope of the project, Seguros Futuro, in conjunction with a national network of medical centres and services, will develop life insurance products that include coverage for preventive health services. The microinsurance product will be sold through savings and credit cooperatives, microfinance institutions, and pharmacies. Initiated in 2012, the first phase of the project sought to understand the needs of cooperative members and their use of other microfinance institutions for health care services, and to identify the service offerings of existing medical service networks. Options for telemedicine and mobile health services for rural areas were also investigated. In the second phase, Seguros Futuro will develop the microinsurance product along with an IT component to administer the product and train the facilitators and FEDCACES member savings and credit cooperatives which will be the main channel for delivering financial education and insurance and for the sale of microinsurance. The project aims to provide more than 12,000 Salvadorans with access to microinsurance which will allow them to obtain preventive health care and to reduce health care costs. It has a budget of just over $1 million USD and will run from 2012 to 2015.[10]

SOCIAL COOPERATIVES

One social cooperative for persons with disabilities was identified, the Integral Pro-Rehabilitation Independent Group Cooperative Association (Asociación Cooperativa del Grupo Independiente Pro Rehabilitación Integral de R.L, ACOGIPRI). It takes the form of a worker cooperative, but is formally categorized as an artisanal production cooperative. ACOGIPRI offers employment, business support, leadership training, and literacy classes. (See "Case Study" below for further information.)

Case Study

Integral Pro-Rehabilitation Independent Group Cooperative Association (Asociación Cooperativa del Grupo Independiente Pro Rehabilitación Integral de R.L, ACOGIPRI). **ACOGIPRI** was formed in 1981 (International Year of Disabled Persons) by a group of visually and hearing impaired young people.

Categorized in official cooperative statistics as an artisanal production cooperative, ACOGIPRI provides employment opportunities in a ceramics workshop, Shicali Cerámica, which began operations in 1982. Shicali Cerámica offers artistic training to its workers, about three-quarters of whom are hearing impaired.[11] Their work enjoys high regard in El Salvador and abroad, where their products are marketed through the European fair trade network.[12] With the financial support of a number of Spanish organizations, Confederación Española de Personas con Discapacidad Física y Orgánica (COCEMFE) and Comunidad de Madrid y Fundación ONC, ACOGIPRI is implementing a project to improve the marketing and sales of its products. It also receives support from the InterAmerican Development Bank through FOMIN and the Trust for the Americas of the Organization of American States.[13]

The cooperative also provides assistance to persons with disabilities (PWD). It provides a job placement service, engages in advocacy to educate and defend the rights of PWDs (including working on legislative and accessibility issues), and undertakes specific programmes to promote women's empowerment.[14] It has trained over 1000 PWDs, many of whom have found formal employment.[15]

The cooperative has a membership of 20 persons (6 men and 14 women)[16] and employs at least 5 persons in its management and administration.

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FINLAND[1]

2014

HEALTH SYSTEM

Population (in thousands): 5,408

Population median age (years): 42.24

Population under 15 (%): 16.42

Population over 60 (%): 25.9

Total expenditure on health as a % of Gross Domestic Product: 9.2

General government expenditure on health as a % of total government expenditure: 12.3

Private expenditure on health as a % of total expenditure: 24.6

Little information was found about Finnish health care cooperatives. In the 1990s, a large number of cooperatives started in Finland in response to the depression and the high employment rate in the country.[2] The cooperatives that emerged from that period were called "new wave cooperatives." In 2010, a total of 92 new social, health and welfare new cooperatives was reported by the Finnish National Board of Patents and Registration, and PELLERVO Confederation of Finnish Cooperatives,[3] which represents 0.3% of Finnish new cooperatives.

Some new wave cooperatives, established as producer cooperatives, were created by people with mental or psychiatric disabilities in an attempt to foster rehabilitation through work and promote employment for people with disabilities.[4]

According to the Finnish Report for the International Year of Cooperatives in 2012, several talks and presentations were held in Finland in 2012 to discuss health care cooperatives as "one solution worthy of consideration in the structural renewal of the Finnish health care system."[5]

No quantitative data was found during the course of the study, due to the lack of resources available in English. Only one second-level health care cooperative was found: Taltioni. In 2010, the Finnish Innovation Fund started a project to establish a Personal Health Record platform and ecosystem in Finland. Taltioni was established in 2010 to operate the technical platform and form the business ecosystem. The cooperative mode was chosen because it enables easy access for companies to join/resign from the ecosystem. Taltioni is thus a user cooperative and aims at providing "citizens with a personal health account which will be available to the user throughout their lives."[6] It had 27 founding members and currently has 63 members. All members are companies from the health IT sector, both private and public. Taltioni has three employees, outsources lot of its operations, and works with a great many partners.[7]

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FRANCE[1]

2014

Equine therapy at Equiphoria in Lozère

HEALTH SYSTEM

The French health system combines universal coverage with a public-private mix of hospital and ambulatory care. It is funded from three sources: obligatory health contributions from all salaried persons, and paid by employers, employees, and the self-employed; central government funding; and from users who have to pay a small fraction of the cost of most of the health care services which they receive. So this is not a single-payer system, but a kind of multilayered system.

Social Security (the name for public health insurance in France) covered 90.7% of health expenditures in 2012. The role of complementary organizations, including health mutuals and other private insurers, has been growing, however, from 3.8% in 2002 to 5.2% in 2012. Although France has a universal health system, in 2010 36% of French declined to get care or postponed it in recent years for reasons of the expense it would involve.[2]

The French health system is based on the principle of freedom of choice for the patient. Medical "first aid" is mainly performed by private practitioners.

However, a lot of collective care is available, whether it's through health centres (especially for low-income patients, with doctors on salary), nursing homes (63% are run by associations, foundations, and mutuals), hospitals (of 2,700 hospitals, 950 are public and 700 are associations) or residential facilities for dependent or disabled populations (30% are under non-profit management).

Population (in thousands): 63,937

Population median age (years): 40.43

Population under 15 (%): 18.26

Population over 60 (%): 23.82

Total expenditure on health as a % of Gross Domestic Product: 11.8

General government expenditure on health as a % of total government expenditure: 15.9

Private expenditure on health as a % of total expenditure: 23.1

CO-OPS & MUTUALS IN THE HEALTH SECTOR

In this landscape, where the nonprofit sector is very active (if increasingly challenged by wealthy and powerful entities), associations and mutual actors dominate. Cooperatives, by and large, are absent.

Given its need to address such new phenomena as "medical deserts," local government has an interest in promoting cooperation among stakeholders – patients, physicians, health care personnel, etc. This state of affairs should encourage the development of cooperatives and other innovative responses to health needs.

The CGSCOP is France's apex association for worker co-ops. In recent years, CGSCOP has been promoting the development of SCICs[3] (Sociétés Coopérative d'Intérêt Collectif/Co-operative Companies of Collective Interest) – multistakeholder co-ops – in the health and social care sector through seminars, networking, advocacy and lobbying to government and other social economy stakeholders, and the production of case files.

The SCIC, first introduced in 2001, has been a real innovation in France's cooperative landscape. By enabling beneficiaries, staff, investors, and public institutions all to become associates in a single enterprise, the SCIC favours territorial mobilization and the hybridization of resources. So it seems perfectly suited to the challenges of social and health services. In the last 12 years, 300 co-ops in a wide range of sectors (catering, agriculture, theatre, IT services, etc.) have opted for this status. However, there is still a long way to go, especially to increase awareness of this new type of cooperative.

A discussion is currently taking place in France over the potential of the SCIC to serve as a tool of "health democracy," that is, to increase the involvement of patients and their representatives in decisions regarding the health care system. The activity of SCICs in the health sector suggests that the debate is well under way. It can be expected to grow all the more animated in the near future. By 2060, France may have 1.8-2.6 million dependent senior citizens. Is there a market there into which SCICs can sink their roots?

Speaking in general terms, in 2012 a total of 21,000 cooperatives employed nearly one million people in France. The cooperatives came in five varieties: business cooperatives, user cooperatives, worker (SCOP) and producer cooperatives, multistakeholder cooperatives (SCICs), and cooperative banks. Their sectoral breakdown was as follows: 41% industrial services, 33% agriculture, 17% housing, 5% banking, 3% consumer services, and 1% pharmacies.[4]

In the health and social care sector, two types of cooperative are active: SCOPs and SCICs.

HEALTH COOPERATIVES

There are very few health co-ops in France. The development of cooperatives in the health sector has been in response to unsatisfied needs and to compensate for the consequences of a public health policy that aims to reduce the duration of hospital stays. Seven worker co-ops active in the ambulance sector have been identified.

Number of cooperatives	7
Types of cooperative	Producer (worker)
Services offered	Emergency transportation & 1st aid (ambulance)

Inventory of Health Co-ops

Name	Activity
Coulaines ambulances Le Mans Transports	Approved ambulances, all for health transport
SCOP des Ambulanciers de l'Ile-de-France	Ambulances and Transport of patients
Alliance Ambulance	Ambulances and health transport
Ambulances de la Selune	Ambulances, health transport, passenger transport
ALRE Ambulance	Ambulances, taxis
AMBU Ouest Alliance	Ambulances
Ambulances Abbayes du Midi	Ambulances, health transport

Source: CGSCOP

Two multistakeholder coops (SCICs) are involved in telehealth:

- **Médectic** (Alsace) - develops communication and information on treatment practices using IT. Develops automated domestic solutions for teleassistance and telehealth. Seven staff in 2004.
- **Platinnes** (Midi-Pyrénées) - assists decision-making during key stages of medico-technological projects. Three staff in 2013.

SOCIAL CARE COOPERATIVES

There are 11 co-ops emerging in the area of social care, including nursing care, home care, and therapy.

Number of cooperatives	11
Types of cooperative	5 Producer (Worker) and 6 Multistakeholder
Services offered	Home care, nursing care, therapy
Number of jobs	95[5]

Inventory of Worker Co-ops in the Social Care Sector

Name	Activity
L'Age D'Or	Home nursing care
SSIAD COSI	Home care and home help – nursing and midwifery
SSIAD SE POURTA BEN	Social housing for senior citizens, home nursing care. Approved by ARS and CRAM for persons over 60 years of age.
La Ferme aux animaux	Social housing and educational care for children in difficulty
CALME (Centre for Action and Liberation of Ethanol Sufferers)	Clinic providing therapy for alcoholism

Inventory of Multistakeholder Co-ops (SCICs) in the Social Care Sector

Name/Start date	Region	Number of employees	Objectives
Activity: Home Help & Support			
AGAD (Agency for Management of home help) (2010)	Nord-Pas de Calais	35	Association of human services providers and beneficiaries which provides affordable human services.
Hestia services à la personne (1995)	Alpes Côte-d'Azur	45	Improve the daily lives of those who have lost autonomy, to enable them to remain in their homes.
Activity: Home/medico-social care			
Centre de soins infirmiers Lille Sud (1974)	Nord-Pas de Calais	9	Offer high-quality health care at home.
Entreprendre pour humaniser la dépendance (2003)	Rhône-Alpes	6.05	Respond to the needs of people who have lost their autonomy due to age, physical, mental, or social disability.
Solidarité Versailles Grand Age (2012)	Ile-De-France	N/A	Create synergy between care networks; facilitate care of socially fragile individuals.
Equiphoria (2014)	Lozère	N/A	Using equestrian techniques, the therapists include in their sessions horseback exercises and games for psychomotor, relational, or learning purposes, depending on the objectives of the therapeutic project.

Case Studies

The **Centre for Action and Liberation of Ethanol Sufferers** (Centre d'Action et de Libération des Malades Ethyliques, CALME) was founded in 1981 near Grasse, Provence, on the basis of a therapeutic protocol developed over the previous seven years. It treats alcohol dependence and associated addictions. The organization expanded with the opening of a centre in Illiers-Combray (southwest of Paris) in 1993.

CALME has been sustained over the last 30 years by the commitment of 30 or so workers on each site: doctors, psychologists, nurses, administrative staff, cooks, and cleaners. Its unique character is the result of several factors.

CALME has developed an original way to treat alcohol sufferers. Based on institutional therapy, treatment involves a humanitarian combination of withdrawal programme and therapeutic activity. The cure is based on a long-lasting, tangible experience, and is officially recognized. (Over 17,000 patients have benefitted from it since 1981.) The progress of the patients has led the Haute Autorité de Santé (Senior Health Authority) to classify CALME's therapy as an "exemplary action."

CALME is a SCOP, and the only clinic in France managed as a cooperative. Decision-making and information exchange take place in a variety of committees that meet three or four times per year. To take one example, the Committee for User Relations and Care Quality has a chair, a doctor-mediator and substitute doctor, a non-medical mediator and substitute, representatives of the paramedical team, of the catering team, a secretary, and the quality and risk management director, as well as user representatives.

Patients speak of the Centre as their "home." Indeed, few of the rooms suggest that the building is a clinic. Everything is done to make the therapeutic process different from that of conventional alcoholism treatment centres. Staff know the residents personally; everyone is on an informal, first name basis. Even the white coats are absent. As the director of the centre, Bruno Perez, explains,"Our aim is to develop relationships between equals with our patients, who are often overwhelmed with feelings of shame and guilt."

Equiphoria, located in the Lozère department in the south of France, became a SCIC in 2014. (Previously, it was another type of co-op.). Currently, it is the second largest SCIC in France in the health and social care sector.

Equiphoria has developed a unique therapeutic project for disabled people. The staff include in their sessions horseback exercises and games for psychomotor, relational, or learning purposes, depending on the objectives of the therapeutic project. The horse is thus used as a therapeutic tool.

The horse acts as a mediator between the patient and the therapist. Every dimension of experience, the psychic, physical, emotional, sensorial, and social, is exercised to a greater degree

than in a therapy room. Horseback riding stimulates patients cognitively. It helps them to grow more aware of their existence and their tone of voice, and encourages socialization.

While equine therapy is widely used in North America, Equiphoria is unique in France. Each week it treats around 50 disabled people. The therapeutic approach is both multidisciplinary and extremely individualized. Equiphoria strives to base its development on training, specialization, research, and international partnership. Its model is well worthy of duplication.

HEALTH MUTUAL ORGANIZATIONS

Over 150 years ago, in 1850, French law recognized mutual assistance companies as organizations whose specific purpose is to assume responsibility for sickness, drawing a line between them and trade union syndicates. The National Federation of French Mutual Companies (Fédération nationale de la mutualité française, FNMF, or simply Mutualité Française) was founded in 1902. Eight years later, mutual companies took an active part in the establishment of workers' pensions. After the Second World War, the status of mutual companies was defined by edict, giving them the principal role in complementary health insurance.

Mutuals are private, non-profit companies. They act in the fields of life insurance, solidarity, and mutual help, in the interests of members and their legal beneficiaries, notably through the payment of subscriptions.[6] Their philosophy is to share the resources of their members, with the aim of addressing the uncertainties of health.

In 2011, there were 6,290 mutuals in France with 119,820 staff.[7] They mostly operate in the health and insurance sectors. Today, their status is under threat from European directives aiming to align them with the status of private insurers.

Mutual companies are in competition with other complementary health insurance providers (e.g., provident societies, managed democratically and set up by collective bargaining agreements and commercial insurers). Where mutuals differ from these competitors is in the principle of non-selection of members on the basis of health.[8]

Here are key figures relating to the health and social care activity of mutuals which are members of Mutualité Française:[9]

- 240 mutuals manage care services, offering mutual support, advocacy, and prevention.
- Annual turnover of $3.86 billion USD.
- 111 hospitals; 82 health care and nursing facilities; 453 dental centres; 355 hearing centres; 715 optical centres; 60 pharmacies; 405 facilities and services for the elderly; and 178 facilities for the disabled.

Case Study

Harmonie Mutuelle was formed in 2012 from the merger of five mutual companies to become the largest mutual company in the country. Today it protects 4.5 million people, has 39,000 member companies, 4,385 staff, and more than 300 branches in 60 departments. It has declared five commitments: to facilitate access to overall health coverage without medical selection; to guarantee quality services; to operate democratically; to encourage social contact; to defend mutual values; and to reconcile performance and social utility.

Harmonie Mutuelle is part of the Harmonie group and takes an active part in facilitating health care and home care access, notably through the intermediary of a network of mutual care and accompaniment services (SSAM). To promote its values abroad Harmonie Mutuelle recently created Harmonie Mutuelle Italia.

Here are key figures descriptive of Harmonie's facilities:

- 125 optical stores
- 80 hearing aid centres
- 8 pharmacies
- 63 dental health centres
- 18 health facilities (medicine, obstetric surgery, sub-acute care and rehabilitation, home care)
- 40 institutions and services for people with disabilities and dependency
- 105 facilities and services for the elderly
- 24 medical equipment branches
- 11 ambulance sites
- 19 hospitals

SOURCES

[1] A more detailed version of this case is available upon request.
[2] Institut Viavoice. 2010. "Les perceptions des français sur les évolutions du système de santé : Sondage Vivavoice pour le CISS [Collectif Interassociatif Sur la Santé] - Octobre 2010." Retrieved September 3, 2014 (http://www.leciss.org/sites/default/files/101012_Sondage-Assurance-Maladie-PLFSS2011_ViaVoice-Ciss.pdf). P. 11.
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[5] Data for four co-ops only.
[6] France's mutuals are organized in seven major groups: inter-professional mutual companies; mutual companies that are de facto subsidiaries of mutual insurance companies; mutual companies that are partners of mutual insurance companies; mutual companies that are de facto subsidiaries of provident companies; government worker mutual companies; and mutual companies for one specific company.
[7] Institut National de la Statistique de des Études Économiques (INSEE). 2011. *INSEE PREMIÈRE*. No. 1342 (March). Paris. Retrieved September 2, 2014 (http://www.insee.fr/fr/ffc/ipweb/ip1342/ip1342.pdf).
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GERMANY[1]

2014

HEALTH SYSTEM

The country of origin of the social insurance scheme (introduced by Chancellor Bismarck in the 19th century), Germany[2] has a universal multi-payer health care system with two main types of health insurance: "compulsory health insurance" and "private."

Compulsory insurance applies to those below a set income level. It is provided through private non-profit "sickness funds" at rates common to all members, and is paid for through joint employer-employee contributions. Provider compensation rates are negotiated in complex corporatist social bargaining between specific autonomous interest groups (e.g., physicians' associations) at the level of the Länder. The sickness funds are mandated to provide a wide range of coverage and cannot refuse membership or otherwise discriminate on an actuarial basis. Small numbers of people are covered by tax-funded government employee insurance or social welfare insurance. Persons with incomes above the prescribed compulsory insurance level may opt into the sickness fund system (which most do) or purchase private insurance. A variety of types of private insurance supplementary to the sickness funds is available.

In Germany, few health care cooperatives exist because the health care sector is strictly regulated. However, the country is witnessing a "revival of the cooperative idea." Since 2008 over 180 new cooperatives have appeared.[3] In the health care sector, doctors and health networks (e.g., hospitals, pharmacies) have emerged. Medics and health networks "are buying and marketing jointly within the cooperatives to achieve advantages or to work together with additional suppliers to create new health care units."[4] Most of the cooperatives identified in this survey fall into this pattern.

Population (in thousands): 82,800

Population median age (years): 45.09

Population under 15 (%): 13.17

Population over 60 (%): 26.72

Total expenditure on health as a % of Gross Domestic Product: 11.3

General government expenditure on health as a % of total government expenditure: 19.1

Private expenditure on health as a % of total expenditure: 23.7

HEALTH COOPERATIVES

One health co-op offering health services has been identified. Medizinische Kooperation Görlitz is an ambulatory health care centre and a producer-based cooperative. It provides medical, dental, and other care services as well a pharmacy.

Health Cooperative Data

Number of cooperatives	1
Types of cooperative	1 Producer
Number of members	N/A
Number of employees	N/A
Users	N/A
Facilities	N/A
Services offered	Illness prevention; Wellness & health promotion; Treatment and cure; Rehabilitation; Lobbying; Purchasing and retail services
Annual turnover	N/A

We also identified second-level cooperatives which undertake purchasing. **Ärztegenossenschaft Nord Cooperative** is a second-level user-based cooperative. Its membership is composed of about 2,300 registered doctors and health professionals. The cooperative is active on multiple levels: it offers lobbying services as well retail and purchasing services for its members. **Dienstleistungs- und Einkaufsgemeinschaft Kommunaler Krankenhäuser** is a retailer cooperative of 70 hospitals. It is one of the largest purchasing groups in Germany with an annual turnover of over $1 billion USD. It also provides its members with consulting and management control services.

PHARMACY COOPERATIVES

One second-level pharmacy cooperative was identified. Noweda is a 75-year-old cooperative of retail pharmacies. It has 16 offices in Germany and one in Luxembourg. With 8,600 pharmacy members and an annual turnover of over $6 billion USD, it is one of Germany's 150 largest companies.

Health Cooperatives

Name of cooperative	Type			Members	Employees				Users	Facility	Types of service					Annual turnover
	User	Producer	Multistakeholder		Number of employees	Doctors	Nurses	Other health prof	Others			Illness & accident prevention	Wellness & health promotion	Treatment and cure	Rehabilitation	
Medizinische Kooperation Görlitz[5]		X		N/A	N/A					N/A	N/A	X	X	X	X	N/A

Name of cooperative	Type	Members	Employees	Users	Facility	Types of service	Annual turnover
Second-level cooperatives							
Ärztegenossen-schaft Nord[6]	X	2,300	14	N/A	N/A		N/A
Dienstleistungs- und Einkaufs-gemeinschaft Kommunaler Krankenhäuser[7]	X	70 hospitals	N/A	N/A	N/A		Over $1 billion USD

Pharmacy Cooperatives

Name of cooperative	Type	Members	Annual turnover	Field of activity
Second-level cooperative				
NOWEDA[8]	x	8,600 pharmacies	$6.2 billion USD	NOWEDA is a 75-year-old retailer cooperative of pharmacies. It has 16 offices in Germany and one in Luxembourg and counts 8,600 pharmacy members. It is one of Germany's 150 largest companies.

SOURCES

[1] We would like to thank Dirk J. Lehnhoff and Klaus Niederländer for their collaboration.

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GHANA[1]

2014

HEALTH SYSTEM[2]

In Ghana, most health care is provided by the government and largely administered by the Ministry of Health and the Ghana Health Service. The health care system has five levels of provider: Health Posts (first-level primary care for rural areas), Health Centres and Clinics, District Hospitals, Regional Hospitals, and Tertiary Hospitals. Funding for these programmes originates with the government, financial credits, the Internally Generated Fund (IGF), and donors. Ghana has about 200 hospitals. Some for-profit clinics exist, but they provide less than 2% of health care services. Health care varies throughout the country, with urban centres having most facilities, whilst rural areas are often deprived. Patients in these areas either rely on traditional medicine or travel great distances for health care.

Under the former health system, known as the "Cash and Carry" system, many people died because they did not have money to pay for their health care needs. An individual's needs were only attended to after payment for the service was advanced – even in cases of emergency.

In order to promote universal coverage and equity in health care delivery, the government of Ghana adopted the National Health Insurance Scheme (NHIS) in 2003, which was fully implemented in 2005. Its purpose was to assure equitable and universal access of all citizens to a package of essential health care services at an acceptable quality and to abolish "out-of-pocket" payment. The ultimate goal of the NHIS is the provision of health insurance coverage for all Ghanaians, irrespective of socio-economic background.

Population (in thousands): 25,366

Population median age (years): 20.45

Population under 15 (%): 38.59

Population over 60 (%): 5.4

Total expenditure on health as a % of Gross Domestic Product: 5.2

General government expenditure on health as a % of total government expenditure: 9.7

Private expenditure on health as a % of total expenditure: 42.9

NHIS covers both formal and informal sectors of the economy. As of June 2009, about 67% of the population had subscribed to the NHIS, which is financed by a National Health Insurance levy of 2.5% on certain good and services, a 2.5% monthly payroll deduction (part of the contribution to the Social Security and National Insurance Trust for formal sector workers), a government budgetary allocation, and donor funding. Formal sector workers pay a registration fee for an identity card for access to health care services. Contributions from informal sector workers are also made to the NHIS, with a minimum and maximum premium of $1.93 and $12.80 USD (7.20 and 47.70 GHS) respectively. However, the core poor, pregnant women, pensioners, and people above 70 and below 18 years of age are exempted from premium payment.

The benefit package of the NHIS consists of basic health care services, including outpatient consultations, essential drugs, inpatient care and shared accommodation, maternity care (normal and caesarean delivery), eye, dental, and emergency care. About 95% of the diseases in Ghana are covered under the NHIS.

Since its inception, the country's health facilities have seen a constant rise in patient numbers and a considerable reduction in deaths. Some major loopholes have been identified in this scheme, however. According to research carried out by health economists, a major challenge disclosed by health care workers is the delay in reimbursement. Providers have not been paid on time, in some cases for as long as six months.

Three types of cooperative were identified and studied: 1) **Health Co-operative** - a cooperative whose business goals are primarily or solely concerned with health care; 2) **Non-Cooperative Enterprise** - a non-cooperative enterprise owned by cooperative or in which cooperatives have a controlling interest; and 3) **Pharmaceutical Cooperative** - a cooperative owned and run by pharmacists for the distribution of pharmaceutical products.

HEALTH COOPERATIVES

The only cooperative of this type to be identified was the OPAD Network Cooperative. It has set up a rural health clinic, the Dufie

Memorial Clinic, which provides illness and accident prevention, wellness and health promotion, and treatment and cure.

Non-Cooperative Enterprise

Dufie Memorial Clinic, owned by OPAD Network Cooperative, is the only example of this type.

Health Cooperative Data

Number of Cooperatives	One, OPAD Network Cooperative
Types of cooperative	Producer (P)
Number of Members	21
Number of Employees	20 (1 medical doctor, 2 physician assistants, 6 nurses, 2 midwives, 1 laboratory technician, 8 administrative staff)
Facilities	Dufie Memorial Clinic
Number of Clients	4,000
Annual turnover	2012: $11,111 USD 2013: $22,222 USD 2014: $66,666 USD (anticipated based on January-March 2014 average of about $5,555 USD/month)
Sources of Revenue	• Capitation transfer from National Health Insurance Scheme (NHIS) • Internal Generated Fund (IGF) • Fees-for-service paid by NHIS • Fees paid by client without health insurance

Case Study

The overarching purpose of the **OPAD Network** is to provide health services to the poor in rural and deprived communities by setting up and running health facilities: clinics, maternity homes, health centres, and hospitals. It is for this reason that OPAD set up Dufie Memorial Clinic in Dida in the Atwima Kwanwoma District of Ghana's Ashanti region. It is named after a seasoned Christian woman of high repute in the community. The district does not as yet have a district hospital, making the availability and accessibility of health facilities of utmost importance to the people.

The vision originates from an understanding that spirituality is the center of all health and healing. OPAD and Dufie therefore attend to the spiritual needs of the communities within which they serve, recognizing Jesus Christ as The Great Physician and Healer. They seek to serve God and humanity by providing holistic care for the sick in the most efficient manner, regardless of socioeconomic status, religion, race, colour, ethnic group, and other discriminating characteristics. OPAD and Dufie work in close collaboration with and within the policy framework of Ministry of Health, the Ghana Health Service, and other agencies engaged in health care.

OPAD has innovatively improved health access for poorer and vulnerable people in rural Ghana by first setting up a health clinic at Dida, a village in the Atwima Kwanwoma district of Ashanti. To make health care more accessible, in 2013 OPAD and Dufie set up a fund of $15,000 USD to mobilize and pay for the NHIS registration of 4,000 prospective patients in the communities neighbouring the clinic. By taking advantage of this government programme, people would improve their health; it would also enable them to use and grow loyal to Dufie Clinic. All the premiums of the patients registered accrue to Dufie clinic in the form of a pre-paid capitation from NHIS.

This exercise has been enhanced by additional disbursements to the fund, which have enabled Dufie to encourage pregnant mothers to access prenatal care, through the hire of a vehicle. Dufie has no ambulance nor does it own transport. The rental vehicle enables pregnant mothers from the communities to come to the clinic, pay for their NHIS registration, and access the "Tom Brown" (roasted maize porridge) food supplement. In addition, newcomers to the hospital who are found to be pregnant are immediately registered in the NHIS. These efforts have increased patient attendance, maternal and child health, and safe motherhood.

There is a plan to provide scanner equipment and space is available to be equipped as a surgical theatre. All these will further enhance health access and help to make OPAD and Dufie financially self-sustaining. The OPAD and Dufie Strategy underscores self-finance, cost recovery, efficiency, and sustainability. It shall accept external funding, but shall not wait for nor be driven by such financing. In all it does, it shall show that it is possible to be both effective and efficient, and meet the double bottom-line of sociability and profitability. It shall ensure at all times that there is a surplus which may be applied to expand growth, execute its responsibilities to stakeholders, plough back, and fairly compensate human resources and the communities.

COOPERATIVE PHARMACIES

Ghana Co-operative Pharmaceuticals Ltd (GCPL) is a private wholesale distributor of pharmaceutical products to retail (community) pharmacies and other health facilities. It is owned and democratically controlled under cooperative governance principles by members/shareholders who are pharmacists operating their own independent retail pharmacies in Ghana.

GCPL aspires to be a leading pharmaceutical business in the country's distribution and manufacturing sectors. It was established in response to the expressed need for a central procurement unit from which proprietor pharmacists operating small pharmacy enterprises could access pharmaceutical products at concessionary terms. GCPL was formed and registered as a Co-operative Society and Pharmaceutical Wholesaler in 1974, the first and the only pharmacy cooperative in Ghana and the sub-region.

Membership of GCPL grew over the years due to its service attractions and currently it comprises over 100 retail pharmacies – and counting.

Number of cooperatives	1: Ghana Co-operative Pharmaceuticals Ltd (GCPL)
Type of cooperative	(P) National Co-operative Group made up of independent retail pharmacies in Ghana, owned by pharmacists, who provide pharmaceutical services to communities.
Field of activity	Wholesale distribution of pharmaceutical products
Number of members	158 registered members. Membership of GCPL is voluntary and is open to retail pharmacies owned by pharmacists. Approval for membership is given after interviewing the pharmacist and payment of the prescribed share capital. Application forms are available online.
Services offered	GCPL provide the following attractions: • A 1-stop facility with a wide range of quality pharmaceutical products at competitive prices • A wide distribution network and ready access to over 100 member pharmacies with potential for growth • Significant patronage and goodwill from member pharmacies • Prompt delivery services • Collaboration with national associations in the industry for advocacy actions to address challenges in the industry
Benefits	Members/Shareholders of GCPL benefit from: • Concessionary trading terms • Attractive returns on their investments • Education, training, advisory, and support services • Solidarity among proprietor pharmacists

GCPL undertakes bulk procurement of quality essential pharmaceutical products from local and overseas manufacturers. GCPL also imports directly from overseas suppliers. It stocks these products for storage and distribution to member pharmacies and other health facilities in Ghana. The GCPL target market includes over 100 members' retail pharmacies, non-member pharmacies, and other health facilities.

The pooled procurement program and the economies of scale enable GCPL to earn bulk discounts. This is translated into competitive prices. GCPL also makes adequate surplus to cover operating expenses and pay returns on shareholders' investment.

Annual turnover	2011:$1,161,252 USD 2012: $1,501,866 USD 2013: $1,817,071 USD (unaudited)
Staff	18 (2014)
Shares in Other Organizations	• Ghana Co-op Pharmacists Credit Union Ltd • Unique Insurance Company Ltd (erstwhile Ghana Co-op Insurance Ltd) • Ghana Commercial Bank Ltd
Affiliations	• Ghana Co-operative Council Ltd • Department of Co-operatives, Ghana • Pharmaceutical Society of Ghana • Community Pharmacy Practice Association of Ghana
Subsidiaries/Branches	Nil

SOURCES

[1] For more information on heath cooperatives in Ghana, contact Nelson Godfried Agyemang, P.O. Box FNT 812, Kumasi-Ghana, Tel+233-265-806375 E-mail: amadehse@gmail.com, farmersallainceghana@yahoo.com, agricoopghana@gmail.com Skype: farmersallianceghana. Nelson is currently promoting cooperatives for professionals in several sectors, including health.

[2] This section is draw from Adinkrah, Julian Mawuli. 2014. "Healthcare System in Ghana – Problems & Ways Forward." *#GlobalHealth: Discussions and perspectives on Global Health from leaders in training*, February 12. Blog. Retrieved August 19, 2014 (http://globalhealthstudents.blogs.ku.dk/2014/02/12/healthcare-system-in-ghana-problems-ways-forward/).

GREECE[1]

2014

SOCIAL CARE COOPERATIVES

Within Greece's health care sector, social care cooperatives and pharmacy cooperatives are active.

In 1999, as a part of a general mental health reform programme, the Greek government established a legal framework (law 2716/99, article 12) to support the setting up of social care cooperatives for the mentally ill. The Social Cooperative of Limited Liability (**KoiSPE**) is an innovative cooperative programme which promotes partnerships and equal participation among three categories of individual: those with psychosocial problems (or IPP, who may constitute as much as 35% of co-op membership);[2] mental health professionals (no more than 45%); and people from sponsoring institutions, or other marginalized groups, including the disabled, the unemployed, etc. (to a maximum of 20%).[3]

The basic aim is the socioeconomic integration of individuals suffering from severe psychosocial problems. The KoiSPE is considered to contribute significantly to the well-being of such individuals.

In terms of employment, KoiSPEs can initiate any number of commercial activities, including farming, animal breeding, apiculture, fishing, foresting, industry, manufacturing, tourism, or services. Each member has the right to buy 1-5 shares.[4] (The third category of member can buy more.) In keeping with cooperative principles, all members have the right to one vote, regardless of the number of shares they own.

Population (in thousands): 11,125

Population median age (years): 42.47

Population under 15 (%): 14.6

Population over 60 (%): 25.41

Total expenditure on health as a % of Gross Domestic Product: 9.3

General government expenditure on health as a % of total government expenditure: 11.4

Private expenditure on health as a % of total expenditure: 32.5

IPP are paid according to their productivity and hours of work. Their wages, which are equivalent to a market wage, are *added* to their benefits and pensions. If they are not registered in with insurance institution, KoiSPE insures them. All members have equal work opportunities. According to the constitution and governance manual, all share the same rights and obligations. KoiSPE are considered "supported employment" under Presidential Act 60. Their profits are reinvested in KoiSPE for training and creation of new job opportunities.

KoiSPEs are at one and the same time independent trading enterprises and official mental health units. That gives them access to national health services staff and premises. Mental health workers – public employees – can work in a KoiSPE on a full- or part-time basis, according to the demands of the commercial activity. More specifically, with their consent, workers in psychiatric, general, or other hospitals can be moved from those institutions to KoiSPE or may work part-time in both situations. Their KoiSPE wage is covered by the psychiatric institution. It also may make available to KoiSPEs movable and immovable property and facilities.

KoiSPE are exempt from corporate taxes except the VAT (value-added tax).

KoiSPEs are owned and managed democratically by their members. By law, KoiSPEs fall under the supervision of the Ministry of Health and the Department for Mental Health. Each KoiSPE is governed by its 7-member executive council: two persons of the first category and five from the second and third categories. Elections take place every three years. A supervisory council is also elected, consisting of three members from the three categories. In February 2011 the Federation of the KoiSPE was established.[5] Sixteen KoiSPE now operate under the common brand "In Business Together."[6]

Case Study

A Social Cooperative with Limited Liability (KoiSPE) has been operating since 2006 in the mental health sector of the port city of Chania, on the island of Crete (population 601,160).

KoiSPEs represent a new pathway to social inclusion for persons with psychosocial disabilities and serves both therapeutic and entrepreneurial purposes. They both broaden the career

opportunities and improve the quality of life of those suffering from mental illnesses. The main themes of the enterprising environment of the **Social Cooperative of Chania** are financial viability, social engagement, and the on-going development of quality working positions for mentally ill people.

The KoiSPE has four main activities, all in the immediate vicinity: a gift shop, a car wash, a canteen, and a site for the preparation and storage of traditional products. Its products and services are noted for their quality, ecological balance, and competitive prices. There are 129 members in the Social Cooperative of Chania. Of these, 59 are people suffering from mental illness, 46 are mental health professionals, and 23 are other individuals and sponsoring organizations.

Many organizations support the KoiSPE's activities. Among them are the Prefectural Administration of Chania, the municipalities of Chania, Kissamos, and Souda, the Municipal Enterprise of Platania, the General Hospital "St. George," the Cooperative Bank of Crete, the Cooperative Bank of Chania, and the Institute of Mediterranean Nutrition.

PHARMACY COOPERATIVE

In Greece, cooperative wholesalers of pharmaceutical products gathered together to create a common platform in 1988. The **OSFE** (FEDERATION-FARMAKOPOION ELLADOS) was founded at the first Congress of Pharmacists Cooperatives in Heraklion, Crete. It was a response to the need for a uniform representative of cooperatives in the country, vis-à-vis the political power of the State and the private sector (farmakemporio).

In the intervening years, OSFE has managed to become a strategic focal point for pharmacist cooperatives – unique businesses, all firmly under the ownership of pharmacists and designed to support the development of Greek pharmacy.

As of 2009, OSFE owned 45 distribution centres across the country, serving approximately 5,500 pharmacies with multiple daily deliveries. It employed 1,500 partners, a fleet of 260 trucks, and worked with 150 manufacturers.[7] The total turnover in 2009 was $3.4 billion USD (2.5 billion EUR). OSFE essentially controlled 50% of the Hellenic pharmaceutical market.

In 2003, OSFE developed a new service, the Information System of Pharmacists Cooperatives, to enable the pharmaceutical industry to become reliable, flexible, and adaptable to its needs. For OSFE, the issue was to have the ability, by means of an on-line connection, to inform pharmacies promptly of the movement, volume, and delivery schedule of OSFE products.

OSFE has also projected the development of a virtual pharmacy network (Green Pharmacy), as well as the establishment of a 3PL (third-party logistics) service with the company Logiscoop.[8] May 27, 2013 was the opening ceremony of the newly-formed logistics company **Osfe Logiscoop SA** at its facilities in Koropi, where it co-locates with the National Pharmacists Cooperative.[9]

Logiscoop is uniquely positioned as a point of marketing, storage, and distribution of pharmaceutical and para-pharmaceutical products throughout Greece. It collaborates with and ships products daily to the majority of private pharmaceutical warehouses and pharmacist cooperatives nationwide. Its premises measure 7,500 square meters. Its innovative and technologically advanced services are of an international standard and create the ideal environment for optimal and faster customer service.[10]

SOURCES

[1] A more detailed version of this case is available upon request.
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[8] For more details (in Greek) go to OSFE. 2014. Website. Retrieved August 14, 2014 (http://www.osfe.gr).
[9] The event was attended by representatives of the Greek parliament, local government, political parties, local authorities and associations, as well as customers and partners. More details (in Greek) at (http://www.pansyfa.gr/index.php?section=441&newsid510=42).
[10] Idem.

GUATEMALA

2014

HEALTH SYSTEM

The Guatemalan health system is composed of a diversity of actors. The Ministry of Public Health and Social Welfare (Ministerio de Salud Pública y Asistencia Social) covers 70% of the population. The Social Security Institute (Instituto Guatemalteco del Seguro Social, IGSS) provides coverage to 18% of the population. The ministries of Defence and the Interior provide health services to members of the armed forces and police, respectively. The private sector, encompassing for-profits and not-for-profit civil society organizations (including non-governmental organizations and cooperatives) as well as religious organizations, covers 18% of the population.[1]

Public sector health care is financed from tax revenue, international development grants and loans for Ministry of Health services, and from contributions (employer and employee) to the IGSS. Of the health care services provided by the private sector, approximately 92% are financed out of pocket. Only the wealthiest members of society, predominantly in the urban areas, have private health insurance. The Ministry of Health and IGSS deliver health care in their hospitals, clinics and health centres, without coordinating services between one another or between the units of these institutions. The ministries of Defence and the Interior also have their own hospitals and nursing homes for beneficiaries. Similarly, the private sector provides services in offices, clinics, and private hospitals.[2]

Population (in thousands): 15,083

Population median age (years):19.19

Population under 15 (%): 40.8

Population over 60 (%): 6.56

Total expenditure on health as a % of Gross Domestic Product: 7.2

General government expenditure on health as a % of total government expenditure: 19.5

Private expenditure on health as a % of total expenditure: 60.5

The cooperative law does not specifically mention health or social care as areas of cooperative activity. It defines single-purpose cooperatives (citing such examples as agriculture, artisanal marketing, consumer, savings and credit, transport, or housing cooperatives) and multipurpose cooperatives, which offer a variety of products and services to satisfy their members' needs.[3]

Notwithstanding, the statistics collected by the National Cooperative Institute (Instituto Nacional de Cooperativas) categorize cooperatives under their main area of activity. Statistics are available for the following groups: agriculture, savings and credit, production, consumer, housing, transport, special services (cable, tourism, public utilities, etc.), fisheries, and marketing. The Institute reports that in 2013 there were 880 cooperatives active in Guatemala with nearly 1.4 million members. The agricultural sector (356 cooperatives with 81,929 members) and savings and credit sector (259 cooperatives with 1,273,060 members) are the two largest.[4] Multiservice cooperatives in these two sectors provide and facilitate access to health care.

HEALTH COOPERATIVES

No cooperative was identified whose primary function is health care. Health care (medical assistance, dental and social care) is however provided as part of multiservice delivery by cooperatives in other sectors, in particular in multiservice agricultural and savings and credit cooperatives.

OTHER COOPERATIVES

A number of cooperatives have partnered with the Ministry of Public Health and Social Welfare to bring health promotion, and preventive and curative health care to vulnerable populations with limited access to public structures. The Ministry contracts with cooperatives, the majority of which serve rural areas, to run community health care centres. Considered non-governmental organizations, they are contracted to extend basic health care coverage (extensión de cobertura[5]), particularly services for women and children, and emergency health care. The standard contract generally covers the cost of mobile health teams. They visit cooperative-run health centres to provide medical check-ups, especially to women (pre- and post-partum check-ups, family planning) and children, to vaccinate and to provide in-home care. It

further covers the cost of trained health workers, of community facilitators who provide emergency medical care and medication, and of midwives who work in the health centres (convergence centres and community centres) run by NGOs, including cooperatives. Partners provide support staff.[6]

The following are examples of the types of cooperative which are currently partners or have partnered with the Ministry.

Cooperativa Agrícola Integral 'El Recuerdo' R.L.: El Recuerdo Cooperative was founded in 1984 as a multiservice agricultural cooperative. As of December 31, 2012, it had a total membership of 1,993 (63% or 1,246 men; 37% or 747 women). Since 2010 El Recuerdo has been contracted by the Ministry of Public Health and Social Welfare to extend health coverage in eight municipalities (90,429 inhabitants) in the department of Jalapa. Under the El Recuerdo model of service, each mobile health team includes a doctor, institutional facilitator, health educator, and a rural technical specialist. In each municipality, 1-5 institutional facilitators or neonatal maternal nurses staff each convergence centre. They provide preventive care, assist in deliveries, and provide home care. An average of 20 community facilitators trained by the cooperative and 30 midwives are found in each municipality.[7]

The health service provider contract was worth $605,180 USD (4,789,631 GTQ) in 2012 and $1.3 million USD (10,545,576,000 GTQ) in 2013.[8] The cooperative's contribution to operating the health centres was $56,850 USD (449,169 GTQ) to cover the cost of office supplies, support staff salaries, training, gas, insurance premiums, and other general operating costs. In-kind expenses included the use of four-wheel drive vehicles to transport staff and pharmaceutical products to the various municipalities. In 2012, El Recuerdo Cooperative recorded 92,861 medical consultations.[9]

Federación de Cooperativas de Las Verapaces, R.L. FEDECOVERA:[10] Established in 1976, by 2012 FEDECOVERA brought together 36 cooperatives and 12 farmer groups with a membership of 25,000 small agricultural producers. The federation established a health centre in 1996. Today, with the assistance of the Ministry, it serves 46,438 people in 48 communities. FEDECOVERA reports that an average of 18,000 people per year receives orthodontic care. The majority are children.

Cooperativa Integral de Ahorro y Crédito "Todos Nebajenses," COTONEB R.L.:[11] Established in 1989, COTONEB is a multiservice savings and credit cooperative which provides health care to the department of El Quiché. With the financial support of the Ministry and the World Bank, 63,692 people (primarily women and children) received care in three municipalities in the Ixil region. The investment was approximately $486,360 USD (3,842,625 GTQ) by the Ministry and $199,350 USD (1,575,227 GTQ) by the World Bank. COTONEB was also contracted as the Ministry's service provider for the municipalities of Sacapulas and Cunén, where an additional 47,082 women and children were served. The cost of the operation was $289,900 USD (2,290,398 GTQ).

Cooperativa Agrícola Integral "Hoja Blanca" R. L.:[12] Hoja Blanca is a multiservice agricultural cooperative established by small-scale coffee producers in 1979. With the support of the Ministry of Public Health and Social Welfare, the cooperative serves 7,500 people in 12 communities in the municipality of Cuilco and five communities in the municipality of Libertad, Huehuetenango.

UPAVIM (Unidas para vivir major), the women's handicraft cooperative, also runs a medical clinic, laboratory, and pharmacy as well as providing social care in the form of a child care centre.[13] With over 80 members, some of which are worker-members, UPAVIM employs 41 salaried workers, including a full-time doctor, nurses, a teacher, administrators, cooks, cleaners, secretaries, bakers, soy producers, and a lab technician.

SAVINGS & CREDIT COOPERATIVES

The savings and credit sector is among the largest of the cooperative sectors, serving over 1.2 million members or approximately 7% of the population. Savings and credit cooperatives provide medical attention, run infirmaries/dispensaries, and provide affordable medicine.[14] They make available insurance plans to cover hospitalization or provide free basic health care. Insurance products are provided through private insurance companies.

INSURANCE COOPERATIVES

In 1994, the Savings and Credit Cooperative Federation (Federación de Cooperativas de Ahorro y Crédito, FENACOAC) established an insurance company, **Seguros Columna**. It is owned by the Federation and 25 individual savings and credit cooperatives. A wide range of life and non-life (auto, home, remittance, etc.) insurance products are offered to cooperative members and to the general public, with members receiving discounted pricing or free access.[15] Insurance products can be contracted through 168 offices in 115 municipalities in 20 departments in Guatemala.

Seguros Columna offers a series of products and services to improve health care access, including:

Health Care Allowance: A daily allowance to help cover health care costs is available to those who hold savings accounts at savings

and credit cooperatives. This coverage is available free to all those with minimum deposits of 500.00 GTQ (approximately $63 USD). The level of payment is in proportion to the level of savings. Daily payments are made for a maximum of 90 days to all persons up to the age of 70.[16]

Savings (GTQ)	Benefit	Max Benefit
500-1,000	50	4,500
1,001-10,000	100	9,000
10,001 and above	150	13,500

Health Days (Jornadas médicas de salud): In collaboration with the savings and credit cooperatives of the MICOOPE system (members of FENACOAC), Columna Seguros organizes "health days" during which it provides free general medical, dental, and ophthalmological care to members and to the community that the cooperative serves. In 2012 it planned 70 such days and benefited 28,000 people.[17]

Operation and Hospitalization Allowance (Seguro Médico de Operaciones y Hospitalización): Columna Seguros offers health insurance to contribute to health care costs. A schedule of recognized medical interventions designates the payment applicable to each operation/hospitalization. Policyholders are free to choose their doctors and medical establishments, as the insurance company does not maintain a network of health providers. In 2009, over 400,000 were covered by the health plan.[18]

'Healthy Life' Insurance (Seguro Vida Saludable): Columna Seguros offers a series of life insurance policies, all of which include unlimited, no-cost basic health care including gynaecological and paediatric care. Annual life insurance premiums range from $19 to $61 USD (150 to 486 GTQ) for coverage ranging in value from $1,200 to $6,300 USD (10,000 to 50,000 GTQ).

SOURCES

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[4] Instituto Nacional de Cooperativas. 2013. "Cooperativas Activas por Region y Clase al 31 Agosto de 2013." Webpage. Retrieved March 27, 2014 (http://inacop.gob.gt/page50.html).
[5] Ministerio de Salud Pública y Asistencia Social, Gobierno de Guatemala. 2014. "Extensión de Cobertura." Webpage. Retrieved April 5, 2014 (http://mspas.gob.gt/index.php/en/extension-de-cobertura.html).
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[7] Cooperativa El Recuerdo. 2014."Programa de salud." Retrieved April 5, 2014 (http://cooperativaelrecuerdo.com/index.php/es/salud.html?showall=1&limitstart).
[8] Ministerio de Salud Pública y Asistencia Social, Gobierno de Guatemala. 2013. "Auditoria Interna Cua. No. 31438. Cooperativa Agrícola Integral 'El Recuerdo' Responsabilidad Limitada. 1 de enero 2012 al 31 de Octubre 2013." Retrieved April 7, 2014 (http://mspas.gob.gt/libreacceso/images/stories/datos/2013/UIPDIC/Articulo%2010.%20Numerales%2014%20y%2019/Auditor%C3%ADas%202013/CUA%20No.%2031438-2013%20Cooperativa%20Agricola%20Integral%20-EL%20RECUERDO-%20Responsabilidad%20limitada.pdf).
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[14] Dardón, Esdras Nehemías Portillo. 2005. "Modelo Organizacional con Énfasis en El Servicio al Cliente para una Cooperativa de Ahorro y Crédito Integral." Ph.D. Dissertation, Facultad de Ciencias Económicas, Universidad de San Carlos de Guatemala. Retrieved March 27, 2014 (http://biblioteca.usac.edu.gt/tesis/03/03_2239.pdf).
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GUINEA[1]

2014

HEALTH SYSTEM[2]

Population (in thousands) total: 11,451

Population median age (years): 18.53

Population under 15 (%): 42.46

Population over 60 (%): 5.03

Total expenditure on health as a % of Gross Domestic Product: 6.3

General government expenditure on health as a % of total government expenditure: 6.8

Private expenditure on health as a % of total expenditure: 71.9

According to latest estimates, 40% of the population of Guinea lives below the poverty line, on less than $300 USD per year. Only 52% have access to safe water and 55% to health services. The latter figures in themselves are achievements, however. They highlight the benefits which have been secured since the introduction of community-based health services. Still, the indicators for levels of health outcomes remain mediocre relative to other parts of the world.

Public expenditure over the decade has focused primarily on services in urban areas (particularly the capital city, Conakry), and overall has benefited the wealthier income groups. In 1994, 48% of government expenditure in health benefited the richest 20% of the population, while only 4% benefited the poorest 20%. Since that time, budget allocations have remained practically unchanged, leaving little hope for improving this situation. Expenditure for medical personnel has also focused on the capital, which explains the concentration of all categories of personnel there. More than 60% of health personnel reside in Conakry, serving only 20% of the country's total population. In fact, the health-personnel-to-population ratio (for all categories of health personnel) is less than the national average in all regions except Conakry.

Despite serious efforts to implement a low-cost, essential drugs policy since 1988 (a time when the Guinean health system was considered path-breaking in Africa), the supply system has not only remained unchanged, it appears even to have jeopardized the health system as a whole. Drugs and vaccine shortages continue to undermine service quality. In this regard, Guinea is way behind countries such as Benin and Burkina Faso, both of which have implemented efficient mechanisms of drug supply.

The poor spend less on health services and resort more frequently to self-medication. Surveys show that about 30-40% of households experience temporary inability to pay for health services, and 10-15% are permanently unable to pay for health services. Nevertheless, only a few exemptions or subsidization mechanisms are in place. Moreover, the poor are required to pay more than the official fees to compensate for the low pay scale of health personnel. In particular, service utilization by children for vaccinations and for respiratory infections remains low in rural areas. Service utilization for assisted deliveries remains extremely low in rural areas as well, despite high utilization rates for prenatal care. This is to some extent explained by the lack of personnel, but also by the perceived low quality of assisted delivery services, in spite of the indisputable relationship between maternal and child health service utilization and maternal and child mortality.

Aside from the fact that public expenditure benefits the poor segments of the population least, per capita health expenditure as well as health expenditure relative to total government expenditure is extremely low in Guinea. Health sector budget allocations invariably have been low over the past decade. They represent less than one quarter of the education sector budget allocation, when in most countries this ratio is closer to one half. While per capita public expenditure has increased in nominal terms, in real terms it has practically remained unchanged, both in GF (Guinea-Franc) and in USD.

MUTUAL HEALTH ORGANIZATIONS

On July 04, 2005, the Republic of Guinea adopted Law 014 (L/2005/014/AN) governing economic groupings of a cooperative nature, mutual organizations of a non-financial nature, and cooperatives. Accordingly, mutual health organizations (MHOs) might expect to be regulated under the second category (Articles 11-14). Unfortunately, Law 014 does not define MHOs in the usual terms. It makes no mention of rights or obligations arising from participation in an activity relating to microinsurance, as usually is the case in MHO regulations.[3]

The legal framework is thus disconnected from reality. It was in this context that, in 2012,[4] the National Organization for Mutual Support in Guinea (ONAM), in partnership with the French NGO ESSENTIAL, observed that the absence of a legislative framework specific to MHOs is a great handicap to their strategy.

Several MHOs have been created in Guinea. Difficulties (mainly in terms of management) have prevented most of these experiments from being pursued. Some MHOs continue their activity, but represent a very small numbers of members. While MHOs have the advantage of being simple and quick to set up, they eventually get integrated into the general framework of insurance.[5]

The informal sector is very important to the country, representing about 80% of the population. The extension of health insurance will not suffice to cover the majority of the population. Therefore, it is necessary to pool health risks. It will be based on community awareness, the development of income-generating activities, and training developers and providers.

In terms of awareness, specialized personnel will carry out socioanthropological studies so as to understand the needs of communities better, to articulate collective goals, and thereby address constraining factors. MHOs will be guided by certain principles: freedom of membership, solidarity between members, democracy of operation, non-profit status, and self-promotion.

In order to strengthen MHO management capacity, technical assistance will be provided. It will consist of the development of draft statutes and rules of procedure, the design of management tools, and training in MHO operation and management.

In Guinea, MHOs are usually guided by supporting entities. We managed to get information about three such entities.

- ESSENTIEL-ONAM-FMG Programme, within the framework of the Support for the National Sanitary Development Programme (Appui au Programme National de Développement Sanitaire, APDNS).

This project was set up very recently, in 2013. According to the data received, it integrates 10 MHOs from three departments. The MHOs are not yet functioning, but they have already started to enroll beneficiaries (between 47 and 300 members per organization). In fact, they have not yet reached the threshold at which support for beneficiaries becomes mandatory. The contribution is paid annually and varies between $49.75 and $62.19 USD (24,000 and 30,000 FCFA).

- ESSENTIEL-ONAM-REMUFOUD, within the framework of Health for All, Health, Social Protection, and Concentrated Dynamics (Santé pour tous, santé, protection sociale et Dynamiques concentrées.)

The first MHOs of this project were created in 2002 and the process continued up to 2013. According to the data received, it integrates 12 MHOs from three departments. The great majority of MHOs are not yet functional. Meanwhile, they are enrolling beneficiaries (between 96 and 1,135 members per organization). In fact, they have not yet reached the threshold at which support for the beneficiaries becomes mandatory. The annual contribution varies between $45.60 and $62.19 USD (22,000 and 30,000 FCFA).

- UMSGF-CIDR Programme, within the framework of MHO Support Projects (Projets d'appui aux mutuelles de santé)[6]

The Union of Mutual Health Organizations of Forest Guinea (l'Union des Mutuelles de Guinée Forestière, UMSGF) is an MHO association established as part of a project initiated in the Republic of Guinea by the Centre International de Développement et de Recherche (CIDR) in 1999. CIDR, a non-governmental organization created in 1961 and based in Autrêches, France, works in many African countries and in a variety of development sectors, such as microfinance, small business, decentralization, microinsurance, management of health services, etc.[7]

In Guinea, CIDR has chosen to organize the management and governance of health services according to the principles of mutuality, taking into consideration the strong social dynamics of the country (village cohesion and multiple mutual-aid organizations) and the absence of formal social or professional organizations which can organize the management and distribution of health products.

Since its founding in 1999, the network has experienced steady expansion. In 2005, UMSGF encompassed 21 rural mutual organizations and 7 urban mutual organizations, comprising 2,656 families and a total of 14,071 beneficiaries, nearly 100 families per MHO (the equivalent of about 10% of the target audience in the area).

To meet the demand and the financing capabilities of the target audience, MHOs had to design low-cost products ($1.60 USD per person per year in 2005), covering medical admissions and surgical procedures through the public health services.

In the space of five years, the adopted management strategy for health microinsurance enabled MHOs to constitute funds sufficient to permit product diversification ($25,206 USD over five years and a volume of $15,000 USD in annual premiums collected for the year 2004-2005). They have a security system that provides access to a contingency fund, should reserves ever diminish below a specified safety threshold. The project has set up a specialized Technical Unit

to organize monitoring and risk management functions which would be beyond the capacity of primary mutual organizations.

Growth in the number of beneficiaries is the challenge which mutual organizations and the UMSGF have to meet in order to achieve their financial independence. The sustainability threshold was established at roughly 60,000 beneficiaries. This objective can be achieved, given the maintenance of service quality by health facilities and growth in the purchasing power of the target audience.

SOURCES

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HONDURAS[1]

2014

Hondurans receive free medical check-ups at a Sagrada Familia "Health Day." Photo: Cooperativa Sagrada Familia.

HEALTH SYSTEM

The health system in Honduras is made up of a public and a private sector. The public sector includes the Ministry of Health (MH) and the Honduran Social Security Institute (HSSI). The private sector is dominated by a set of providers offering services paid mostly out-of-pocket. The National Health Plan 2010-2014 includes a set of reforms and anticipates the creation of public health insurance for the poor and the transformation of the HSSI into a public insurance agency, contracting services for its affiliates with public and private providers under a family medicine model.[2]

Cooperatives are involved in assisting their members to access health care. According to the Cooperative Institute of Honduras (IHEDCOOP), there are just over 650 active cooperatives in Honduras. They are categorized by activity: in order of importance, multipurpose, agricultural, agro-forestry, savings and credit, coffee, transport, industrial, housing, fisheries, student, and consumer cooperatives.[3] Health and social care cooperatives are not specifically noted as categories of activity.

Notwithstanding, the savings and credit cooperative sector has taken a lead in providing access to health care. In addition, the medical profession is well-serviced by savings and credit cooperatives, with a number having launched as closed cooperatives catering only to health professionals. As they grew, many opted to change their statutes to enable all persons to join.

Population (in thousands): 7,936

Population median age (years): 21.57

Population under 15 (%): 35.72

Population over 60 (%): 6.41

Total expenditure on health as a % of Gross Domestic Product: 8.6

General government expenditure on health as a % of total government expenditure: 11.8

Private expenditure on health as a % of total expenditure: 49.7

HEALTH COOPERATIVES

Two health cooperatives were identified. No further information on their structure or activities was available. Cooperativa de Servicios de Salud Mutual, Ltda (COSSAMUL) is a health service cooperative. Cooperativa Mixta Salbar Limitada is a community health cooperative established in Esperanza in 2009.[4]

SAVINGS & CREDIT COOPERATIVES

Savings and credit cooperatives often provide their members specific loan products for medical attention in case of illness or accident. Some are also involved in health promotion, providing members with information on such issues as hypertension, diabetes, and breast and other cancers. Still others run clinics and pharmacies or provide ad hoc health services. Here are some examples:

Cooperativa Sagrada Familia, the largest savings and credit cooperative in the country, provides employee with free health care services and life insurance, among other benefits. It offers members a medical assistance plan (Plan asistencia medica CoopSalud), which provides access to a network of health providers at discounted prices. For senior members of the cooperative, access is free of charge. (See "Case Study," below.)

Cooperativa Ceibeña, established in 1979, offers its members and their immediate families primary health coverage through CoopSano. Under the programme, members benefit from access to free and unlimited general medical consultations and basic medication. In addition, members benefit from discounts on specialized prescriptions. In 2013 it operated three clinics in La Ceiba, San Juan Pueblo, and Jutiapa and was to open a fourth clinic in Tocao. In branch offices where clinics do not operate, the cooperative organizes health days, providing basic medical consultation services and health promotion on issues such as hypertension and diabetes.[5] Through its foundation it also runs a health programme which benefits both members and the wider community. Cooperativa Ceibeña has 13 branch offices around the country.[6]

Cooperativa de Ahorro y Crédito Fé y Esperanza Limitada is a savings and credit cooperative founded in 1989. It serves workers, including informal sector and independent workers. It operates a medical clinic offering basic health services including health check-ups for children and pregnant women. It also provides services to control diabetes and hypertension, performs minor surgery, and runs a detox programme for alcoholics.[7] Cooperativa Fé y Esperanza has four branch offices.

Cooperative de Ahorro y Crédito ELGA is the second largest savings and credit cooperative, with 101,687 members in 2013. It runs health days where members have access to free medical exams, including eye and helicobacter pylori (H. pylori) exams, and tests for levels of cholesterol, blood sugar, and triglycerides.[8]

COMIXMUL (Cooperativa Mixta Mujeres Unidas Limitada) is a women's cooperative with 25,000 members. Officially categorized as a "mixed" cooperative by IDEHCOOP, COMIXMUL is essentially a financial cooperative, although initially it provided other services. In 2006 it spun off its education and health programme to its then newly-established Foundation for the Development of Women and Family (Fundación Para el Desarrollo Integral de la Mujer y la Familia, FUDEIMFA). FUDEIMFA is considered its technical arm. It receives funding from COMIXMUL (5% of its surplus) and NGOs as well as support from the national health system. Through FUDEIMFA, COMIXMUL runs a comprehensive health programme. The programme includes operating a clinic where COMIXMUL members obtain as a membership benefit free health care, including preventive check-ups. The clinic is equipped to provide members with access to general medical consultations, mammography, ultrasound, and cancer screenings. The clinic also carries out medical procedures including biopsies, cauterizations, and minor surgery. COMIXMUL is able to visit its 13 branch offices in order to attend to members. In 2011 a total of 2,556 members received care, including 506 medical procedures and 23 surgeries.[9] The programme also runs a social pharmacy which provides access to affordable medicine through 140 dispensaries reaching about 10,000 families (56,000 people) in 190 communities.[10] FUDEIMFA provides training for community leaders to run the dispensaries and provide advice on the proper use of medication. In 2014, COMIXMUL also introduced a specific loan product for health care-related credit, "CREDI SALUD."[11]

The sector has also established a wholly-owned insurance company, **Equidad Compania de Seguros** S.A, to provide insurance services to the members and employees of the savings and credit cooperative sector. The insurance company offers life and non-life insurance products, including health insurance covering illness and accidents. (For more information, see "Insurance Cooperatives," below).

Finally there are savings and credit cooperatives that were established by health professionals to service their financial needs. Many have opened their membership to the communities in which they operate.

Case Study[12]

Cooperativa Sagrada Familia was founded on February 14, 1969 by three Canadian priests, Muisse Joseph, Norman McPhee, and Bernie McAdam. Today it has 40 branches nationwide and a membership of over 276,000 and 457 employees. Its activities are based on the original mission of its founders: "to provide an option for the poor" with savings and credit products and services that respond to their needs while keeping in mind the well-being of all Honduran families.

This was the umbrella under which Sagrada Familia introduced the Medical Assistance Plan COOPSALUD (Plan asistencia medical) to enhance the quality of life of members and their families through improved family health.

The cooperative entered into a strategic alliance with a well-respected health care provider, recognized for the quality of its services both in Honduras and Latin America.

Through COOPSALUD, members, their spouses, and children under 18 years of age can access quality medical services. Members receive a debit card which, when presented in one of the hospitals, clinics, and pharmacies, entitles the bearer to discounted rates on health care services. Members who are seniors and comply with their membership requirements (maintaining monthly balances on their senior savings account) receive free health care services in 37 localities, with the cooperative covering their health care expenses. Currently 90 seniors benefit from this free service.

The COOPSALUD Plan provides for the following services:

- Ambulance services for medical and paediatric emergencies, illness, or accident
- Medical consultations at any of the clinics in the network
- House calls in case of serious emergencies
- Access to medical advice via a telephone service
- Laboratory network
- Dental care (including emergency dental care)
- Paediatric care
- Preferential rates on pharmaceuticals, diagnostic imaging, etc.

Over 800 members benefited from the COOPSALUD Plan February-March 2014. Sagrada Familia also offers life insurance at no charge to members.

As part of its social responsibility activities, the cooperative also supports community access to health-related services. This includes support to modernize various health centres, hospitals, and morgues, and donations of pharmaceuticals. During health days at its branch offices, tents are set up and free medical care is extended to both members and community residents.

Head Office of the Cooperativa Sagrada Familia in Comayagüela

PHARMACY COOPERATIVES

Founded in December 2005, the Cooperativa Mixta SOLFAHSA (Solidaridad Farmacéutica Honduras Saludable Ltda) is a purchasing, preparation, and distribution cooperative of independent pharmacists. Members are part of the SOLFARMA network, purchasing their pharmaceuticals for as much as 35% below market prices. With 800 employees, SOLFAHSA provides technical assistance to members, including marketing assistance and human resource development, and represents its members in negotiations with insurance companies. It operates the largest network of pharmacies in the country, with locations in Atlántida, Choluteca, Colón, Comayagua, Copán, Cortés, El Paraíso, Francisco Morazán, Gracias a Dios, Intibucá, Islas de la Bahía, La Paz, Lempira, Ocotepeque, Olancho, Santa Bárbara, Valle, Yoro.[13]

INSURANCE COOPERATIVES

Equidad Compania de Seguros S.A. is an insurance company owned by the Federation of Credit Unions of Honduras (FACACH) and 41 individual savings and credit cooperatives.[14] It is the only insurance institution supporting the cooperative sector in Honduras, providing a wide range of insurance products, including a health insurance plan named Medicoop. The plan covers 80% of the cost

of ambulatory care and hospitalization for illness and accidents, dental care (for accidents only), laboratory costs, ambulance service, orthopedics, child health, maternity, and psychiatric care in Honduras and Central America. Equidad Compania de Seguros insures more than 400,000 people. No specific number of health insurance policyholders is available, however.[15]

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INDIA

2014

HEALTH SYSTEM[1]

Today, most Indians seek health care in private facilities. Owing to many years of neglect, lower-level public health care facilities often suffer from a variety of problems, including worker absenteeism and dual public-private practice, low demand for their use, and shortages of supplies and staff. By contrast, private health care varies greatly in quality of care, being unregulated and financed largely through out-of-pocket payments. In the private sector, there are a large number of health workers who have only a high-school education or no medical degree.

There are at least two major health care programmes in India. The first is the National Rural Health Mission (NRHM). It is the central government's attempt to improve delivery of services in public facilities as well as public health and preventive interventions, led by the Ministry of Health and Family Welfare. The second is the Rashtriya Swasthya Bima Yojana (RSBY), a health insurance programme delivered by the Ministry of Labour and Employment. In most states RSBY covers people "below the poverty line" for a specific list of tertiary care services. NRHM, launched in 2006, has had some success in improving access to certain services, such as maternal health care (under the Janani Suraksha Yojana programme). Less clear is the impact which NRHM has had on other services. However, there is early evidence that RSBY has been somewhat effective in reducing out-of-pocket payments for tertiary care. Whether this programme also improves population health is uncertain.

Population (in thousands): 1,240,000

Population median age (years): 26.07

Population under 15 (%): 29.43

Population over 60 (%): 8.1

Total expenditure on health as a % of Gross Domestic Product: 4.1

General government expenditure on health as a % of total government expenditure: 9.4

Private expenditure on health as a % of total expenditure: 66.9

HEALTH COOPERATIVES

The development of cooperatives in India begins in 1904 with the passage of the Cooperative Credit Societies Act. Today, cooperatives are active in approximately 99% of Indian villages and 71% of the country's rural households. Co-ops are especially important in to agricultural credit, fertilizer production and distribution, sugar production, cotton spinning, and the dairy sector.[2]

In India, health co-ops generally include in their name the words "hospital society." For this study, several attempts have been made to collect relevant data but with very limited results.[3]

Under the rubric "hospital society," using two different lists,[4] we have been able to identify 109 health co-ops. Unfortunately, detailed information about these health co-ops (other than the geographic location) is not available, with one exception. Shushrusha Citizens' Co-operative Hospital Ltd. provided us with key figures. See table, opposite.

The National Co-operative Union of India reported 221 hospital cooperatives with 155,978 members in 2009-2010.[5] Its report also specifies a "government participation of 32.54%." Comparing this number of co-ops and members with 2008-2009 data (216 co-ops, 150,801 members), a modest increase is discernible.

Shushrusha Citizens' Co-operative Hospital Ltd Data[6]

Number of cooperatives	1
Types of cooperative	User (1) Multi-stakeholder (-) Producer (-)
Number of members	User: 20,000 Producer: 200 doctors, 100 nurses, 150 administrative staff, 200 support staff
Number of customers (or other enrolled users)	Tie-up with 20 companies
Services offered	Cancer, heart ailments, eye ailments, treatment of various diseases, orthopaedic, spinal surgery, etc.
Number of employees	450 staff, 200 doctors
Facilities	1 hospital at Dadar, 1 maternity unit at Vikhroli
Annual turnover	$3,304,966 USD (Rs. 20 Crores)
Revenue sources	Out of pocket - No external sources

COOPERATIVE INSURANCE

In Karnataka State a health plan programme, Yeshasvini Co-operative Farmers Health Care Scheme, has been implemented in collaboration with existing co-ops.[7] The programme offers free outpatient diagnosis and lab tests at discounted rates. More importantly, it covers less discretionary inpatient surgical procedures in cases of emergency. An evaluation of the scheme gives it high marks:

> "Generally, the programme is found to have increased utilisation of health-care services, reduced out-of-pocket spending, and ensured better health and economic outcomes.... however, these effects vary across socio-economic groups and medical episodes. The programme operates by bringing the direct price of health-care down but the extent to which this effectively occurs across medical episodes is an empirical issue. Further, the effects are more pronounced for the better-off households."[8]

The evaluation demonstrates that community insurance presents a workable model for providing high-end services in resource-poor settings through an emphasis on accountability and local management.

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ITALY[1]

2014

HEALTH SYSTEM

Italy's health care system is a regionally-based National Health Service (Servizio Sanitario Nazionale, SSN) which provides universal coverage free of charge at the point of service. The national level is responsible for ensuring the general objectives and fundamental principles of the national health care system. Regional governments, through the regional health departments, are responsible for ensuring the delivery of a benefits package through a network of population-based health management organizations and public and private accredited hospitals.

> "There is a considerable north-south divide in the quality of health care facilities and services provided to the population, and there are significant cross-regional patient flows, particularly to receive high-level care in tertiary hospitals. Health care is mainly financed by earmarked central and regional taxes. Each region is free to provide additional health care services if budgets permit, as long as they also deliver the basic package. However, regional budget deficits historically have been a major problem and reform efforts since the 1990s have aimed, in part, to enforce balanced budgets.... Due to near universal coverage, voluntary health insurance (VHI) does not play a significant role in funding health care in Italy. Spending on VHI, both as a percentage of total expenditure and of private expenditure, is well under 5%."[2]

Population (in thousands): 60,885

Population median age (years): 43.99

Population under 15 (%): 14.04

Population over 60 (%): 26.97

Total expenditure on health as a % of Gross Domestic Product: 9.2

General government expenditure on health as a % of total government expenditure: 14.2

Private expenditure on health as a % of total expenditure: 21.8

Italy has a long tradition of co-op development, starting in the 19th century with both worker and housing co-ops. Over the next decades, the co-ops took root in other types of activity. Since the end of the 1960s, a new model has come to life, the social co-op. Law 381/1991 explicitly recognizes that such cooperatives pursue the "general interest of the community, for the human promotion and social integration of citizens" (Article 1). It also recognizes that people who are engaged solely as volunteers may be members of these structures. It recognizes the existence of a special relationship between public administrations and social cooperatives. They tend to be one of two types:[3]

- Type A: originating in the health and social care sectors in addition to education and daycare, offering services to seniors and disabled people.
- Type B: targeting the social inclusion of people marginal to the job market, e.g., in agriculture, arts, environment, or printing.

Another characteristic of the social co-op is that it generally has more than one category of member: workers and volunteers, for example. In this sense, Italy's social co-ops are pioneers of the multistakeholder co-op model.

Over the years, the Italian State has recognized the importance of co-ops, even constitutionally. In 2013, Italian Prime Minister Enrico Letta underlined that cooperatives are "a virtuous example of resilience to the crisis and an experience to replicate and support."[4]

Three apex organizations encompass the majority of Italy's co-ops, regardless their business activity: AGCI, Confcooperative, and Legacoop. In the last few years, these three have gained their own apex or umbrella organization, the Alliance of Italian Cooperatives (Alleanza delle cooperative Italiane).

HEALTH, SOCIAL, & PHARMACY CO-OPS[5]

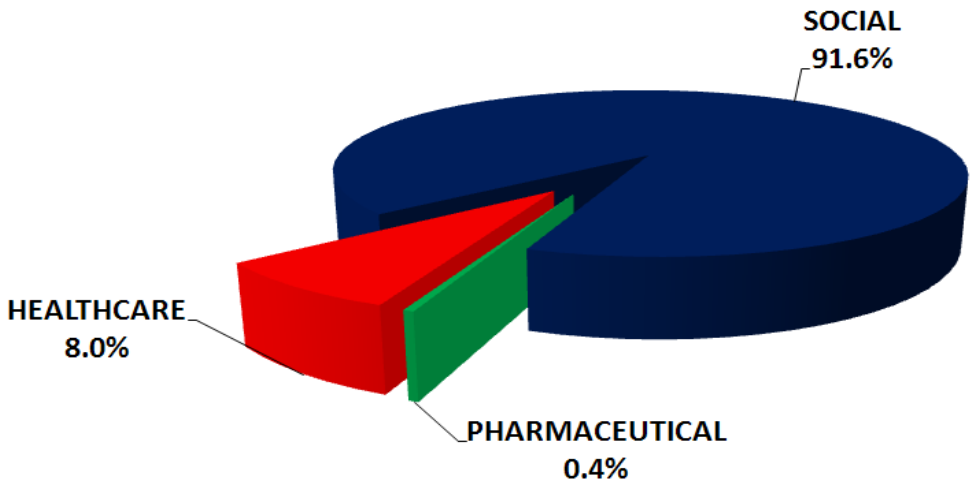
Cooperatives active in the health care sector in Italy in 2013 numbered 11,830; 98% are SMEs. (See Graph 1, next page.) Of these, 945 (8%) work in health care in the strictest sense. They have approximately 50,000 members, 28,124 staff, and 865,000 users.[6] Three-quarters (75.7%) of this subset are social cooperatives specializing in health care. They provide any of a number of services: home care; care in social and health facilities with inpatient services; hospital care; outpatient care services; emergency and immediate care services; medical treatment; therapeutics and rehabilitation; and prevention and well-being programmes as well as health care training. The remaining quarter (24.3%) are service cooperatives (non-social co-ops) which work in health care provision. Among

them are the doctor cooperatives, which mainly provide various forms of associated medical care.

Altogether 10,836 cooperatives (91.6% of the total) operate in the social sector, mainly in social assistance and individual services of a non-healthcare nature. This involves 97% of the social cooperatives (excluding Type B coops and those active in the agricultural, industrial, and services sectors, but not linked to social assistance). The number of users for these social cooperatives is not available, but for all kinds of social cooperative in Italy, a total of approximately seven million clients is estimated.[7]

Forty-nine cooperatives (0.4% of the total) are active in the pharmaceutical sector, particularly in the supply of pharmaceutical and para-pharmaceutical products. In some cases these cooperatives also manage pharmacy stores.

Graph 1: Distribution of cooperatives operating in the health care sector



CASE STUDY[8]

Today in Italy primary health services are characterized by fragmentation. There is a lack of integration between providers, a lack of a planned continuity between hospitals and local and regional health authorities, and a shortage of tools for clinical governance of primary care.

Cooperatives in the medical and pharmaceutical sector, social care cooperatives, and social-health mutual societies are working together to create a dynamic alternative which focuses health services on the emerging needs of people and families. Their goal is to create a network which responds to different levels of need with a *continuum of care* and conserves resources while integrating the services of diverse providers.

It is called the **Consortium for Primary Care** (Consorzio per l'Assistenza Primaria) or simply **CAP**.

The first CAP was established in March 2012 in order to transform primary health care across the Lazio Region (i.e., Rome and its neighbouring districts). It is a collaborative of innovative general practitioner cooperatives; two cooperatives which affiliate more than 800 pharmacies; social cooperatives engaged mainly in health activities; a cooperative diagnostic laboratory; and a social cooperative (OSA) which is a national leader in the field of home care. CAP is also supported by a consortium of the region's main social care cooperatives.

The range of services they offer is broad. It extends from needs assessment, to home care, nursing, physiotherapy and social services, diagnostic imaging, and also telemedicine and remote assistance. The intention is to make them available to all citizens in a timely manner and at affordable and sustainable costs.

At present, the experiment has been launched in about 30 locations in the Lazio Region, all open 12 hours a day, 7 days a week. With the support of cooperative banks, a Fidelity Card will be issued with which residents can gain access to health and social care. A system for the measurement and tracking of customers' service satisfaction and expectations is also planned.

Thanks to the support of Federazione Sanità-Confcooperative, the CAP model set up in the Lazio Region has already enabled the launch of other primary care consortia in many other parts of the country, including Calabria, Puglia, and Piedmont. These consortia are working to build up a national network and from there, a homogeneous cooperative welfare system to provide health care services across Italy.

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JAPAN

2014

Health Check in a Japanese Health Co-op. Photo: HeW Co-op Japan.

HEALTH SYSTEM

In Japan, universal access to health and medical care has been guaranteed by the government since 1961. The universal health insurance system covers comprehensive and uniform services, including inpatient, outpatient, and dental care. This system has two parts: Employees Health Insurance (EHI) and National Health Insurance (NHI). The latter is intended to cover the self-insured, fisherman, farmers, the retired, and the unemployed.[1] However, with the challenges posed by an aging society, changes in employment patterns, and the emerging issue of the uninsured, it is understood that the social health insurance system is under threat.[2] Coupled with these demographic crises are the fiscal difficulties which Japan faces. With the sharp increase in national medical expenditures, a co-payments policy has been in place since 1984 for all medical services. Furthermore, the Japanese social welfare system underwent drastic changes during the 1990s when social welfare laws were revised to enable municipalities to outsource in-home services to non-public providers. Perhaps the most significant market reform came with the enactment of public, mandatory Long Term Care Insurance (LTCI) in 1997 and its implementation in 2000. This law is perceived to have opened the door to non-public entities, including cooperatives, to operate in the health care and social care sectors.[3]

Population (in thousands) total: 127,000

Population median age (years): 45.53

Population under 15 (%): 13.12

Population over 60 (%): 31.92

Total expenditure on health as a % of Gross Domestic Product: 10.1

General government expenditure on health as a % of total government expenditure: 19.4

Private expenditure on health as a % of total expenditure: 17.5

The worldwide problem of aging is most serious in Japan, due to a combination of declining fertility rates and rising longevity. Japan's total fertility rate dipped from 2.13 in 1970 to 1.37 in 2009 (far below the replacement rate of 2.1).[4] Over the same period, the average life expectancy for Japanese women and men was 86.44 and 79.59 years, respectively – the highest in the world.[5] By 2013, 32.3% of the Japanese population was over 60 years old; by 2050 this figure is projected to rise to 42.7%. With the aging trend, obviously, fewer young workers are available to support more retirees. In 2000, the aged dependents ratio (number of working people divided by aged dependents) was 3.9 active workers to each person 65 and above. By 2010, this figure was fewer than three workers per retiree.[6] In the long run this will likely bring about a decline in Japan's GDP.

With regard to work patterns, corporations in recent years have preferred to hire more irregular workers (i.e., temporary, part-time, and contracted out) in order to maximize profits. Since those working less than three-quarter time need not be enrolled in employee-based plans, the composition of health insurance enrollment has been transformed.[7] For example, the proportion of workers engaged in the primary industries has decreased from 42% in 1965 to 3% in 2008. In the meantime, the proportion of retirees and others not working has increased from 7% to 40%. The proportion of those who are employed, but not covered by employee-based plans, has increased from 25% to 34%.[8] Moreover, as Japanese women attain higher levels of education, their values with respect to work, marriage, and childbirth have changed considerably.[9] Many of them choose to work or to pursue other interests rather than purely family careers.

Finally, growing numbers of Japanese are unwilling or unable to enroll in social health insurance. According to a national survey,[10] 1.3% of the sampled population was not paying social health insurance premiums although their incomes were high enough to be taxable. That means 1.6 million people have no insurance, which "might bring into question Japan's status as a country with universal coverage."[11]

Coupled with those demographic challenges, the development of Japan's health care and social care sectors has been hampered by the national fiscal crisis. The copayment rate was first set in 1984, when the revision of the Health Insurance Act led to the introduction of a 10% employee co-payment. This rate gradually increased to 20% in 1997 and to 30% in 2003.[12] A flat amount for seniors reached 30% in 2006. The co-payment is now 30% on all services, except for people aged 70 and older on low incomes, who pay 10%, and for children under six, who pay 20%.[13] However, the increase in the co-payment rate has led lower-income patients to use fewer medical services, thus discouraging patients with acute conditions from accessing the health care system.[14]

Since the 1990s, Japan's social services provision system also has undergone drastic change. For example, up to the year 2000, exclusively municipalities and social welfare corporations provided elder care services.[15] With the implementation of LTCI in 2000, competition was introduced between for-profit and non-profit service providers. In the health care sector, the number of state and public hospitals has been falling. Currently they account for 17.8% of all hospitals in Japan.[16] Clearly, public institutions are "retreating from service provisions while concentrating their role as financers and regulators."[17] In particular, they are leaving in-home services to the non-profit and for-profit sectors, with only 6-9% of in-facility services.[18] Moreover, while all medical institutions must be non-profit according to the Medical Service Law, they operate under various organizational forms, including as medical corporations, public institutions,[19] private and other entities including health cooperatives.

In these heavily regulated markets, cooperative organizations are understood to provide better access to health care for the increasing number of Japanese excluded from services due to unemployment and low income. In Japan, cooperatives offer a variety of services to farmers in under-populated rural areas and empower urban consumers through learning and participation.[20] In Asia, Japanese health cooperatives provide assistance to other members of the Asia-Pacific Health Co-operative Organization (APHCO), participating in study tours and exchanges with cooperative hospitals or dental clinics in Nepal, Sri Lanka, South Korea, and Mongolia.[21] (They mobilized to help rebuild health infrastructure in Sri Lanka after the tsunami of 2004.) In summary, they present a pioneering example of the vibrant cooperative movement emerging in health and social care sectors worldwide.

HEALTH COOPERATIVES

In Japan, health cooperatives operate in two forms. Those operating in rural areas (i.e., Koseiren) are regulated by the Agricultural Co-operative Law of 1947; those functioning in urban areas are registered under the Consumer Co-operative Law of 1948. **Koseiren** federations are affiliated with the National Welfare Federation of Agricultural Co-operatives. They are secondary-level organizations owned and controlled by primary cooperatives, where individual members are the beneficiaries of

health and social services provided by hospitals and clinics. They were designated as public institutions to provide health services to the rural population. All 36 Koseiren federations initiated welfare businesses under the LTCI system in 2000.[22] In 2006, Koseiren service providers under the LTCI system included 130 hospitals and clinics, 110 visiting nurse stations, and 26 health facilities for the elderly.[23]

Most urban health and welfare cooperatives are owned and controlled by consumer-members. They generally provide medical and nursing care services to local residents. Any resident is eligible to become a member. Medical professionals, such as doctors and nurses, and almost all staff members are also members. To join one such cooperative, a member normally provides $9.75 USD (1,000 JPY) as share capital, although the minimum amount of share capital varies from organization to organization. Non-members may also use services up to a maximum of 50% of total business volume. Cooperatives strongly encourage non-member users to join up.

HeW Co-op Japan is a national federation of health and welfare cooperatives. The Federation comprises 111 member cooperatives and the Japanese Consumers' Co-operative Union (JCCU). HeW opened its doors in October 2010 after being a JCCU member since 1957 under the name Health Co-operative Association of the Japanese Consumers' Co-operative Union (HCA-JCCU). The cooperatives are found all over the country except on the island of Hokkaido. One of the main activities organized by these health and welfare cooperatives is health promotion in their home communities. They provide local citizens with opportunities for health checks (blood pressure, body fat measurement, health consultation, etc.). These health promotion activities are also made available to the local residents during certain special occasions, like annual festivals or "World No Tobacco Day." Moreover, local health and welfare co-ops also hold health workshops for children in order to raise their health awareness.[24] Finally, since their early days these cooperatives have promoted HAN, a fundamental unit of preventive health practice. HAN groups are cells of 10-20 citizens living in the same vicinity, on the same street, in the same neighbourhood. They agree voluntarily to meet at a local hall or a recreation centre for a few hours once a month on average and take part in an ongoing process of disease prevention. It is estimated that there are more than 25,000 HAN groups in the HeW network. In 2007 and 2010, two Canadian study tours came to Japan. As a result of these visits, the HAN model has been replicated and adapted by a number of health co-ops in Canada. (See the Canada national case, p. 31.)

In response, a HCA-JCCU delegation conducted study tours in Canada in 2004 and 2008, where they were introduced to health cooperatives in Québec and Saskatchewan, respectively.

A "World No Tobacco Day" Event
Photo: HeW Co-op Japan

Health Cooperative Data[25]

Number of cooperatives	111 health and welfare cooperatives (affiliated with HeW Co-op Japan)
Types of cooperative	User only
Number of members	2.84 million
Number of employees	35,131 (affiliated with the HeW Co-op Japan Federation) Doctors: 2,008 Dentists: 221 Nurses:18,966 Chemists: 418 Others: 13,518
Users	3.55 million[26]
Facilities	Medical facilities: 77 hospitals (12,511 beds), 348 primary health care centres, 69 dentist offices, 202 home-visit care stations (all managed by the HeW Co-op Japan Federation) Nursing care facilities: 26 nursing care homes, 181 helper stations, 161 ambulatory rehabilitation offices (all managed by the HeW Co-op Japan Federation)
Services offered	Health and welfare businesses, such as hospitals, primary health care centres, elder care centres, home-visit care centres, rehabilitation centres, outpatient care services, home care services, elder housing, etc. Illness/accident prevention Wellness and health promotion Treatment and cure Rehabilitation
Annual turnover	(HeW Co-op Japan) approx. $30.862 million USD (3,144 million JPY) (all member health and welfare cooperatives) approx. $3.122 billion USD (318 billion JPY)
Revenue sources	(all member health and welfare cooperatives) net sales of medical business (81%), net sales of welfare business (18.5%), other sales (0.5%)

Case Study

Saitama Medical Co-operative[27] is located in Saitama Prefecture, just north of Tokyo. With a population of 2.88 million people, this region is characterized as the most rapidly aging nationwide. It also has the lowest density of physicians. As of March 2013, Saitama had 242,098 members and 2,072 employees. It consisted of 153 branches and 1,340 branch committees. In that year, total share capital reached $61 million USD and the total turnover $189 million USD. It counted a total of 33 business facilities, including 4 hospitals, 8 medical clinics, 2 dental clinics, and 19 home care support offices. Of the 4 hospitals, Saitama Co-operative Hospital was set up in Kawaguchi City (population 580,000) in 1978. Today it has 401 beds and 18 diagnosis and treatment departments. On average it receives 1,044 outpatients per day. Because of the high quality of its medical services, this cooperative hospital enjoys a high ranking: second among 20 emergency hospitals in Kawaguchi City, and the best in the private sector.

Saitama has been a pioneer in the promotion of citizen empowerment and civil participation. Saitama encouraged its members to draw up activity plans, and to design and implement events not only for health promotion, but also network building.

Among its various domains of activity, Saitama has paid particular attention to health promotion and prevention. Co-op members, together with local residents, organize study meetings. Those who attend go on to lead and support other events (e.g., "Kenko Hiroba" activities). They organize physical exercise in local public facilities and parks, such as walking, dancing, practicing yoga, and other fitness activities. All activities are open free of charge to anyone. In total, 134 cooperative branches organize 573 events at 86 venues every month. Besides these regular events, Saitama organizes health promotion activities during special public occasions. For example, on "World Health Day," they provide health checks on blood pressure and body fat measurement in the street. On "World No Tobacco Day," co-op members work together with local doctors and nurses to conduct questionnaires and consultation to raise citizens' understanding of the risks of smoking. These activities all help to enhance the health awareness of both members and local communities.

Moreover, in coordination with local government and other social organizations, Saitama combines health promotion with local community development. For example, it organized a "Child-Raising Festival" as a commissioned Project of Saitama Prefecture City, with support from students of Saitama Prefectural University. Physical training instructors from the university offered local kids health promotion classes at a nursery, which helped raise their interest in working in the health care sector in the future.

As regards network building, Saitama members plan and organize community exchange programmes (e.g., "Anshin Room activities"). Normally they hold tea parties either in members' houses or in public or cooperative facilities. At these parties, members were able to take part in homemade cooking sessions, handicraft workshops, singing performances and games, etc. Like health promotion activities, these events too are open to everyone free of charge or for a nominal fee ($3.00-5.00 USD). So far, members of 65 Saitama branches have organized events at 86 different locations.

Through planning and organizing events by themselves, Saitama members have grown more motivated to participate in civil affairs not just in their co-ops but in their local communities. For example, they have engaged in activities based on the World Health Organization's concept of Age-Friendly Cities. They also lobby local governments with residents' opinions about how to make an area a better place to live. With the success of these activities, Saitama has witnessed a rise in its participant numbers. For Kenko Hiroba and Anshin Room activities, the number of participants has increased from 5,700 to 7,000 per month, and from 900 to 1,400 per month, respectively.

SOCIAL COOPERATIVES

No specific legal framework has been designated for Japan's social cooperatives. Nevertheless, a wide range of cooperatives provide social services under the LTCI system: consumer, health, senior citizen, Koseiren, agricultural, small- and medium-sized enterprise (SME), fishery, and so on. Of these, the first three are incorporated under the Consumer Co-operative Law; agricultural co-ops and Koseiren are regulated under the Agricultural Co-operative Law; and fishery co-ops by the Fishery Co-operative Law. In the absence of a legal framework for worker cooperatives, the latter are often registered under the SME Co-operative Law or the NPO Law.[28]

Together those various kinds of cooperative play a significant role in the provision of social services. As one source indicates,

> "consumer co-operatives started members' mutual help groups to provide domiciliary services in the 1980s and later entered the LTCI business. Agricultural co-operatives offered training for members' wives to become in-home caregivers to provide services [...]. Health co-operatives became largely involved in both in-home and in-facility elderly care services as a natural extension of health services in hospitals and clinics. Care workers have formed worker co-operatives to provide mainly in-home services, while self-help groups are organized to provide work places and residences for the handicapped."[29]

In 2005, there were 881 cooperatives providing home help services, 586 offering in-home care planning, 363 operating visiting nurse stations, 214 providing daycare services, and 218 engaged in leasing equipment for daily use by seniors.[30]

Note that Koseiren and consumer cooperatives were encouraged to enter the welfare business under the LTCI scheme because both had already mobilized a high percentage of rural and urban women to provide services as care workers.[31]In 1999, the Ministry of Health, Welfare and Labor issued an administrative notice to allow consumer cooperatives to do business with non-members in the elder care service sector. When the LTCI law took effect in 2000, 40 out of 160 consumer cooperatives started welfare businesses, already having been involved in home help services, in-home care planning, daycare services, and the like.[32]

Health and welfare cooperatives provide social services not only in-home and in-facility "as a natural extension of health services in hospitals and clinics," but also in the form of mutual help in the community. For example, they organize retired teachers as cooperative members to teach children in the community on a voluntary basis. They also provide transportation and shopping assistance to those living far from supermarkets. Finally, after the 2011Fukushima disaster, HeW Co-op Japan engaged in recovery and reconstruction activities. Besides medical supports, health co-operative members provided recreation opportunities to children who were forbidden to play outside for fear of exposure to radioactive materials.

This study uncovered data for neither health mutual organizations nor pharmacy cooperatives in Japan.

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KENYA

2014

HEALTH SYSTEM

Kenya does not have a compulsory public health insurance scheme. Instead it has a government National Health Insurance Fund (NHIF)[1] that provides comprehensive health care for the general public (both formal and informal sectors). It is compulsory for the employed but voluntary for the rest of the population. However, it is not adequate since it applies only to inpatient services. A proposal to include outpatient services has yet to receive approval.[2]

Proponents of adequate access to health care in Kenya still face a myriad of challenges. According to 2010 statistics, NHIF had 2.8 million principal members (6.6 million, including dependents). The number of members has increased in the last three years because of increased awareness and the latest government quest to create more access to health care. The current, devolved governance system is also playing a key role in pushing this agenda.

Population (in thousands): 43,178

Population median age (years): 18.72

Population under 15 (%): 42.37

Population over 60 (%): 4.25

Total expenditure on health as a % of Gross Domestic Product: 4.7

General government expenditure on health as a % of total government expenditure: 5.9

Private expenditure on health as a % of total expenditure: 61.9

INSURANCE CO-OPS

In Kenya there appear to be no cooperatives intended purely for health. If any do happen to exist, there are no verifiable data. But we can mention the CLUSA,[3] which has been working to enable a cooperative health sector in Kenya. "In 2001, CLUSA, international program of the National Cooperative Business Association, began providing community health mobilization services in rural Kenya. Since its first project began in western Kenya, CLUSA has assisted over 2,000 communities to form village, multi-village, women's and youth-based health associations and to develop and implement community health plans. CLUSA has also trained over 4,000 village-based, community health workers. Altogether, over one million community residents in Kenya have benefited from this program."[4]

In Kenya, primary cooperative societies are engaged in a wide range of activities, all falling into the following seven broad categories (although the list is not exhaustive): agricultural, savings and credit (SACCOs), housing, service, industrial, consumer, and multipurpose.

Based on our research, there is nothing to report in terms of health or social care co-ops. We found only a case relating to health plans. Data is only available for what the **Co-operative Insurance Company of Kenya (CIC)**,[5] an insurance cooperative, does as a company, especially its medical insurance department.

CIC Profile

Basic Facts

- CIC was incorporated in 1978.
- The Company is owned by 1,560 cooperative societies and around 3,900 individuals.
- The Co-operative Bank of Kenya owns a significant stake, providing leverage in bank assurance.
- CIC is the fastest growing insurance company in Kenya. It ranks Number 2 in terms of market share and is the leading cooperative insurer on the continent of Africa.
- The CIC Group has three subsidiaries: CIC Life Assurance, CIC General Insurance, and CIC Asset Management.
- CIC is a market leader in group life business in Kenya and a leading microinsurer in Africa and the developing world.
- CIC is a role model in the cooperative movement of the developing world.
- Under general business, CIC champions health insurance for the Kenyan market – low-, middle-, and high-income segments.

How CIC's Health Insurance Works

- CIC began its health insurance business in 2001.
- CIC Insurance designs and develops health insurance products adapted to the market's needs.
- Health coverage is targeted to the larger market as well as the cooperative sector. CIC products are designed and customized to

meet the specific needs of the low-income and the high-end corporate market segments.
- Distribution occurs through SACCOs, co-ops, MFIs, and direct marketing.
- CIC doesn't run its own health care facilities. The health care value-chain (hospitals, pharmacies, laboratories, outpatient clinics, referral hospitals, etc.) is completed through partnerships with both government and the private sector.
- CIC has a whole department led by a medical doctor and with a competent team of medical underwriters, claims analysts, and staff (nurses, etc.)

CIC Business Turnover & other data

Microhealth only	Dec-2013	Mar-2014
Number of policyholders	3,560	4,699
Total beneficiaries	9,680	12,640
Annual turnover (USD)	$471,695	$471,695
Combined (Microhealth & Corporate)	**2012 - Dec 13**	**Mar 2014**
Number of co-ops covered	141	32
Lives covered	15,105	4,881
Turnover (USD)[6]	$2,006,244	$735,112

OTHER

There are some community health initiatives in Kenya but they cover a limited population, as earlier indicated. Most **community-based health financing/insurance schemes** (CBHFs) in Kenya have been initiated within integrated development activities with donor support.

According to 2010 statistics, there are a total of 38 CBHF schemes. They have about 100,510 principle members who contribute for 470,550 insured beneficiaries. The numbers are still growing. However, these CBHFs are not necessarily cooperatives. They are registered as Self-Help Groups or as Community-Based Organizations.[7]

Perhaps the government could support their transformation into cooperatives. This can be done through the elaboration of an appropriate legal framework, followed by a suitable policy. They can also pool their efforts by uniting as national, regional, and international apexes.[8]

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MALAYSIA

2014

HEALTH SYSTEM

The Malaysian health care system can be divided into two distinctive parts, public and private sector health care. In other words, the Malaysian health care system consists of tax-funded and government-run universal services on the one hand, and a fast-growing private sector on the other.[1] The private sector mainly aims to serve urban regions and better-off patients, while the public sector, due to its mission of social equity, provides primary care services to the disadvantaged poor and the rural population. In the meantime, government servants are privileged to use public hospitals, almost free for all outpatient and inpatient treatments.[2]

With regard to the recent development of Malaysian health care, a most important change occurred in 1970, when the previous three-tier public sector system switched to the current two-tier system. These two tiers now include health clinics (providing outpatient services, dental care, health promotion, family planning) and community clinics (providing home care, family planning).[3] Later on, during the Mahathir years (1981-2003), the privatization of the economy proceeded apace. In 1985, a health privatization policy was launched.[4] In accordance with the economic privatization process (particularly profound under the 7th Malaysia Plan 1996–2000),[5] the private health care sector is today regarded as the "engine" of economic growth. It has been designated as one of the catalysts of the Government Transformation Plan, so as to assist the country in attaining the status of a high-income society.[6]

Population (in thousands): 29,240

Population median age (years): 26.99

Population under 15 (%): 26.65

Population over 60 (%): 8.21

Total expenditure on health as a % of Gross Domestic Product: 4.0

General government expenditure on health as a % of total government expenditure: 6.2

Private expenditure on health as a % of total expenditure: 45.1

There are two main social security funds targeting private sector employees, the Social Security Organization and the Employee Provident Funds.[7] Private health insurance is voluntary with variable premiums charged on the basis of the health status of the insured, the type of health insurance, and the level of coverage. Generally speaking, private hospitals are profit-oriented and financially independent from the government.[8]

Although the Malaysian health care system performs relatively well compared with other developing countries in the Asia-Pacific Region,[9] a series of challenges have generated public and policy concerns. In addition to the aforementioned two-tier system (with public care for the poor and private care for the rich), there is an outflow of professionals from the public to the private sector, poor regulation regarding quality of care, and the absence of private sector engagement in health promotion and prevention activities.[10]

In the meantime, the Malaysian government has attached high importance to the cooperative movement. The cooperative sector has been regarded as the third crucial engine after the public and private sector in driving the nation's economic growth,[11] and as a sector "balancing market based economic activities under capitalism and state sector."[12] The launching of the 2002-2010 National Co-operative Policy, together with the second National Co-operative Policy (2011-2020), are expected to coordinate the development of the Malaysian cooperative movement. Moreover, the Malaysia Co-operative Societies Commission was set up early in 2008 as another government initiative to support the cooperative model.

To tackle those health care challenges within an environment supportive to cooperative development, a cooperative model in health care has been proposed. For example, **KDM Koperasi Doktor Malaysia Berhad** (or the Malaysian Doctors' Co-operative Society Ltd, hereafter KDM)[13] proposed a health cooperative system in the form of an inter-organizational network, with secondary cooperatives comprising diversified members (such as KDM and other medical cooperatives) and primary cooperatives active in health issues, community-based health cooperatives, fiscal intermediaries, etc.[14] The proposed Malaysian cooperative health model should be feasible because on the one hand, provider-consumer collaboration is a concept favoured by the government, and on the other hand, promotion of a healthy lifestyle is consistent with the government's vision, mission, and strategies.[15]

Furthermore, learning from Japan, Malaysia is seeking to enhance health promotion by way of underlining community involvement in self-care and a healthy lifestyle.[16] The Ministry of Health endeavours to engage community groups in promoting population health, such as women's groups, youth groups, social clubs, and cooperative societies.[17] Finally, the need to include women, especially single mothers and youth in diversified cooperative businesses, such as health centres, has been emphasized by Malaysian experts.[18]

HEALTH COOPERATIVES[19]

In Malaysia, currently there is only one cooperative for doctors in the private sector, namely KDM, a health care producer cooperative with about 600 doctors as members. These doctors own their own (single- or multi-doctor) clinics that provide health care to the public and to third-party administrators at a variable cost. KDM's mission and objectives are to uphold the economic and social interests of members, and to implement businesses and services in the medical and health fields.

Moreover, according to KDM, as of March 2014 there is no health cooperative hospital in Malaysia.[20] However, owing to rising health care costs, it is likely that a health care insurance scheme is to be launched, managed by the Malaysian government.

Health Cooperative Data[21]

Number of cooperatives	1
Type of cooperative	Producer (1)
Number of members	600
Number of employees	N/A
Users	N/A
Facilities	N/A
Services offered	N/A
Annual turnover	N/A

SOCIAL COOPERATIVES

According to the Minister of Domestic Trade, Co-operatives and Consumerism, Malaysia is "keen to expand social co-operatives as distinct from co-operatives engaged purely in business activities as a means to maximize socio-economic benefits blending concern for community with economic progress."[22]

The Malaysia Co-operative Societies Commission identified four cooperatives for handicapped persons and two single mothers' cooperatives involving in health care services and consumer activities.[23] Although no detailed information seems to be available, it is very likely that these can be labeled "social cooperatives." They are situated in Perlis, Kuala Terengganu, Penang, Selangor, and Wilayah Persekutuan. Furthermore, seven community-based multipurpose cooperatives have also been recorded, targeting the Orang Asli ethnic minority. These cooperatives carry out activities in agriculture, supplies, bookselling, and consumer activities. They were set up by the members with the purpose of "helping, developing and promoting activities to enhance the well-being of their community."[24]

Social Cooperatives Data

Number of cooperatives	13
Type of cooperative	N/A
Number of members	N/A
Number of users	N/A
Services offered	Services and activities for handicapped persons and single mothers, health care services, community support for an ethnic minority, etc.

PHARMACY COOPERATIVES

Inside KDM there is a Pharmaceutical Division with the purpose of bulk purchasing of medicines and providing member doctors with medicines at the lowest price possible. In this way, in the view of KDM, the cost of providing health care to the public can be reduced.

Based on the information provided by KDM, there are no health mutual organizations in Malaysia.

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MEXICO

2014

Inauguration of Panamédica pharmacy. Photo: Panamédica

Population (in thousands): 121,000

Population median age (years): 26.64

Population under 15 (%): 29.02

Population over 60 (%): 9.18

Total expenditure on health as a % of Gross Domestic Product: 6.2

General government expenditure on health as a % of total government expenditure: 15.8

Private expenditure on health as a % of total expenditure: 48.2

HEALTH SYSTEM

Public health care is guaranteed to all Mexican citizens as per Article 4 of the Constitution. Health care is provided though public social security institutions and the private sector. Public social security institutions include those related to particular professions (public workers, petroleum industry workers, armed forces, etc.) and those providing services to formal sector workers within those institutions. Everyone else receives services through another set of institutions, the majority of which also provide services in their own facilities. Users generally make small co-payments (except for the poorer segments of the population, which receive free health care). The private sector provides services to those with the ability to pay for health care either out-of-pocket or via private health insurance schemes.[1]

In 2012 Mexico achieved universal health coverage by introducing a variety of schemes to reach self-employed, informal workers, and the unemployed and their families. Nevertheless, the health system continues to be challenged by access to health care – including geographic issues, facilities not adapted to demand, etc. It is these shortcomings which cooperatives are addressing.

Cooperatives are regulated by a General Cooperative Law (1994), currently under revision. The law makes specific mention neither to cooperatives providing health care nor to health cooperatives, but tacitly allows them within the defined categories of cooperatives, namely producer and consumer cooperatives. It specifically allows savings and credit cooperatives to provide social services by means of their social protection funds.

Within this framework, cooperatives engage in a wide range of activities, including savings and credit, agriculture, fisheries, forestry, consumer, cement industry, transport, textiles, artisanal production, artist, education, tourism, and medical services.[2] According to the National Statistical Institute (Instituto Nacional de Estadística, Geografía e Informática, INEGI), there were 8,974 active cooperatives in Mexico in 2013.[3] In 2010, cooperatives numbered 4.5 million members and provided direct services to 10 million people.

HEALTH COOPERATIVES

There are few cooperative health experiences in Mexico. However, a number of cooperatives whose primary activities are in other sectors also provide medical services to their members and

facilitate access to health care by entering into strategic alliances with health care providers.

The health cooperatives identified take various forms – consumer, producer, and mixed consumer-producer cooperatives.

The first health cooperative in Mexico was founded in 2007. **Panamédica Cooperativa de Salud** was established by five health professionals, a number of members of a local association, and members of a multipurpose cooperative (savings, credit, and consumer). Its aim was to provide basic health care services to a community which was inadequately serviced by public health facilities. In 2010 it founded a health mutual to provide health care insurance, since consumer and producer cooperatives are barred from engaging in financial services as per cooperative law. (For further information on Panamédica, see "Case Study," below.)

Two consumer health (user) cooperatives have also been identified.

Cooperativa de Salud Tosepan Pajti is a community health care cooperative which was established in 2009. It is a consumer/service cooperative focusing on preventive health care and serving indigenous families in Cuetzalan in the state of Puebla. It provides health care services in six health centres, each staffed by a doctor and health promoter. Health promoters provide information on good health practices, and offer courses and training for making soap and composing traditional medicines. They also promote organic horticultural production, the use of biodigesters, and water capture systems. Tosepan Pajti is a member of the Cooperative Union Tosepán (Unión de Cooperativas Tosepán) which brings together 320 local cooperatives and 110,000 members of Nahuátl y Totonaku origins.[4]

According to INEGI, **Clinica de Especialidades, Sociedad Cooperativa de Consumo Clinica San José SC de RL de CUV,** located in San José Iturbide in Guanajuato, provides specialized medicine hospital services and employs 11-30 persons.

Other cooperatives identified are:

- **Cooperativa Bamboo**, a producer health cooperative made up of health professionals. Located in San Cristobal Ecatepec in the state of México, it provides health care through alternative and traditional medicine. Its holistic care includes rehabilitation, physiotherapy, acupuncture, podiatry, as well as counselling to assist with recuperation.[5]
- **Cooperativa Medica Social** in Salinas, San Luis Potosi is described in the INEGI register as an outpatient health services provider with fewer than five employees. No further information is available.

Health Cooperative Data (2013)

INEGI identifies 10 cooperatives active in health and social care activities, with a breakdown between those providing outpatient medical services, hospital, health and social care residences, and other social care activities. However, the registry is not comprehensive. Therefore, the table below is a compilation of data from the INEGI and other publically available information.

	Panamédica (data for 2013)	Cooperativa de Salud Tosepan Pajt	Cooperativa Bamboo[6]	Others
Number of cooperatives	1	1	1	2
Types of cooperative	Users and Producers	Users	Producers	1 consumer and 1 unknown
Members	12 health professionals/Users	N/A	N/A	N/A
Employees	31 health professionals	6 doctors, 6 health promoters	N/A	<35
Users	2,491, of which 598 are women (2013)[7]		N/A	N/A
Facilities	Clinic, pharmacy, optical store	6 health centres (casas de salud), pharmacy	N/A	1 clinic, 1 medical office
Services	General medicine, dentistry, psychology, optometry, nutrition; orthopaedics, prosthetics, sports medicine, clinical learning and alternative therapies; laboratory services, social pharmacy, health and cooperative education.	Community health care: health promotion, preventive, and curative	Health promotion, curative, rehabilitation	Health promotion, preventive, and curative services
Revenue sources	Payment for services		Payment for services	

Case Study

Panamédica Health Cooperative is located in Colonia Villa Panamericana, home to 25,000 people and one of the largest welfare housing developments near Mexico City. The cooperative was founded in 2007 in response to the lack of access to (distance from) public health facilities, dissatisfaction with the quality of public services, and the high cost of alternative services offered by private health services. It began providing services in 2010. It was formed by five recently-graduated health professionals who not only sought employment opportunities but wanted to provide a human approach to medical care to members of a local association (Vecinos Organizados" del Pedregal de Carrasco) and of a savings, credit, and consumer cooperative (Movimiento y Desarrollo Cooperativo, MOVIDECO).

Panamédica is a producer-user cooperative that delivers quality and accessible health care, preventive health care, and health promotion under the principles of cooperation and solidarity economy.[8]

Initial capital enabled Panamédica to purchase equipment. Agreements were reached with local associations for its clinic.[9] The cooperative originally offered only limited medical and dental consultations. In 2008 the Metropolitan Autonomous University (Universidad Autónoma Metropolitana) accredited Panamédica as a training clinic. This allowed medical interns (doctors and nurses) to join the five doctors then on staff to increase its service offerings. In 2010, it founded a mutual, Panamédica Mutual de Salud, and opened a social pharmacy.

Dental care at Panamédica

Inauguration of Panamédica pharmacy

Panamédica grew to have team of 31 health professionals (10 of whom are members), providing psychological counselling, nutrition, ophthalmology orthopaedics, dental care, sports medicine, and holistic massage therapy. It also runs a clinical laboratory and offers health seminars.[10]

Users of the clinic's services pay for services. However, in order ensure affordability, Panamédica has an innovative alternative to lower fees. Users can choose to pay a full fee or a "solidarity" fee, which is 50% of the full fee, paid in-kind through community service.[11]

In 2012 Panamédica reported that it had an average of 4,000 users per year from Colonia Villa Panamericana and environs (delegación Coyoacán).[12]

Panamédica prides itself in being an autonomous and sustainable cooperative. It receives no support from the government or from political parties.

SAVINGS & CREDIT COOPERATIVES

The savings and credit cooperative sector is active in promoting health by facilitating access to preventive, curative, and rehabilitative health care. Its financial products enable members to access loans and grants to cover health care costs. It also operates a number of health care delivery programmes. A number of savings and credit cooperatives also have agreements with medical service providers and suppliers (pharmacies, laboratories, etc.) which enable members to benefit from discounted prices.

The following are examples of the types of service provided.

Caja Popular Cristóbal Colón was founded in 1971 to provide members with financial services. In April 2011, in response to the growing need of members to access medical services, it established PROSALUD. PROSALUD offers free health care to members and to young persons who have savings accounts but

are not of legal age to become full members of the cooperative. It provides services in the areas of general medicine, dentistry, nutrition, and psychology, and engages in health promotion campaigns and disease prevention. PROSALUD benefits 40,000 members and nearly 20,000 children who hold savings accounts with the cooperative.[13]

Cooperativa de Ahorro y Préstamo Caja Popular Atemajac (Caja Popular Atemajac) established a family medical service unit in 2008 at its office in Zapopan, part of the Guadalajara metropolitan area in the state of Jalisco. The unit, now called UniMedCoop, provides a range of health care services to both members and non-members, with members benefiting from reduced rates. The medical services provided include general medical care and specialist care in homeopathy, psychology, nutrition, paediatrics, gynaecology, cardiology, otolaryngology, angiology, counselling, and individual or family therapy and dentistry. In 2014, the cost of services for members was approximately $3.80 USD (50 MXN) for general consultations and $11.50 USD (150 MXN) for specialist services; for non-members, the price range was $6.10-19.20 USD (80-250 MXN). In addition, members benefit from discounted pricing for laboratory tests and pharmaceuticals through the cooperative's partnership agreements. The cooperative, established in 1959, has 44,000 members and 32 branch offices around the country.[14]

Caja Popular San Nicolas in León, Guanajuato also runs a family medical unit for its 13,000 members and the community in which it operates. The unit provides basic health care, health promotion, and disease prevention. Members have discounts of 50% or more on general medical consultation, gynaecology, orthodontic and dentistry services, paediatrics, nutrition, and psychological care.[15]

Caja Popular Mexicana (CPM) takes a proactive role as an employer in promoting health. It is one of the largest savings and credit cooperatives in the region with 463 branch offices in 22 states, 1.8 million members, and nearly 6,000 employees. CPM runs an interdisciplinary health project, the **Integral Health Project** (Proyecto Integral de Salu), designed to maintain and improve the physical and mental health and social development of their employees, cooperative leaders, and their families. The project includes the following: programmes for health emergencies such as epidemics; health fairs offering free health consultations and diagnostics, and at which nutritionists, dentists, ophthalmologists, laboratories and government institutions provide services and promote health; free counselling for occupational stress; a nutritional programme to help employees adopt a healthy lifestyle (physical activity, proper diet and positive attitude), with 50% of costs covered by the cooperative; a sports programme which organizes a "mini-Olympics" among the branch offices; and a traffic education programme to reduce road accidents. The project also has entered into a strategic alliance with health care providers. Its organizational innovation was recognized by the Mexican government in 2010, when CPM received the national labour prize – Premio Nacional del Trabajo.[16]

OTHER COOPERATIVES

Cooperatives active in other sectors also operate medical centres. For example, **Cruz Azul** was established as a worker cooperative in 1934 by 192 cement workers. Today the Cruz Azul Group brings together 10 cooperative societies, workers, service, and savings and credit cooperatives, and operates a number of subsidiaries in horizontal activities including social enterprises. One of these, Médica Azul S.A., provides medical services (superior to those set out by law) for its members, workers, and their families.[17] It owns and operates two hospitals and one clinic, located in Mexico City, Hidalgo, and Oaxaca. In 2012 Cruz Azul provided medical attention to 2,160 persons in 20 communities.[18] It is the third largest cement company in Mexico, controlling 16% of the market. It secures the livelihoods of more than 8,000 families.[19]

INEGI also identifies cooperatives that operate outpatient medical care services for their members and the communities in which they operate. These include medical offices operated by a butchers' cooperative (Sociedad Cooperativa de Tablajeros SC de RL de CV) in Pijijiapan, Chiapas and by a child care cooperative (Cooperativa Jardin de Niños Valentin Zamora) in Iztacalco, in the Federal District of Mexico. A clinic was also set up by a transport cooperative (Cooperativa Transfluvial in Coatzacoalcos) in Veracruz de Ignacio de la Llave. INEGI reports that all these medical services have five employees or less.

SOCIAL COOPERATIVES

Four social care cooperatives figure in the INEGI registry. These are providing services and/or sheltered employment to persons with physical and mental disabilities or with drug or alcohol dependence. These cooperatives (and one other) are identified as follows:

- Scodich Sociedad Cooperativa de Discapacitados de Chiapas (disabled persons)

- Cooperativa Kinal Anstetik San Cristóbal de las Casas, Chiapas (social services, including sheltered employment)
- Cooperativa la Piña de Vila Purificacion, Villa Purificación , Jalisco (persons with dependence)
- Grupo Patoni, Tlalnepantla de Baz, Estado de Mexico (persons with dependence)
- Cooperativa Neuroticos Anonimos Grupo Redencion, Tláhuac, Distrito Federal (persons with dependence)

Social Cooperative Data (2013)

Number of cooperatives	5
Types of cooperative	N/A
Number of employees	<30 (data for 4 cooperatives)
Services	Services for person with disabilities and drug and alcohol dependencies, counselling, employment

INSURANCE

A cooperative society, Protecciones y Beneficios S.C. (PRYBE), offers a wide range of insurance products to the cooperative sector, including complementary health insurance, Seguro de gastos médicos mayores.[20] In 2011, it provided health insurance to more than 2,000 people.[21]

MUTUALS

A general law regulating insurance mutuals has existed since 1935: Ley General de Instituciones y Sociedades Mutualistas de Seguros (revised in 2014). The law allows mutuals to provide their own health insurance and health services.

In 2010, the Panamédica Health Cooperative began promoting a mutual to provide health insurance. On March 10, 2014 it started enrollment for the "Mutual Panamédica Scheme," which is expected to attract current users of the health facilities and their families who lack access to health care coverage via social security.[22]

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MOROCCO[1]

2014

HEALTH SYSTEM & THE ROLE OF MHOS[2]

Population (in thousands): 32,521

Population median age (years): 26.7

Population under 15 (%): 27.85

Population over 60 (%): 7.61

Total expenditure on health as a % of Gross Domestic Product: 6.3 (2011 data)

General government expenditure on health as a % of total government expenditure: 6.0

Private expenditure on health as a % of total expenditure: 66.5

The Moroccan health system is undergoing profound changes in epidemiological, demographic, and socio-economic terms. Overall health expenditure is low: $59 USD per capita per year and 6.3% in relation to GDP. In the awareness that the cost of medical goods and services are high, the public's use of care remains low. The main source of health financing remains the direct payments from households (52%), against 44% from collective health funding, national and local taxes (28%), and insurance (16%). With 80% of the bed capacity of the country, the Ministry of Health receives only about 31.4% of the national health system's funding. Of the total expenditure of the Ministry of Health in 2001, 49% went to profit hospitals, 37% to the health care network base, and 10% to central and local government. Of all the direct payments from various health insurance plans, public hospitals receive only 6%, whereas the share of private firms (34%) as well as private clinics (32%) is quite large. In addition to the diagnosis and treatment of illness and the rehabilitation of disabilities, promotion of health and prevention are generally carried out by the health care system.

The Ministry of Health adheres to a public health policy which relies heavily on public health programmes. The most important are:

- Programmes of Maternal and Child Health
- Programmes of Collective Sanitary Prevention
- STI- AIDS Programme
- Other programmes (diabetes, tuberculosis, oral hygiene, school and university health, etc.)

Through its budget, the Ministry of Health also provides support to those in need. In principle, all patients presenting themselves as poor, regardless of their place of residence and regardless of the type (i.e., governance) of the hospital that receives them, should receive free medical care upon presentation of a certificate of need issued by the local authority.

International cooperation organizations also fund some of these programmes. The UN has set up a dedicated Multilateral Fund to fight STI-AIDS. NGOs (including associations) are involved in prevention, education, and even funding health programmes for the general population (against AIDS, cancer, etc.) or those targeted to benefit specific populations or regions.

The budgets of other ministries also enable them to engage in health financing to a minor degree (approximately $7,057,328 in 2001 USD).

The health activities of local governments are of the order of 1% of total health expenditure, in the form of in-kind contributions (personnel, assets, logistical support, etc.) to the Ministry of Health and direct financial aid to NGOs. Transition to a system of compulsory basic medical coverage has been gradually realized. Until August 18, 2005, the date on which Law No. 65-00 on basic medical coverage came into effect, Morocco knew no compulsory health insurance scheme.

The country chose to generalize basic medical coverage using existing structures. The first initiative was Basic Mandatory Health Insurance (AMO). It targeted active employees and pensioners of the public and private sectors with two executive agencies (CNOPS and CNSS) and other medical coverage. Together they have increased coverage of employees from 16% to 34%. Basic health insurance for certain employees remains the responsibility of other entities (and mutual insurance companies), at least during the five-year transitional period. From 2006, fraternal benefit societies are responsible for two components:

- The Mutual Health Organization (MHO) component of CNOPS continues to manage the supplementary medical coverage of AMO. In this context, the MHOs are conducting actuarial studies to assess contribution levels which will enable them to balance their books. In addition, they are responsible for the management of certain tasks of CNOPS under AMO.

- The other MHOs continue to manage basic medical coverage in addition to supplementary medical coverage. Some of these MHOs have also commenced actuarial studies to assess feasibility.[3]

Individual contracts or groups offer health insurance coverage, underwritten by individuals or by employers, supplementary to the guaranteed base coverage benefits (compulsory insurance contracts or plans). Coverage and premium levels vary according to the needs of the insured.

CURRENT DEVELOPMENTS

In terms of medical care, the mutual sector is still underdeveloped in Morocco. Its focus is mainly dental care, optical centres, and certain specialized consultations. However, 14% of payments go to the CNOPS mutual sector.[4] Under Article I of statute 1963 Dahir 1-57-187 on the status of mutuality, "friendly societies are non-profit groups, which ... propose to conduct ... a share of providence, solidarity and mutual aid designed to cover the possible risks to the human person". Article 138 of the Royal Decree[5] states that MHOs can "sign agreements with doctors, dentists, pharmacists and even create social works such as dispensaries, maternity and baby clinics for the benefit of their members."

The reform of the Code of Mutuality, currently under discussion,[6] includes a restriction to the scope of MHOs. Chapter II (Social Oeuvres), Article 144, states that MHOs "can create and manage social works for the protection of children, family, elderly, or disabled dependent, with the exception of institutions providing services for diagnosis, care or hospitalization and/or establishments for the supply of medicines, equipment, and medical devices as well as any work of a commercial, profit-making or under an organized and/or governed by specific legislation."

The current range of care across all sectors does not respond satisfactorily to the needs of the population in terms of basic health care. The development and organization of the mutual sector is required to improve the access to care.

CASE STUDY[7]

After a rescue that lasted more than a year (2011-2012), the **Mutuelle Générale du Personnel des Administrations Publiques (MGPAP)**, an MHO for public administration personnel, has undertaken a programme of restructuring and development to improve the services it provides to 1.2 million beneficiaries, including 360,000 members. (It has yet to pay off its deficits.)

The board of directors has decided to raise premiums and benefits in order to align them with those of other mutual funds. Other new services will be decentralized to enable members residing in cities remote to the Rabat-Casablanca axis to avoid long and expensive trips. Currently, most hospitalization centres are concentrated at the administrative capital.

Now MGPAP is posting representatives to remote cities to bring services closer to members. The choice of locations was made on the basis of the results of a member survey as well as information collected from hospital centres.

This extension of MGPAP's network has not required large investments, but has relied primarily on public bodies. It has necessitated an insignificant increase in the contribution rates which now range from $3 to a maximum of $6.078 USD for the mutual sector.

MHO Medical & Social Performance (2013)[8]

Facilities	#	Staff							Beneficiaries
		Doctors		Paramedical					
		Non-Permanent Employees	Permanent Employees	Non-permanent Employees	Permanent Employees				
					Assistants	Professionals	Others	Total	
Dental Hospitals	165	-	148	-	143	246	171	560	395,621
Clinics	3	26	8	55	-	-	-	16	15,760
Polyclinics	1	37	12	33-	-	-	-	31	23,608
Optics	1	-	-	-	-	-	-	11	8,700
Consultations/ Infirmary Care	24	54	16	-	-	-	8	23	83,986
Labs	1	-	2	3	-	-	-	28	28,076
Centre for the Disabled	2	-	1	-	-	-	-	30	123
Centre for Dialysis	1	-	2	-	-	-	-	4	306[9]
Total	198	117	189	91	143	246	179	703	556,180

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[4] More details at Caisse Nationale des Organismes de Prévoyance Sociale. 2014. Website. Retrieved August 18, 2014 (http://www.cnops.org.ma/).
[5] Royal Decree No. 187-7-5-1 issued in November 1996, concerning the Mutual Aid Scheme.
[6] For the text of the project go to Conseil Economique, Social et Environnemental. 2013. "Projet de loi n° 109-12 portant code de la mutualité." Avis du Conseil Economique, Social et Environnemental Saisine no. 6. Rabat Morocco. (http://www.ces.ma/Documents/PDF/Avis-S-6_2013-VF.pdf).
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NEPAL

2014

HEALTH SYSTEM

Nepal is one of the least developed countries in the world, with 80% of Nepalese people living in rural areas. According to the analysis of health outcomes data in Nepal, inequities are increasing between socioeconomic groups and geographical regions. Another noteworthy aspect of health outcomes: out-of-pocket expenditure accounts for 55% of total health expenditures. This high level runs the risk of pushing vulnerable people into poverty. According to the World Health Organization (WHO), to this factor can be attributed a 2.5% point increase in the country's poverty.[1]

In Nepal, besides the public sector, the commercial sector, civil society organizations (particularly after the First People's Movement in 1990), and international donors are all active in health service delivery.[2] Statistics show that in Nepal a major source of health financing is the private sector (60%), followed by government (21%), as well as the donors and charities (19%).[3]

Regarding the public sector, the Nepal National Health Policy (1991) is regarded as the foundation of the current national health policy framework. In accordance with that policy, the government has implemented the Nepal Health Sector Programme (NHSP, 2004-2009) and the second Nepal Health Sector Programme (NHSP-II, 2010-2015) in order to improve health outcomes and to address the overarching goal of universal coverage.

Population (in thousands): 27,474

Population median age (years): 22.02

Population under 15 (%): 35.58

Population over 60 (%): 7.65

Total expenditure on health as a % of Gross Domestic Product: 5.5

General government expenditure on health as a % of total government expenditure: 10.4

Private expenditure on health as a % of total expenditure: 60.5

Apart from a small number of government agencies providing medical benefit packages to their employees, Social Health Insurance exists for government and corporate employees.[4] In fact, the government has been actively fostering the development of health insurance systems. Since 2003, the government has introduced six pilot schemes for community-based health insurance. But so far, the schemes seem to function ineffectively, with limited coverage and access. The Nepalese government has not been able to provide the public with sufficient health care services.

Instead, a major proportion of the country's health facilities is provided by private corporations, including two-thirds of Nepal's approximately 20,000 hospital beds (2006), and three times more health laboratories than the public sector operates.[5] In parallel with government-initiated community-based insurance schemes, commercial insurers are also involved in providing private health insurance, aimed primarily at Nepalese with higher incomes. Finally, international organizations, NGOs, health cooperatives, and self-help groups have taken initiatives in community-based microhealth insurance schemes, aimed particularly at low-income groups.

HEALTH COOPERATIVES

Currently, no national umbrella organization seems to be in charge of health cooperatives or health insurance programmes.[6] Despite this, health cooperative initiatives have been emerging and developing at a rapid pace.

The establishment of health cooperatives first occurred after 2000, when the Public Health Concern Trust (Phect-NEPAL), a not-for-profit NGO, started to promote its community health development programme through health cooperative initiatives:[7]

> "Phect-NEPAL aims to create an environment where people themselves have right, power and ability to maintain and decide for their health. Health cooperative movement was seen a strategy to achieve this since the inception of Phect-NEPAL. Health cooperatives are [...] autonomous organizations owned and managed by the people themselves. Health cooperatives run curative as well as promotional and preventive health activities."[8]

Currently, there are 90 health cooperatives registered in Nepal, of which 60% are basically functioning. These organizations have in total 14,000 members, providing health services in 15 hospitals, 20 clinics, and 22 pharmacies. In addition, seven nursing schools are

operated by health cooperatives. Currently the construction of two medical colleges is under consideration.[9] In addition to the cooperatives initiated by Phect-NEPAL, some other significant organizations are Nepal Health Care Co-operative Ltd. (2006),[10] Jaljala Health Cooperative Limited (2010),[11] and Dhaulagiri Health Co-operative Ltd. (2011).[12] In total, expected investments have reached $20,004,000 USD.[13]

Finally, with regard to revenue sources, very few cooperatives in Nepal receive donations or special government programme supports. Those which operate clinics, hospitals, or pharmacies rely mainly on membership fees, shares, and service charges. For those which run nursing schools or academic institutions, tuition fees are another source of income.[14]

Health Cooperative Data[15]

Number of cooperatives	90 (about 60% of which are functioning)
Type of cooperative	N/A
Number of members	14,000
Number of employees	N/A[16]
Users	N/A
Facilities	15 hospitals (around 900 beds in total), 20 clinics, 22 pharmacy or medicine shops, 7 nursing schools, 2 medical colleges (proposed)
Services offered	Preventive and health promotion activities like awareness campaigns, health education programmes, health camps, screening, etc.
Annual turnover	N/A

Case Studies

Phect-NEPAL is a not-for-profit Nepalese NGO which was founded in 1991 and is partly financed by the Canadian International Development Agency. Phect-NEPAL aims to create a model of sustainable health care based on principles of equity, social justice, participation, and self-reliance. To fulfill its aims, Phect-NEPAL has been active in providing clinical and diagnostic services, community health and academic programmes, as well as research, advocacy, and networking activities.

Over the past two decades or more, Phect-NEPAL has become a leader in promoting the health cooperative movement in Nepal. The establishment of health cooperatives started after 2000, when Phect-NEPAL started to promote its community health development programme through health cooperative initiatives.

At the moment, there appear to be four health cooperatives initiated or supported by Phect-NEPAL: Women's Health Cooperative Tikathali, Setidevi Health Cooperative, Bikalpa Cooperative Kirtipur, and Rajmarga Health Cooperative in Baireni. These four health cooperatives have shown a gradual growth in membership since 2007-2008, when there were 2,350 members. Four years later, their number has increased to 6,000.

In 2013, Phect-NEPAL operated three hospitals, two in central Kathmandu as well as one smaller hospital in a rural part of Nepal.[17] Phect-NEPAL offers the four health cooperatives access to the medical services which these three hospitals provide. Except for primary care, provided at the cooperatives' own clinics or a recognized local clinic, secondary and tertiary health care are offered via Phect-NEPAL's community health development programme with services available at a 50%[18] or 70%[19] discount (including doctors' consultation, bed charges, diagnostic investigation, medical and surgical procedures, and maternity care, but not medicinal costs).[20]

One pioneering Phect-NEPAL initiative, **Women's Health Cooperative**, is located in Tikathali village near Kathmandu and the Himalayas. Having begun with 25 women, it now has more than 300 members and is a model initiative in Nepal. Membership is given to the family as a unit. The local women value its easy access to affordable health care services. In the words of one member, "If I went to the government clinic, I would have to wait five, maybe six hours. [...] Here, I can ask the doctor how I should take the medicine. At a government clinic, you don't have time to do that."[21] Also, according to Dr. Shresth, Chairman of the Cooperative, "Sometimes, the government doctors will just look at the patient and write a prescription without even talking to the patient."[22]

The cooperative pays close attention to health promotion and prevention. Entrenchment in the community facilitates this by enabling villagers to engage in prolonged conversations on long-standing health issues, to address the problem rampant alcoholism, for example, or local social taboos, such as "a woman who is pregnant should not take vegetables."[23] The cooperative also has a training programme for teachers and students on the prevention of diarrhoea.

Finally, this cooperative operates in a creative way with regard to the acquisition of cooperative capital. It runs a secondary school programme involving two annual check-ups and free medications to roughly 600 secondary school students. In return, the cooperative receives 15 cents per month from each student.[24] In this way, the cooperative taps a new revenue source to guarantee its sustainability.

Although these health cooperative programmes are still operating on a relatively small scale, Phect-NEPAL sees them as

exemplars as to how the coverage of health care services could be extended more widely in Nepal.[25]

The **Nepal Health Care Co-operative Ltd.** (NEHCO)[26] was founded in March 2006. Beginning with 28 share members, the cooperative currently has over 2,100 members and 270 employees. The founding members – five doctors and five nurses, plus medical professionals, businessmen, and social workers – provide health services to marginalized groups and run health science education programmes in order to help lift the standard of medical training in the country.[27]

One of NEHCO's first actions was therefore to establish the 100-bed Manmohan[28] Memorial Community Hospital in Thamel, Kathmandu. It opened in 2006 with about 400 founder-shareholders. The construction of a 900-bed teaching hospital is currently underway in Swoyambhu, Kathmandu. In the same way, the cooperative also set up Manmohan Memorial Health Foundation and Manmohan Memorial Savings and Credit Co-operative Ltd. in 2006 and 2008, respectively.

Significantly, NEHCO is now the country's largest cooperative health service and trainer of health professionals. Soon after its registration, the cooperative founded the Manmohan Memorial Institute of Health Sciences to conduct academic health programmes in nursing, pharmacy, public health, and medical laboratory technology. In 2012, the Manmohan Memorial Medical College, the first cooperative medical college in the country, was established. It is affiliated under Tribhuvan University with other doctor training programmes. In the near future NEHCO is planning to found Manmohan Adhikari Co-operative University, the country's first cooperative university.

NEHCO members enjoy a number of benefits, including a 20% discount for services in the cooperative hospital, and 30% discount on the cost of complete annual health check-ups (for members and their family members). Members' children who are students at Manmohan Memorial Institute of Health Sciences or Manmohan Memorial Institute of Medical Sciences receive a 10% discount on monthly fees or admission fees. A scholarship policy also has been set up for members' children. Furthermore, members enjoy a travelling allowance on the occasion of observation tours organized by NEHCO. Finally, in case of serious illness, a minimum of $332 USD (20,000 NRS) or 15% of a member's total share amount will be provided by a Share Member Relief Fund. In case of accidental death, $1,660 USD (100,000 NRS) will be issued via NEHCO's insurance scheme.[29]

HEALTH MUTUAL ORGANIZATIONS

No data are currently available regarding health mutual organizations in Nepal. According to previous studies, health insurance in Nepal does not seem to be adequate.[30]

A survey undertaken by the International Labour Organization shows that in Nepal, community-based health insurance schemes have three models, namely, the community-based health post model, the health cooperative model (e.g., Phect-NEPAL), and the social health insurance model.[31] The three are similar in that they all operate on a non-profit basis and are implemented through community-based groups, NGOs, cooperatives, or business associations. That said, the service delivery approaches and service coverage differ. In the first two models, primary health care is provided in the community for small user fees. The microinsurance schemes cover only referral cases at discounted prices. In the third model, however, a wide range of treatment services is provided by covering all major as well as minor illnesses for the insured members at a designated hospital.[32]

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[3] Ministry of Health and Population. 2012. "Nepal National Health Accounts, 2006/07-2008/09." Kathmandu: Health Economics and Financing Unit, Ministry of Health and Population, Government of Nepal; and Ghimire, R. 2013. "Community Based Health Insurance Practices in Nepal." (http://www.academia.edu/5587577/Community_Based_Health_Insurance_Practices_in_Nepal.)
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[5] WHO 2013:19.
[6] For example, concerning community-based health insurance schemes in Nepal, Ghimire (2013:14) suggests a lack of "the umbrella of single organized and systematic institution" and thus of "a strong support structure at a higher level" as one main reason for their not-so-promising future. Prior to 2011, the Nepal Health Central Cooperative Union and Nepal Central Herbal Cooperative Union were established. However, it is not clear whether they function as umbrella organizations for health-related organizations. See National Cooperative Federation of Nepal. 2014. "Historical Events: Important Events of the Cooperative Movement in Nepal." Webpage. (http://www.ncfnepal.com.np/historicalevents.html).
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[10] Nepal Health Care Co-operative (NEHCO). 2014. Website. (http://www.nehco.org.np/).
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[12] Dhaulagiri Health Co-operative Ltd. Nepal (DHC). 2014. Website. (http://dhcnepal.org.np/).
[13] The investments range from $1,500 USD to (in the case of one co-op) $10,000,000 USD. Data provided by Dr. Basant Maharjan from Phect-NEPAL.
[14] Information provided by Dr. Basant Maharjan from Phect-NEPAL.
[15] As of June 2014.
[16] No specific data available. However, most of these health cooperatives have 2-5 employees, and those which run hospitals or academic institutions have far more. Normally, there is at minimum one administrative staff in each organization. As regards technical staff, the number can range from none to many. Information provided by Dr. Basant Maharjan from Phect-NEPAL.
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[19] For those paying an annual premium of $5.00 USD (290 NRS) per member.
[20] ICMF Microinsurance 2013.
[21] Glauser, W. 2010. "Cooperative clinics revolutionizing primary care in Nepal." *CMAJ*, July 19. (http://www.cmaj.ca/content/182/12/E553.full).
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[23] Glauser 2010.
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[26] Ranicki, Carla. 2014. "448. Hospitals and Health Training for Nepal." Stories.coop. (http://stories.coop/stories/hospitals-and-health-training-for-nepal/).
[27] NEHCO. 2014. "Introduction." Webpage. http://www.nehco.org.np/index.php.
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[32] ILO 2002:7-8.

NETHERLANDS[1]

2014

SOCIAL CARE COOPERATIVES

There are no health co-ops in Holland. Two social care co-ops have been identified. The health care insurance sector is cooperatively organized to a significant degree: four health mutual organizations were identified.

Zorgcoöperatie Noord U.A. is a cooperative for small-scale providers in Friesland. It targets "people with disabilities and/or in need for care" and reaches about 1,200 people.[2] It offers a number of services: "outpatient care, housing counseling, guidance and sheltered housing, day care, respite, training, and treatment."[3] **Thuiszorg Dichtbij** is a cooperative of independent working nurses and careers. It specializes in palliative care and provides 24-hour domiciliary care.

Social Care Cooperatives Data

Number of cooperatives	2
Types of cooperative	2 Producer-based
Number of members	N/A
Number of employees	N/A
Users	N/A
Facilities	N/A
Services offered	Illness prevention Wellness and health promotion Treatment and cure Rehabilitation
Annual turnover	N/A

Population (in thousands): 16,714

Population median age (years): 41.47

Population under 15 (%): 17.21

Population over 60 (%): 23.02

Total expenditure on health as a % of Gross Domestic Product: 12.4

General government expenditure on health as a % of total government expenditure: 19.7

Private expenditure on health as a % of total expenditure: 13.4

PHARMACY COOPERATIVES

According to a 2009 survey of European cooperatives active in the pharmacy sector, there are two small purchasing cooperatives in the Netherlands.[4]

HEALTH MUTUAL ORGANIZATIONS

Under the Health Insurance Act (Zorgverzekeringswet), all residents of the Netherlands have to take out health care insurance. It covers standard medical expenses such as general practitioner consultations, hospital care, or pharmaceutical expenses. Each year the government determines which services the national health care scheme will cover.

Even the insurance companies have a responsibility: the so-called "open enrollment." They have to accept anyone who applies for national health care insurance, regardless of their age or state of health.

Supplementary insurance can be taken out for expenses that are not included in the national package ("basic insurance"), such as physiotherapy or dental care. Indemnities and premiums vary per insurer. Requirements can be imposed by the insurer and a person can be refused access for these insurance packages. The government does not interfere in these matters.[5]

Four major health mutual organizations were identified: Menzis, Achmea, CZ, and Coöperatie VGZ. Achmea is a leading insurance company based in the Netherlands and provides health and other types of insurance to about half of all Dutch households.[6] CZ offers general health insurance policies as well as dental and alternative care reimbursement. Menzis and Coöperatie VGZ operate on a smaller scale.

Health Mutual Organizations Data

Number of cooperatives	4
Types of insurance	Supplementary and complementary
Users	Over 12,200,000
Facilities	N/A
Annual turnover	Over $40.8 billion USD

OTHER

Two user-based cooperatives provide insurance adapted to their members' needs. Boer & Zorg is a farmer cooperative and provides health benefits to its farmer members.[9] The membership of Coöperatie Zorg & Co comprises self-employed workers. It provides them with health benefits and administrative services.

Social Care Cooperatives

Name of cooperative	Type			Members	Employees					Types of service				Annual turnover
	User	Provider	Multistakeholder		NB	Doctors	Nurses	Other health prof	Others	Illness & accident prevention	Wellness & health promotion	Treatment and cure	Rehabilitation	
Zorgcoöperatie Noord U.A.[7]		X		N/A	N/A						X	X	X	N/A
Thuiszorg Dichtbij[8]		X		N/A	N/A		X	X		X	X	X	X	N/A

Health Mutual Organizations

Name of cooperative	Type				# people reached	Basic information including examples of service costs	# employees	Infra-structure	Turnover
	Substitutive	Supplementary	Complementary	Duplicative					
Menzis		X	X		N/A	Menzis offers health insurance and is based in the Netherlands.	N/A	N/A	N/A
Achmea[10]			X		About 8,000,000	Achmea operates in the Netherlands and eight other countries through a portfolio of companies. Vereniging Achmea (Achmea Society) is its customer society, founded following the merger of a number of mutual insurance companies and health insurance funds. Vereniging Achmea holds 65% of ordinary shares and monitors Achmea. Each customer is automatically a society member.	17,000	N/A	Over $40.8b USD
CZ[11]		X	X		N/A	CZ offers three insurance policies for general health care: general practitioner, hospital, and pharmacy (from $94.80 USD/month); six packages cover reimbursements excluded from the general policy, such as physiotherapy, glasses, and alternative therapies (from $9.29 USD/month); and two dental packages (from $23.15/month).	N/A	N/A	N/A
Coöperatie VGZ[12]			X		4,200,000	Coöperatie VGZ is a non-profit health insurer, which plays an active role in the organization of care in the Netherlands. It is active in five locations in the country.	N/A	N/A	N/A

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NEW ZEALAND[1]

2014

HEALTH SYSTEM

New Zealand's health care system is a mix of public and private (for-profit and not-for-profit) ownership across a wide range of health services.[2] New Zealand has a largely tax-funded health system, with 78% of total health expenditure financed by public sources.[3] Out-of-pocket payments (16%) and private health insurance (6%) finance the remaining expenditure. Most hospital services in New Zealand are delivered in State-owned hospitals, fully tax-funded for all citizens. During the past two decades, government health spending has been gradually rising in real per capita terms, from 15.5% of government expenditure in 1993 to 17.3% in 2012. Public health expenditure has also been growing as a proportion of GDP, from 5.1% of GDP in 1993 to 10.3% in 2012.[4]

Primary health care services are provided by self-employed private practitioners, usually in group practices and only 60% funded by government.[5] Most community-based services and long-term residential care services are also delivered by private organizations, usually on a not-for-profit basis.

Earlier observations have indicated significant and enduring health disparities in terms of both ethnicity and deprivation.[6] For example, Sheridan et al. (2011) have pointed out the widening health gap between Māori and Pacific population[7] with lower socioeconomic status than other New Zealanders. The Māori and Pacific populations have been experiencing much higher levels of chronic disease. Life expectancy among Māori New Zealanders is about nine years less than other New Zealanders.[8] With respect to access to primary health care, significant financial, cultural, and geographical barriers still exist in some parts of the country.[9]

Population (in thousands): 4,460

Population median age (years): 36.85

Population under 15 (%): 20.26

Population over 60 (%): 19.01

Total expenditure on health as a % of Gross Domestic Product: 10.3

General government expenditure on health as a % of total government expenditure: 20.3

Private expenditure on health as a % of total expenditure: 17.3

Facing with the problem of a significant health gap, the health care system has experienced more than three decades of radical restructuring.[10] Since 2000 a greater emphasis has been placed on equal access to primary health care.[11] Aimed at reducing health access barriers, the country's current Primary Health Care Strategy is characterized by "the groupings of the primary care providers (including general practitioners, primary care nurses and other health professionals such as Māori health providers and health promotion workers) into networks called Primary Health Organizations."[12] According to the strategy put forward by the new Labour-led coalition government in 2001, primary health organizations need to be "community owned and governed, not-for-profit, and include other primary care professionals and lay members on their governance boards."[13]

In the meantime, 21 District Health Boards were established, governed by locally-elected representatives and funded on a population basis.[14] These Boards integrate hospitals into their funding bodies, and "plan, manage, provide and fund services for the populations of their districts" (including "funding for primary care, public health services, aged care services and services provided by other non-governmental health providers, such as Māori and Pacific providers").[15] The 21 District Health Boards fund the provision of primary health care through 84 Primary Health Organizations of various shapes and sizes. As a result of this reform, the fee paid by patients for a visit from a general practitioner has been reduced to $21 USD (25 NZD). Even this sum still may make the access to primary care "unaffordable for those with fewer financial resources."[16]

Finally, community pharmacies are regarded in New Zealand as "an integral part of primary health care", although they serve as "an underachiever in terms of the expectations of current policy."[17]

HEALTH COOPERATIVES[18]

In New Zealand, two health cooperatives were identified. **City Medical** Ltd. (1986; often referred to as the Napier Health Centre) is owned and operated by more than 40 local doctors from the Napier/Taradale area. These members are a mix of staff doctors headed by a medical director, locums, and rostered doctors from the local community. Supported by more than 70% of all general

practitioners in the area, the cooperative provides both urgent medical care and other kinds of care service, including pre-employment health checks, staff health checks, immunizations, day surgery, and personal advice. City Medical operates with the support of the Hawke's Bay District Health Board and Accident Compensation Commission. With its 13 practices in total, the cooperative has about 35,000 patients each year.[19]

Anglesea Clinic Accident and Medical Ltd. (1987) is located in the greater Waikato region, in the heart of Hamilton. Its medical centre has four combined areas: Anglesea Clinic, Symmans House, John Sullivan House, and the Knox Street Clinic. Based on its website, the clinic provides "an extensive range of private specialist services in conjunction with compatible professional activities."[20]

Health Cooperative Data[21]

Number of cooperatives	2
Types of cooperative	Producer (2)
Number of members	N/A
Number of employees	N/A
Users	N/A
Facilities	>13 practices
Services offered	Primary care, emergency care, private specialist services, health checks, immunization, day surgery, personal advice Illness/accident prevention: Yes Wellness and health promotion: Yes Treatment and cure: Yes Rehabilitation: No
Annual turnover	N/A

HEALTH MUTUAL ORGANIZATIONS

In terms of organizational structures, New Zealand's private health insurers range from mutuals, friendly societies, and not-for-profits through to for-profit companies.[22] According to the Health Funds Association of New Zealand,[23] by March 2013 1.34 million New Zealanders had health insurance, approximately 30% of the national population. This percentage was a decline of around 4% (55,000 people) from a peak in December 2008.[24]

Eleven health insurers are members of the Health Funds Association.[25] Six of them are private, not-for-profit organizations, namely, Accuro Health Insurance, EBS Health Care, Manchester Unity Friendly Society, Police Health Plan Ltd, Southern Cross Healthcare, and Union Medical Benefits Society Ltd (Unimed). Most of them are open to the general public, except for EBS Health Care (open to members or employees of the education union), and Police Health Plan Ltd (open to current and former sworn and non-sworn employees of the New Zealand Police, and their families). Among them, it is estimated that Southern Cross alone has 75% of market share.[26] The Medical Protection Society and the Medical Assurance Society are two other health mutuals which do not belong to the Health Funds Association of New Zealand. In total, eight health mutual organizations are registered in New Zealand.

Reportedly, the environment for the development of health insurance has grown less favourable in the country. So far, there has been "little recognition from officials" of the value of health insurance, and "recent engagement with officials looking at policy options whereby health insurance might play a greater role in helping fund future healthcare costs has been disappointing." Until recently there had been an increasing acceptance "that health insurance is an option in its own right for helping address the unsustainability of public health spending."[27]

PHARMACY COOPERATIVES

Four pharmacy cooperatives were identified in this study. Compared with health cooperatives, the development of pharmacy cooperatives in New Zealand is advanced and has a much longer history.

The earliest pharmacy cooperative in the country, CDC Pharmaceuticals, was established in 1927 in Christchurch. After several expansions, this producer cooperative has become a wholesaler providing to its members (pharmacy business owners) various medical goods, including pharmaceuticals, over-the-counter medicine (OTC), and veterinary products.[28]

In 1978, two other producer-owned pharmaceutical wholesaler cooperatives came into being, Pharmacy Wholesalers (Central) Ltd.[29] and Pharmacy Wholesalers (Bay of Plenty) Ltd.[30] These two wholesale suppliers offer a comprehensive range of pharmaceutical and related products, such as OTCs, and retail lines. They service pharmacies and hospitals throughout the central regions of the North Island (Pharmacy Wholesalers Central) and Taupo north of New Zealand (Pharmacy Wholesalers Bay of Plenty). In total they have four full-line warehouses, situated in New Plymouth, Napier, Wanganui (Central), and Tauranga (Bay of Plenty).

Another, more recent pharmacy cooperative, Health 2000, was founded in 1993. This cooperative group is active in the natural health retail sector and has been formed by members "who had a passion and belief in natural health."[31] Indeed, many of them are naturopaths, homoeopaths, herbal specialists, or sports therapists who own their stores independently. These 82 stores are spread over 15 regions out of 16 in the country.[32]

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NICARAGUA

2014

HEALTH SYSTEM

Nicaragua began privatizing the health care system in the late 1990s and continued into 2000. Notwithstanding, health services are mainly provided by the public sector and financed by general taxes. The primary health provider is the Ministry of Health (MINSA), which officially covers about 70% of the population. The Nicaraguan Social Security Institute (INSS), which covers formal sector workers, finances the health care of about 10% of the population. Only a small percentage of the population receives private (for-profit or non-profit) health care services.[1]

The General Law of Cooperatives (Ley 499) adopted in 2004 specifically provides for cooperatives to be active in a number of sectors, including agriculture, consumer, housing, savings and credit, fisheries, utilities, and youth. However, it is not restrictive and allows for cooperatives to form in other sectors to provide services as defined by their members.

Nicaragua is estimated to have 4,500 cooperatives with 300,000 members.[2] Some are involved in health promotion and care, but are categorized by their primary area of activity, i.e., savings and credit, housing, and agriculture. However, like other countries in the region, many cooperatives provide multiple services and health care is often among them.

Mutuals are also providers of health care. To provide health insurance to their members, cooperatives have also become members of a health mutual. Cooperative organizations, including FENACOOP and the National Union of Agricultural and Livestock Producers of Nicaragua (Unión Nacional de Agricultores y Ganaderos de Nicaragua, UNAG), are members of a mutual which provides complementary health care and covers health services. (See "Mutuals," below.)

Population (in thousands): 5,992

Population median age (years): 22.74

Population under 15 (%): 33.37

Population over 60 (%): 6.59

Total expenditure on health as a % of Gross Domestic Product: 8.2

General government expenditure on health as a % of total government expenditure: 19.7

Private expenditure on health as a % of total expenditure: 45.7

HEALTH COOPERATIVES

Only two cooperatives were identified whose primary activities focus on health care.

Cooperative Salud para todos was founded in 2010 in Estelí. It is a user-owned health cooperative which provides general medical care, runs an infirmary and specific clinics for gynaecological, dental, and psychological care, as well as offering preventive care seminars. Its focus is on children and women's health. (See "Case Study," below.)

Cooperativa "Tininiska" Centro de Salud Holística is a user-owned cooperative providing holistic health care. It was founded in 2009 in Managua by a group of people seeking to improve their physical, emotional, mental, and spiritual health. It runs a medical, psychological, and naturopathic clinic, offering psychotherapy, acupuncture, and chiropractic treatments, and alternative therapies. Tininiska offers yoga courses and is involved in health promotion with seminars and workshops. It also operates a natural products shop offering medicinal and beauty products, as well as organic foods.[3]

Health Cooperative Data

Number of cooperatives	2
Types of cooperative	Users
Users	16,800 (for Cooperativa Salud para todos only)
Services	General medical care, gynaecological, dental, and psychological care, alternative medicine, physiotherapy, health promotion
Source of revenues	Payment for services, member equity

Case Study

In 2010 **Cooperativa Salud para todos** was founded with the assistance of a non-governmental organization, Familias Unidas. The NGO opened a health clinic in 2000 to provide health care and dispense medicine. It worked with beneficiaries to set up a user-

owned health cooperative which now provides general medical care, runs an infirmary and specific clinics for gynaecological, dental, and psychological care, as well as offering preventive care seminars. In 2012 more than 16,800 patients were treated, 5,075 prescriptions filled, 120 seminars on preventive care were held for 2,003 patients, and 13,248 laboratory exams were carried out.[4]

SAVINGS & CREDIT COOPERATIVES

Savings and credit cooperatives facilitate access to health care by serving their members both as financial and as health services cooperatives. The purpose may be to offer better service or to make health services more readily accessible. For example:

- **Cooperativa de Ahorro y Servicios Médicos en Nicaragua, COMENICSA, R.L.**, was established by health professionals and is both a savings and credit cooperative and a medical service cooperative. It was founded in 2011 by 20 health professionals.[5]
- In 2013, the largest savings and credit cooperative in the country, **Cooperativa de Ahorro y Crédito, Caja Rural Nacional (CARUNA, R.L.)** partnered with COMENICSA to provide health service to CARUNA employees. CARUNA will provide free vouchers for both pre-employment and annual check-ups for its staff. CARUNA and its federation, FEDECARUNA, also signed an agreement with the largest insurance company in Nicaragua to offer member and users a wide range of life and non-life insurance products, including medical insurance.[6] The insurance is offered through branch offices, in order to benefit members with more accessible insurance products. FEDECARUNA has more 31,000 members and 33 cooperatives and operates 37 branches around the country. While initially it served only rural communities, it now serves both rural and urban areas. It provided loans to more than 100,000 people in 2012.[7]

OTHER COOPERATIVES

Cooperatives in other sectors also provide and facilitate access to health care. One is the women's cooperative **Cooperativa María Luis Ortiz**, which runs a rural clinic providing basic medical care as well as a pharmacy. It has treated more than 36,000 patients, but also has many other activities. It undertakes housing and latrine construction, operates a seed bank, runs a literacy programme, and trains health workers.[8]

Ad hoc health care services are also provided by agricultural or rural cooperatives. For example, the National Federation of Agricultural and Agro industrial Producers (Federación Nacional de Cooperativas Agropecuarias y Agroindustriales R.L., FENACOOP) provided health care services to 703 beneficiaries in 2001.[9] Rural-based cooperatives organize periodic delivery of women's health services, including gynaecological exams and cervical cancer screening. This is the case with the Union de Cooperativas Agropecuarias Augusto Cesar Sandino, also known as the Unión de Cooperativas Agropecuarias San Ramón (Union of Agricultural Cooperatives), where more than 1,085 women have undergone exams.[10] Other rural cooperatives have entered into agreements with local clinics to enable member families with limited financial resources to access medical care. For example, the 630-member agricultural marketing cooperative Unión de Cooperativas Tierra Nueva has partnered with the UNICA school of dentistry. With the support of local associations, UNICA established a dental clinic within the cooperative to serve members and the community.[11]

SOCIAL COOPERATIVES

The government authority regulating cooperatives does not provide information on social care cooperatives. However, indications are that these exist at the local level. One cooperative established as a worker cooperative for persons with disabilities was identified, promoted by the Nicaraguan Association of Physically Disabled Persons (Asociación de Discapacitados Físico Motores de Nicaragua, Adifin) in Ciudad Sandino. Founded in 1993, this cooperative creates employment opportunities by providing carpentry services. Its members report that they are able to earn only a very small income, but the cooperative responds to their need to feel useful to society. The cooperative receives some support from Adifin and has received donations in the past, but is otherwise self-sustaining.[12]

PHARMACY COOPERATIVES

There are no cooperative pharmacies, although some cooperatives are authorized to sell pharmaceuticals. In 2010, the Association of Nicaraguan Pharmacies (AFUN) sought the approval of the Ministry of Health to create a cooperative pharmacy (Cooperative of Independent Pharmacies) in order to import pharmaceuticals. The Ministry never considered the proposal, however.[13]

MUTUALS

Mutuals are receiving increased attention in Nicaragua as a means to address gaps in the public health care system. Mutuals facilitate and provide medical services and access to pharmaceuticals at affordable prices. They also are involved in health education and promotion.

With the support of the European Union and a Belgian NGO, 11 community-based mutuals were formed through the project *Promoting the Creation of a Legal Framework for Mutual Initiatives in Nicaragua*. It concluded in 2011.[14] The initiative was supported by existing mutual organizations.

1. A rural-based mutual association, **Asociacion Civil Mutua del Campo**. The first mutual, Mutua del Campo was established in 1995 by 444 coffee producers to address the reduction of public health services. It currently includes members of the agricultural workers association and trade union, Asociación de Trabajadores del Campo (ATC) as well as agricultural cooperative federation, Federación Nacional de Cooperativas (FENACOOP), the Unión Nacional de Agricultores y Ganaderos (UNAG) as well as a rural foundation, Fundación para el Desarrollo Socio-Económico Rural (FUNDESER). In 2008 it reported more than 7,000 members and operated in several districts.[15]
2. An urban-based mutual association, **Asociacion Mutua Urbana de Salud**, founded in 1977, includes members of the Confederation of Self-Employed Workers (Trabajadores por Cuenta Propia, CTCP) and the National Workers Front (Frente Nacional de los Trabajadores, FNT).
3. A national mutual organization, **Asociación de Nicaragua Mutualista** (AMUN), was recently founded, bringing together cooperatives, trade unions, foundations, and others.

At the end of 2010, 5,200 families or an estimated 31,250 people were covered by mutuals.[16] The European Union project reported in 2011 that the 11 mutuals created during the project had 4,565 members and 6,009 beneficiaries. The project had also established a training centre. Another important result of the project was the adoption of the Framework Law on Mutuals in October 2009. This is the first law on mutuals in the Central American region.

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PANAMA

2014

HEALTH SYSTEM

Panama has had a policy of "Health for All" since 1969 and is striving to provide universal health care. Those who have no social protection the Ministry of Health (Ministerio de Salud, MINSA) covers through its public health facilities (MINSA clinics and hospitals), funded through general taxes. The Social Security Institute (Caja de Seguro Social, CSS) covers formal workers and is financed through employer and employee contributions. The private sector provides health care services to those who are capable of paying for these services either out-of-pocket or through private health insurance. According to the World Health Organization, in 2011 public health services accounted for 67% of total health care costs, 27% were out-of-pocket expenses, and 6% were covered through private health insurance.[1] Cooperatives are part of the private health care system.

Population (in thousands): 3,802

Population median age (years): 27.64

Population under 15 (%): 28.65

Population over 60 (%): 10.13

Total expenditure on health as a % of Gross Domestic Product: 7.6

General government expenditure on health as a % of total government expenditure: 12.7

Private expenditure on health as a % of total expenditure: 31.4

The Autonomous Cooperative Institute of Panama (Instituto Panameño Autónomo Cooperativo, IPACOOP) reports that the cooperative movement in Panama has seen growth over the last five years. Over 100 new cooperatives have been established, mainly in the multipurpose and savings and credit sectors. In the third trimester of 2013 there were 593 registered cooperatives with a total membership of 206,228 (approximately 6% of the population). That total is equally divided between men and women. The largest number of cooperatives are classified as multipurpose (208), followed by savings and credit cooperatives (169). Official statistics also exist for the following classifications: youth/school (111), transport (34), production (20), worker (10), fisheries (10), consumer (8), housing (6), service (5), production and marketing (4), marketing (4), tourism (3), and health (1).[2] A number of social cooperatives have been identified, although official statistics do not recognize this area of activity.

One cooperative has for its main objective the provision of health care. However, health professionals have also established multipurpose or savings and credit cooperatives. In addition, savings and credit cooperatives generally offer a number of products related to health care, including hospitalization insurance, insurance to help cover cancer treatments, and specific loans.

HEALTH COOPERATIVES

Health cooperatives are defined as entities providing full health care to their members, beneficiaries, and third parties.[3] In 2013, the Institute for the Promotion of Cooperatives (Instituto Nacional de Fomento Cooperativo, INFOCOOP) identified one health cooperative, Cooperativa de Servicios y Atención en Salud (COOPASI).[4] COOPASI was established in 1970 as a user cooperative. In the 1990s it was reported to have approximately 300 members. By 2013, however, membership was down to 37 members.[5]

Health Cooperative Data (2013)[6]

Number of cooperatives	1
Types of cooperative	Producer
Number of members	37 (12 men, 25 women)

SOCIAL COOPERATIVES

A number of cooperatives of and for persons with disabilities were identified in Panama. They take the forms of multipurpose, worker, and consumer cooperatives. No further information was available on the activities undertaken by these cooperatives.

IPACOOP's 2011 Annual Report makes reference to an agreement with the National Secretariat for Disabilities (Secretaría Nacional de Discapacidad, SENADIS) to create a fund to assist in the development of cooperatives of or for persons with disabilities (Fondo de Desarrollo para Personas con Discapacidad y Sus Familias, FONDECOOPEDIS). The beneficiaries of the fund are both

persons with disabilities and their families and friends. Nine cooperatives received support in 2011:[7]

- Cooperativa de Servicios Múltiples San Judas Tadeo, R.L.
- Cooperativa de Servicios Múltiples Manos Diligentes R.L. (24 members[8])
- Cooperativa de Servicios Múltiples Unidos por la Diversidad, R.L.
- Cooperativa de Trabajo Sordos Santa Librada, R.L.
- Cooperativa de Servicios Multiples Padres, Personas con Discapacidad y Amigos de Personas con Discapacidad de Chiriquí, R.L.
- Cooperativa de Consumo de Padres, Amigos y Discapacitados del Distrito de Barú, R.L.
- Cooperativa de Consumo Pedro Pablo Ortega del Discapacitado, R.L.
- Cooperativa de Servicios Múltiples de Personas con Discapacidad Familiares y Amigos de Herrera, R.L.
- Cooperativa de Servicios de Personas con Discapacidad Familiares y Amigos de Bocas Del Toro, R.L.

Social Cooperative Data (2013)

Number of cooperatives	9
Types of cooperative	User, Producer
Number of members	20 (for Cooperativa de Servicios Múltiples Manos Diligentes R.L.[9])

SAVINGS & CREDIT COOPERATIVES

Savings and credit cooperatives offer loans to defray health expenses, and offer insurance products for hospitalization and accident-related health care. For example, one of the largest savings and credit cooperatives is Cooperativa de Ahorro y Crédito, "El Educador", R.L, with a membership of over 60,000 education professionals. It offers insurance plans for hospitalization and accident (covering health-related costs) and a specific insurance plan to cover cancer treatments.[10] Another large savings and credit cooperative, Cooperativa de Ahorro y Crédito San Antonio, R.L. (CACSA) provides group health insurance plans for its 39,400 members.[11]

OTHER COOPERATIVES

Cooperativa de Servicios Múltiples de Profesionales de Panamá R.L is a multipurpose cooperative serving 9,148 health professionals and 1,813 associate members or "terceros" (members of the family of a principal cooperative member).[12] It provides a variety of financial products, including hospitalization and cancer treatment insurance.[13]

MUTUALS

At least one mutual insurance company, Catholic Mutual, offers health insurance coverage (medical and dental) and care to Panamanians. Through national networks of providers, Catholic Mutual provides such services to a number of countries in the region.[14]

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PARAGUAY

2014

HEALTH SYSTEM

In 1996, Paraguay adopted a law creating a National Health System that guarantees universal health care to all (Ley N° 1032 que crea el Sistema Nacional de Salud).[2] Later decrees enabled a decentralization of service delivery of health care to public, private (for and non-profit organizations, including cooperatives), and so-called "mixed" or parastatal organizations, such as the Red Cross. In 2008, universal health care became a government priority to enable free health care services for users. Approximately 95% of the population is provided with health care through public social protection schemes with 70% of the population using public health care provided through the Ministry of Public Health.[3] Approximately 7% of the population are covered by private health schemes.[4]

In 2011, the health sector of Paraguay consisted of 23 general hospitals, 101 second-level hospitals, and 971 outpatient health centres. There were 9,070 doctors, 4,700 orthodontists, 28,895 nurses, technical and support personnel.[5]

Current providers of health care are the public sector (through the Ministry of Health and a number of autonomous institutions), the Social Security Institute (IPS), and the private sector. Each finances health care provision in their own facilities, with little coordination between them. The Ministry of Health provides health care at its facilities at a subsidized price, charging user fees for most procedures. The Social Security Institute is financed with a payroll tax on employers, on employees, and a contribution from the government, split between its various insurance schemes – old age, disability, survivors, and sickness. Private sector fees are not regulated.[6]

Population (in thousands): 6,687

Population median age (years): 23.59

Population under 15 (%): 32.78

Population over 60 (%): 8.01

Total expenditure on health as a % of Gross Domestic Product: 10.3

General government expenditure on health as a % of total government expenditure: 11.2

Private expenditure on health as a % of total expenditure: 58.0

Health services are among the top activities in which cooperatives are active.

The recent 2012 National Cooperative Census (based on 2011 data) found that 450 cooperatives were active in Paraguay. 47% (330) of cooperatives are in the financial sector; 14% (64) in the non-financial sector, that is, in the consumer, marketing, health and social care, housing, and communication sectors; 10% (46) in agricultural, fisheries, forestry and salt production; and 2% (10) in the electricity, gas, and water sectors.

According to the Confederation of Cooperatives of Paraguay (Confederación de Cooperativas de Paraguay, CONPACOOP) and its observatory (OBSECOOPY), health services are among the most common services provided by cooperatives of all types, accounting for 47.9% of all social services provided by cooperatives. This attests to the fact that many cooperatives are classified in their main area of activity but provide multiple services.

CONPACOOP reports that in 2011, 115 cooperatives of all types were active in the area of health in seven of the country's 18 departments and served approximately 8% of the total population.[7] Cooperatives were found to provide or manage medical services or pharmacies, to offer health insurance through wholly-owned companies, and to provide health-related loans.

In addition, cooperatives of all sectors are known to have engaged in health education and disease control. Currently, cooperatives have partnered with the Ministry of Public Health and Social Well-being to implement the campaign against dengue fever.[8]

HEALTH COOPERATIVES

The National Census on Cooperatives (2012) identifies five health and social care cooperatives (1.1% of all cooperatives).[9] They bring together 834 members and operate in the departments of Concepción (1), Itapúa (1), Caaguazú (1), and Alto Paraná (2). In 2011, they provided health services to 257,627 people, up from 230,354 in 2010, i.e., an 8.9 % increase in one year.

The following table lists the five health cooperatives.[10]

Name	Type
Cooperativa Comunitaria de Salud Naranjaty Limitada	User
Cooperativa Médica Multiactiva de Trabajo y Servicios PLANMED Caaguazú Limitada	Producer
Cooperativa Multiactiva de Ahorro y Crédito, Consumo. Servicio y de Trabajo Médico UNICOM Ltda	Producer
Cooperativa Multiactiva de Trabajo y Servicio Itapua COMEDI Ltda.[11]	Producer
Cooperativa Multiactiva de Trabajo y Servicios UNIMED[12]	Producer

Health Cooperative Data (2011)

Number of cooperatives	5 cooperatives whose primary purpose is health care	105 cooperatives whose services include health and social care
Types of cooperative	Producer and User	
Number of members	834 (711 men and 123 women)	
Number of employees	Worker members N/A 22 indirect jobs	
Users	257,627 537,904 for all cooperatives in 2011 (479,817 in 2010)	280,277
Services	Illness and accident prevention, wellness and health promotion, treatment and cure, rehabilitation including cardiology, paediatric and geriatric care, gynaecology and obstetrics, traumatology, nephrology, urology, respiratory medicine, psychology dermatology, orthodontic care, ophthalmology, pharmacy and laboratory services as well as nursing care and ambulance services	
Annual turnover	Approx. $13 million USD (59,222,834,349 PYG)	
Sources of revenue	N/A	N/A

Case Study

The community health cooperative **Cooperativa Comunitaria de Salud Naranjaty Limitada** (COSAN) was established by 185 people in response to the absence of adequate medical care at reasonable cost in the Alto Paraná region. Today it has 292 members (rural producers in the majority) and continues to seek to expand its membership.

COSAN was formally established in 2001. In its formative phase, the founders were supported by various religious organizations and other cooperatives in the region, including the agricultural cooperative, Cooperativa de Producción Agropecuaria Naranjal Ltda (COPRONAR). A number of COPRONAR members were founding members of COSAN, providing cooperative education and training to those interested in starting the health cooperative.[13]

Initially COSAN provided health education and disease prevention. Its aim, however, was to open a hospital.[14] In 2005 it was able to secure a donation of medical equipment and furniture from Collaboration Internationale Santé, a Canadian NGO which recovers unused medical equipment and materials from Quebec's health network.[15] This enabled COSAN to open a modern hospital, Hospital Cosan Naranjal. Today it provides 24-hour medical attention and offers a range of services including laboratory analysis, radiology, orthodontic care, ophthalmology, and the distribution of pharmaceuticals.

Hospital Cosan Naranjal is part of the network of health providers recognized by the prepaid health insurance plan offered by Cooperativa UNIMED Alto Paraná.[16]

OTHER COOPERATIVES

The Census identifies an additional seven cooperatives whose secondary activity is the provision of health and social services in the departments of Asunción (1), Central (5), and Ñeembucu (1). Health and social services are the third most important activity of another five cooperatives.

Of the 436 cooperatives surveyed (excluding the five who reported their primary activity to be health-related), 105 reported that they provided health services. The majority are multiservice cooperatives. In 2011, a total of 280,277 people used their health-related services, an 8.9% increase over 2010 when there were 249,463 users.[17]

Cooperatives provide services in both public and private medical structures. The services provided are varied and include cardiology, paediatric and geriatric care, gynaecology and obstetrics, traumatology, nephrology, urology, respiratory medicine, psychology dermatology, orthodontic care, ophthalmology, pharmacy, and laboratory services as well as nursing care and ambulance services. The majority are providers of prepaid health services.[18]

The following table breaks down the activities which cooperatives perform and the number of users each has.

Area of activity of cooperative	Number of users	
	2010	2011
Activities related to public hospitals	200	200
Activities related to private hospitals	34,100	38,891
Medical attention	81,622	98,487
Orthodontic attention	2,276	3,417
Facilities with nursing care (infirmaries)	79,229	81,655
Medical and diagnostic laboratories	37,708	44,782
Other activities related to human health	19,362	18,686
Other social services without residential care	4,920	5,259
Total	259,417	291,377

Source: OBSECOOPY, based on National Cooperative Census 2012

An example of a multiservice cooperative is **Cooperativa Comecipar** (Cooperativa de Consumo Producción, Ahorro, Crédito y Servicios de Profesionales de la Salud Limitada). It provides financial assistance (grants/subsidies) to members and their families to help defray costs related to incapacity, maternity and prenatal pathologies, hospitalization, and death. In 1995 it established a pre-paid health insurance provider to offer health insurance to its members. (See "Insurance," below.) In November 2012, it also established its own laboratory service, SPS Laboratorio, which enables members to access the SPS laboratory itself and 60 other laboratories with which it has strategic alliances.

SOCIAL COOPERATIVES

The National Cooperative Census 2012 identified 633 cooperatives as providing social services. Of these, 110 provided social services in the area of health with no specific breakdown within the category. The other areas of activity include the provision of credit for improved social well-being, technical assistance, support to academic institutions, recreation and sports, donations, scholarships, support to local authorities, community work, environmental projects, and legal assistance.

PHARMACIES

Among the 105 cooperatives providing some type of service related to health care are those that offer pharmaceutical services or operate pharmacies. For example, the national-level multipurpose cooperative, Cooperativa Multiactiva de Consumo y Servicios de Personal Policial "17 De Mayo" Ltda., owns and operates five pharmacies in various locations around the country under the name "Farmacia Santa Rosa."[19] The Cooperativa Multiactiva Neuland Ltda., a multipurpose cooperative primarily active in the agricultural sector, owns and operates "Farmacia Concordia."[20] A third example, the multipurpose savings and credit cooperative, Cooperativa Multiactiva de Ahorro, Crédito y Servicios San Lorenzo Ltda, operates the Farmacia Pytyvo.

A cooperative owned by pharmacies also exists, Cooperativa Multiactiva de Propriedad de Farmacias (COOFA). No information on its activities or form was identified, however.

INSURANCE

Cooperatives are also involved in providing health insurance through wholly-owned insurance companies.

Cooperativa Comecipar (Cooperativa de Consumo Producción, Ahorro, Crédito y Servicios de Profesionales de la Salud Limitada) was founded in 1967 by 61 health professionals as a savings and credit cooperative. In 1980 it diversified its activities to include consumer services and in 1995 established the **Sistema de Proteccion Salud** (SPS),[21] to provide prepaid health insurance. Initially it provided health insurance exclusively to Comecipar members. In 2004 it extended coverage to the entire cooperative movement, and in 2010 to the general public. In 2013 SPS provided health services through its network of health providers – 1,075 health professionals and 122 health centres. It insured 18,112 persons, 97.6% of whom were cooperative members and their families. Its health insurance premiums totalled $6.6 million USD (31,323,736,669 PYG) in 2013.[22]

Health insurance is also provided by a wholly-owned subsidiary of an Argentinian insurance cooperative, **Sancor Seguros del Paraguay** S.A. Established in 2009, Sancor Seguros del Paraguay provides personal and commercial life and non-life insurance coverage, including agricultural insurance. At the end of 2013 the Association of Insurance Companies (Asociación Paraguaya de Compañías de Seguros) ranked Sancor Seguros del Paraguay the six largest of 35 insurance companies operating in Paraguay.[23]

Two other insurance companies owned by the cooperative movement provide health coverage under their accident insurance: Aseguradora Tajy Propriedad Cooperativa de Seguros and Panal Compañía de Seguros Generales S.A.

MUTUALS

Health care services (medical, orthodontic, and pharmaceutical) and health insurance are also delivered through mutuals. Some were established by specific laws. Others were set up to operate on the basis of the principle of mutuality prior to the regulation of mutuals under Law No. 3472 (2008).[24]

Ayuda Mutual Hospitalaria (AMH) provides mutual health insurance and comprehensive medical care[25] to indigenous communities in the Chaco region. Established by law in 2006 (Ley N° 3050/2006), it provides health insurance and services. A decentralized organization, AMH works through 26 funds (Cajas). In 2009, it served 25,000 people.[26]

The **Mutual Health Institute** (Instituto Mutual de la Salud) was established in Paraguay in 1995. It provides insurance coverage to health professionals and their families in a number of countries. It offers a wide range of medical services, pharmacies, and laboratory services to the staff, doctors, and nurses of the Hospital de Clinicas, Neuropsychiatric Hospital, Institute Andrés Barbero, and Research Institute of Health Sciences (Instituto de Investigación en Ciencias de la Salud). The mutual has agreements with a number of clinics and laboratories. These enable members to receive treatment and services in various locations in the capital city.[27]

Although primarily a mutual set up as a retirement fund, the **Caja Mutual de Cooperativistas del Paraguay** also provides coverage for health care in intensive care units. It was established in 1985 by the cooperative movement in order to provide social protection (retirement plans) for members of cooperatives and similar enterprises which are not covered by the public social protection system. The Caja Mutual de Cooperativistas del Paraguay provides a daily allowance (grant) to members for hospitalization in an intensive care unit. Members receive approximately $550 USD per day (2,500,000 PYG) after the fourth day of ICU hospitalization for a period up to 12 days. It currently has 23,334 members.[28]

Number of mutuals	3
Number of members	Caja Mutual de Cooperativistas del Paraguay - 23,334

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PERU[1]

2014

HEALTH SYSTEM

Peru has a decentralized health care system administered by five entities: the Ministry of Health (MINSA), which provides health services to 60% of the population; Social Security (ESSALUD), which provides services to 30% of the population; and the Armed Forces (FFAA), National Police (PNP), and the private sector together provide services to the remaining 10%. (See diagram, below.)[2]

The private sector consists of a broad spectrum of health care providers of different levels of complexity, from doctors' offices to specialty clinics, from clinical laboratories to basic and specialized imaging centres. The private sector generally serves the higher-income population. It includes smaller scale non-profit organizations such as NGOs, associations, cooperatives, and mutuals. The resulting system contains multiple providers of services and insurance.

In 2011 approximately 73% of population (22.1 million) were covered by some form of health insurance. Approximately 38% were covered by public insurance (Seguro Integral de Salud), 33% by social security, 2% through the Armed and Police Forces, and 1% by private insurance. Approximately 21% of the population which is not covered by health insurance currently pay for health services out-of-pocket. Of these 6.2 million people with the capacity to pay, 31% work in microenterprises and 21% are self-employed. They constitute a potential market for private health insurance.[3]

Population (in thousands) total: 29,988

Population median age (years): 26.16

Population under 15 (%): 29.18

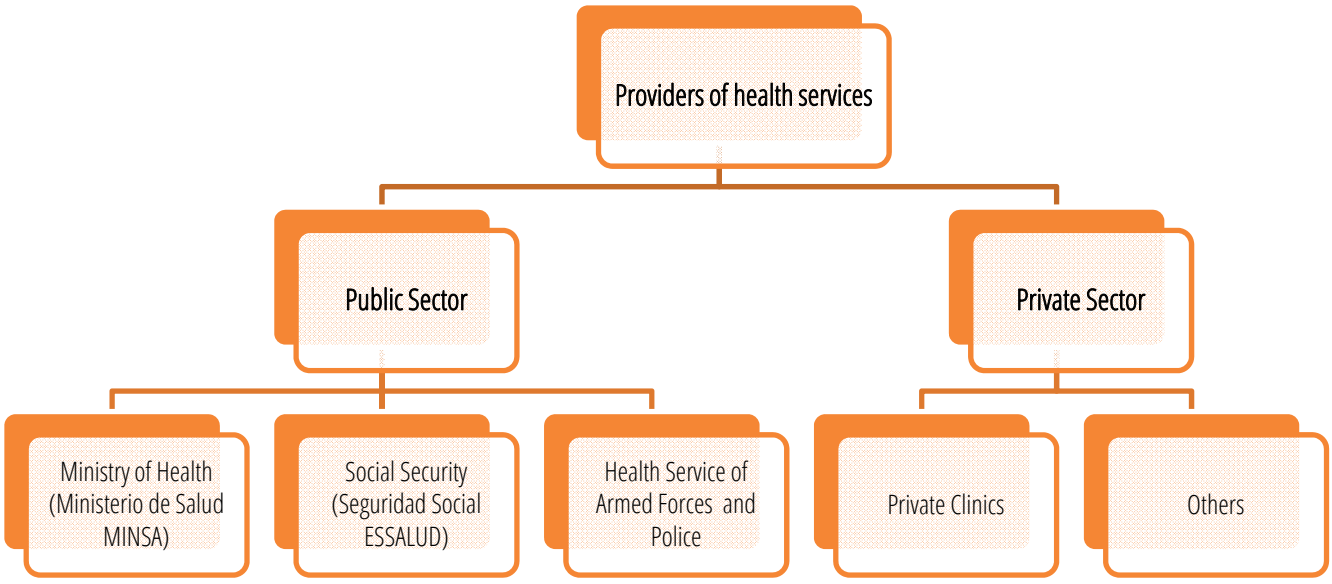
Population over 60 (%): 9.12

Total expenditure on health as a % of Gross Domestic Product: 5.1

General government expenditure on health as a % of total government expenditure: 18.3

Private expenditure on health as a % of total expenditure: 41.1

The ministry in charge of cooperatives, the Ministry of Production (Ministerio de Produccion), estimated in 2012 that there were 1,765 cooperatives. However, the National Directory of Cooperatives includes only 640 registered cooperatives, the majority of which are savings and credit cooperatives, followed by agricultural cooperatives.[4] There are very few health and social cooperatives per se. However, as in other countries in the region, cooperatives in a variety of sectors provide social services, including primary health care (infirmaries and occupational health care centres). They run their own health facilities or have agreements with health care clinics so that their members may access health care at discounted prices.[5] Health professionals have also formed savings and credit cooperatives to provide financial services, including such insurance products as disability, funeral, and hospitalization insurance.



More detailed information on the cooperative movement will be available in the future thanks to the 2014 initiative by the Ministry of Production to establish Peru's first online national directory of cooperatives. It is calling on all cooperatives to register their information online. The initiative is being undertaken in collaboration with the cooperative movement and cooperative stakeholders, including United Nations agencies. The directory will categorize cooperatives as agricultural, fisheries, mining, construction, savings and credit, multiservice, and other; it will not classify health and social cooperatives as a specific category or type of cooperative.[6] Nevertheless, once this information is recorded, it may be easier to identify those making significant contributions to the accessibility or quality of health and social care services.

HEALTH COOPERATIVES

There are no known primary health cooperatives in Peru. However, cooperatives active in other sectors provide and facilitate access to health care.[7] They provide preventive care, contract with provider institutions to facilitate medical and dental visits for members and their families, or own or manage medical facilities (offices, clinics) themselves. The coverage they provide is limited, due to the range of public health services which are available. These cooperatives are found in the savings and credit, coffee, and multipurpose sectors.

There is however a cooperative central, Cooperativa Central (SERVIPERÚ), which provides both medical services and insurance products. It is considered a pioneer in the provision of cooperative health care. Established initially in 1966 as an insurance cooperative, in 1996 SERVIPERÚ changed its status to that of a service cooperative since, under a new insurance law, cooperatives were no longer allowed to undertake insurance functions. It established two subsidiary companies to provide insurance brokerage services and funeral care services. In 1998, SERVIPERÚ started its health service programme, establishing medical facilities and providing health insurance coverage. (See "Case Study," below.) SERVIPERÚ's membership consists of 103 cooperatives (primary, centrals, and a federation). The majority of its members are from the savings and credit cooperative sector. Total membership is 520,450 individuals.

Health Cooperative Data (2013)[8]

Number of cooperatives	1 central
Types of cooperative	User
Number of members	103 cooperatives with 520,450 individual members in total
Number of employees	121 in total (67 men and 54 women) • 85 on payroll: 32 health professionals (7 doctors, 8 nurses, and 17 aides), 17 business professionals, and 36 administrative staff • 36 health professionals on a part-time basis via reciprocal service contracts
Users	36,750 medical procedures, including 1,244 surgical procedures
Services	Ambulatory care, hospitalization, medium complexity surgery, rehabilitation, physiotherapy, odontology, ophthalmology, otorhinolaryngology, cardiology, dermatology, gynaecology, traumatology, and plastic surgery
Annual turnover	Approx. $2,852,000 USD (8,039,273 PEN) of which approx. $825,000 USD (2,870,824 PEN) was for health services
Sources of revenue	Payment for services, member equity, surplus from insurance operations

CASE STUDY[9]

SERVIPERÚ Central Cooperativa de Servicio was already considered a pioneer in the provision of cooperative health services when it launched the SERVISALUD program in 1998.

SERVIPERÚ is a service cooperative central which mobilizes both corporate bodies and individuals to the provision of health services, insurance, and mutual aid. It was founded in 1966 as an insurance cooperative. In 1996 it changed its status in response to a new insurance law which authorized insurance to be delivered by joint-stock companies, but no longer by cooperatives. SERVIPERÚ offers insurance brokerage services and funeral insurance services through its two subsidiary companies, Cooperadores Corredores de Seguros SAC and Funerales Los Olivos SAC.

SERVIPERÚ has benefited from technical and financial support from SOCODEVI of Canada and the Canadian International Development Agency (CIDA), including support specifically for the expansion of SERVISALUD. It also benefited from Collaboration Santé Internationale of Quebec (Canada) which organized the donation of medical equipment from Canada.

Membership

SERVIPERÚ is a user cooperative which brings together 103 cooperative organizations, including three centrals and the National Federation of Savings and Credit Cooperatives (Federación Nacional de Cooperativas de Ahorro y Crédito del Perú, FENACREP). Its total individual membership is 520,450.

Health Services

The SERVISALUD programme provides services through a medical clinic in the district of Jesús María and a polyclinic in the northern zone of metropolitan Lima. Its services include:

- **Outpatient and emergency care** in 20 medical specialties.
- **Surgical and hospital services**. The clinic is equipped to handle surgical procedures of medium complexity. It has two operating rooms, 16 inpatient beds, and a surgical sterilization centre.
- **Auxiliary Services**. The clinic maintains pharmacy services and a clinical and pathology laboratory. It has ultrasound and pharmacy professionals to facilitate early diagnosis and appropriate care.
- **Preventive medical services**, including occupational health services, and health and psychological examinations for driver's licences.[10]

In 2013 SERVISALUD performed 36,750 medical procedures, of which 1,244 were surgical interventions.

SERVISALUD facilities

Insurance

SERVISALUD also provides microhealth, life, and disability insurance.

The **SERVISALUD Family Insurance plan** (SERVISALUD Previsión Familiar) covers members' costs of hospitalization in case of illness or accident (including reimbursement of accident-related medical expenses), doctor visits, diagnostic services, medical emergencies, and funeral services.

SERVISALUD Medical Clinic, Lima

The insurance is provided through SERVISALUD. It contracts a corporate insurance plan with a local insurer through SERVIPERÚ's insurance brokerage firm. Plans cover members and their families (up to five persons per household). A number of plans exist for those with the ability to pay and already covered by public insurance schemes, as well as those not covered by social security and without access to private insurance (i.e., Lima's poor). In the latter case, members pay a monthly premium of $4.25 USD (12.00 PEN) which covers them for health expenditures up to $3,571 USD (10,000.00 PEN). In 2013, 15,626 families were covered by this insurance plan – a decline from previous years, reflecting the increased service offerings and competitive pricing of the public health system.

In order to offer the plans at affordable prices, SERVIPERÚ manages the marketing of insurance to its members, issues certificates of coverage, collects premiums, and contracts with a network of health providers to complete its clinic's service offerings. It receives a commission for the administration and 5% of the premiums to defray operating costs.

SERVIPERÚ also provides **microinsurance products** for individual members of its member cooperatives.

- **Protección al Prestatario**. Members and their families benefit from loan repayment insurance. It covers the full amount of loans outstanding in case of death or total and permanent disability due to illness or accident. As of December 2013, 211,287 individual members received this insurance.
- **Protección al ahorrista**. In case of death, members' families benefit from a lump sum payment similar to the capital and savings held by the member at the time of death. As of December 2013, 61,885 individual members benefited from this coverage.
- **Mutual aid**. In case of death, members' families are guaranteed compensation for the contract amount, with double indemnity if death is by accident or in the case of permanent disability. As of December 2013, 39,235 individual members were covered by this service.

Staff

SERVIPERÚ has 121 employees, 55% male and 45% female. This includes 85 persons on payroll, 32 of whom are health professionals (7 doctors, 8 nurses, and 17 auxiliary personnel), 17 are professionals in the business sector, and 36 are administrative personnel.

The central also contracts 36 health professionals to provide medical services. These are doctors, dentists, and other specialists who are employed in public and private hospitals but work with SERVIPERÚ on a part-time basis, in accordance with the needs of the service. SERVIPERÚ offers these specialists and small medical companies what are called "contracts of reciprocal service." They commit each party to develop health services for the benefit of members and the community. The following table itemizes their contents.

Reciprocal Service Contract

SERVIPERÚ	Contractor
• Provide equipped medical facilities free of charge • Discounted pricing for use of operating rooms for contractors' clients • Cover medical assistants' and administrative fees related to the provision of health services • Cover general operating costs • Undertake promotion and marketing to increase members and clients	• Attend to patients, members and clients at rates and during hours established by SERVIPERÚ • Support the design of health plans • Support the free health campaigns • Provide services to their private clients at the rates established by SERVIPERÚ

Financial Information

In 2013, SERVIPERÚ reported a sales volume of $2,852,000 USD (8,039,273 PEN) of which approximately $825,000 USD (2,870,824 PEN) was for health services.

SERVIPERÚ's revenue sources are payments for services, the equity contributed by the member cooperatives, and significant surplus from its insurance operations.

SAVINGS & CREDIT COOPERATIVES

In addition to their primary function – providing financial services to persons who are for the most part outside the traditional financial system – Peru's savings and credit cooperatives facilitate access to health services. They provide loans which help to cover out-of-pocket health care expenses. They offer a number of social protection packages that provide health care, life and funeral insurance to members and their families. They also have solidarity programmes to assist members in times of need. The National Federation of Savings and Credit Cooperatives (FENACREP) does not collect data on these activities. The following are a few examples of the services provided.

- **Cooperativa Ahorro y Crédito San Cristobal de Huamanga**[11] was founded by 14 members in 1960. It currently brings together 80,000 members and provides a wide range of financial services for both individuals and enterprises. It also provides social services, one of which is a social welfare fund entitling members under the age of 69 to medical care. To take part, members make an annual payment of $12 USD (35.00 PEN) and a monthly contribution of $3.45 USD (10 PEN). Children can be covered for an annual fee of $5.10 USD (15 PEN) and a monthly fee of $1.70 USD (5.00 PEN). This entitles them to 10 medical visits including general medicine, paediatrics, internal medicine and obstetrics, six sonograms, and psychological consultations. It also makes available dental care, including a yearly cleaning, two extractions, two fillings, and two fluoride treatments for children. All care is provided through their own medical clinic, Centro Medico San Cristobal.
- **Cooperativa de Ahorro y Crédito Crl. Fransisco Bolognesi**, a savings and cooperative serving the armed forces of Peru, was established in 1970. It provides its 14,000 members (2011) with financial and non-financial services, including free and subsidized health care.[12] Members and their families benefit from no-cost, personalized medical and dental care, a vaccination service, blood pressure and diabetes screening, advice on family planning, nutrition, dental check-ups,

psychological care, physical therapy, and access to a gym. It also has service agreements with suppliers, including optical stores.[13]

- **Cooperativa de Ahorro y Crédito Tocache (COOPACT)**, one of the 30 largest cooperatives in the sector, has 17,000 members. It operates a programme called CSalud, a social welfare fund (Fondo de Previsión Social) which entitles members and their families to medical and dental health care, indemnities for maternity, disability, and death. COOPACT insures medical and dental service delivery by health providers (clinics and medical centres) with which it has service or contractual agreements.[14]

The savings and credit cooperative movement in Peru encompasses 167 savings and credit cooperatives which together total more than 1.25 million members (53% men and 47% women). The majority (70%) live in urban areas.

OTHER COOPERATIVES

Coffee and cocoa production cooperatives provide essential health care services to rural populations in the inter-Andean high forest areas. Due to their remote location, the small producer members often lack easy access to public health services. Appropriate medical attention is rarely to be had at poorly-staffed and -equipped medical outposts where a doctor may only be available once a month.

To address this problem of access, a number of these cooperatives provide health care for their members and communities. Cooperative education committees often promote and manage these activities. A number of coffee and cocoa production cooperatives run and operate medical offices or medical dispensaries of varying quality, and offer preventive health campaigns. The more economically successful cooperatives have created special funds to cover health care-related costs. Some have established their own savings and credit cooperatives to address financial risk. Cooperatives seeking or operating under Fair Trade certification also are encouraged to invest surplus in improving the health of their members and to provide some forms of health care.[15]

The sector brings together more than 50,000 families (approximately 250,000 people) in 78 coffee cooperatives and 180 small producer associations. Their activities thus have an impact on a potentially large segment of the population with limited access to health care.

Cooperatives in other sectors, particularly those categorized as "multipurpose," also provide health care services.

SOCIAL COOPERATIVES

Social care cooperative data are not collected by public authorities. To collect such information would require an extensive investigation of cooperative areas of activity. However, initial research revealed that cooperatives do provide elder care and care for persons with disabilities. Housing cooperatives, for example, provided residential care facilities for the elderly. The National Council for the Integration of Persons with Disabilities (Consejo Nacional para la Integración de la Persona con Discapacidad, CONADIS) promotes worker cooperatives which create sheltered employment opportunities for persons with disabilities. Two cooperatives of persons with disabilities are currently registered with CONADIS: Cooperativa de Servicios Especiales de Trabajadoras y Trabajadores con Discapacidad Victor Raul Haya de la Torre and Cooperativa de Producción y de Trabajo Talleres Electro Multiples Fe Limitada N° 36.[16]

MUTUALS

Some mutuals of professional organizations facilitate access to health care by providing members with a number of social protection services. Generally, they provide life and funeral insurance, but in some cases hospitalization plans as well. This is the case of the Mutual Association for Air Force Personnel, Asociación Mutualista de Técnicos y Suboficiales de la Fuerza Aereas del Perú, which provides hospitalization insurance.[17]

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POLAND

2014

HEALTH SYSTEM

Poland[1] has a good standard of compulsory, state-funded health care. Medical staff are extremely well trained and health care in Poland is available to all citizens and registered long-term residents. The Ministry of Health is in overall charge of policy and regulation of the health care system and the National Health Fund. The Ministry's regional branches assist with the management of the health care insurance scheme. Private health care is also available. Many citizens prefer it to avoid the long waits imposed by the State system.

The State health care system is funded in two ways: through government budget allocations to health care and through compulsory individual contributions to the State health care insurance scheme.

Few cooperatives and mutuals are active in the Polish health sector. There are some doctor cooperatives, pharmacy cooperatives, and mutuals, however.

Population (in thousands): 38,211

Population median age (years): 38.55

Population under 15 (%): 14.91

Population over 60 (%): 20.48

Total expenditure on health as a % of Gross Domestic Product: 6.7

General government expenditure on health as a % of total government expenditure: 11.1

Private expenditure on health as a % of total expenditure: 29.9

DOCTOR COOPERATIVES

Doctor cooperatives are part of the worker cooperative sector, according to the apex organization for Polish cooperatives.[2] The search engine of the National Auditing Union of Workers Cooperatives (their apex body) lists[3] 17 doctor cooperatives among 188 associated worker cooperatives and more than 17,000 cooperatives overall.

In light of this, it is correct to conclude that their participation in both the cooperative sector and the medical sector is negligible, and they do not seem to be growing more popular.[4]

PHARMACY COOPERATIVES

In Poland no cooperative is active in the pharmacy sector as wholesaler, nor are there any cooperative pharmacies. However, a relatively relevant sector for the cooperative movement in this country is pharmaceutical manufacture. In fact, there are at least six cooperatives in this field, some of them extremely modern and with a significant market position.

Cooperative Drug Producer Data[5]

Name	Country of manufacture	Employees	Turnover
UNIAPharmaceutical Plant Co-op in Warsaw	Poland	264	$20,296,506 USD (estimated)
FILOFARM Pharmaceutical Workers' Cooperative in Bydgoszcz	Poland	124	$11,597,184 USD (2007)
SPEFA Chemistry and Pharmacy Cooperative in Warsaw	Poland	105	$6,955,633 USD (2008 - projected)
SEPTOMA Chemical and Pharmaceutical Workers' Cooperative in Zabki	Poland	36	$771,341 USD (2007)
GALENA Pharmaceutical Manufacturing Cooperative in Wroclaw	Poland	140	$11,597,525 USD (2007)
LABOR Pharmaceutical and Chemical Workers' Cooperative in Wroclaw	Poland	48	$3,477,651 USD (2007)
Total		717	$54,698,732 USD[6]

HEALTH MUTUAL ORGANIZATIONS

In Poland, we identified only one mutual involved in the health sector: **TUW SKOK**[7] based in Sopot, and operating since 1995. It offers a selected range of property and casualty products, including car insurance. Premiums for 2012 totaled $70,963,868 USD. The membership stands at 865,000. Health premiums are reported to account for less than 5% of TUW SKOK's total premiums.

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PORTUGAL[1]

2014

HEALTH SYSTEM

All residents in Portugal have access to health care provided by the National Health Service, financed mainly through taxation. Co-payments have been increasing over time, and the level of cost sharing is highest for pharmaceutical products. A 2011 review of the Portuguese health system noted that approximately one-fifth to a quarter of the population has a second layer of health insurance coverage (and some even more) through health subsystems and voluntary health insurance.[2]

Health care delivery is based on public, private, and cooperative providers.[3] Public provision is predominant in primary care and hospital care. Pharmaceutical products, diagnostic technologies, and private practice by physicians constitute the bulk of private health care provision. Social economy institutions, including cooperatives, mutuals, and misericórdias (religious-based institutions) all play a role in providing access to health and social care in Portugal.

Article 4 of the Cooperative Code states that the cooperative sector includes 12 subsectors: consumer, trade, agriculture, credit, housing, industrial production, handicraft, fisheries, culture, services, education, and social solidarity cooperatives. Multipurpose cooperatives are allowed, but statutes must specify the subsector with which members choose to identify, in accordance with their main activity. Health cooperatives per se are not a recognized cooperative subsector. This is despite the fact that the government in 2001 proposed a working group to define a new sector for health and medical cooperatives which would be compliant with the Cooperative Code.

Population (in thousands) total: 10,604

Population median age (years): 41.81

Population under 15 (%): 14.92

Population over 60 (%): 24.39

Total expenditure on health as a % of gross domestic product: 9.5

General government expenditure on health as a % of total government expenditure: 12.5

Private expenditure on health as a % of total expenditure: 37.4

Notwithstanding, the cooperative form of enterprise has been chosen by health care providers and users. Bulk purchasing and marketing of pharmaceuticals is undertaken through secondary level cooperatives owned by independent pharmacies, and social solidarity cooperatives care for the physically and mentally disabled, children, the elderly, and other vulnerable groups.

HEALTH COOPERATIVES

In Portugal health cooperatives provide medical and dental health care services.

Health Cooperative Data

Number of cooperatives	38
Types of cooperative	User and Producer
Services offered	Health and well-being services, including health care promotion, prevention, curative care, and rehabilitation. Medical and dental services.
Sources of revenue	Transfers from National Health System, direct payments, donations

The pilot project of the Satellite Account of Social Economy (SASE) for the year 2010 reported that approximately 38 (1.7%) of Portugal's 2,260 cooperatives are involved in activities related to health and well-being.[4] The report does not provide a breakdown of the activities of cooperatives in that category.

Case Study

The **Cooperativa de Solidariedade Social do Povo Portuense** CRL[5] was founded in 1900 to provide affordable services to members, including health care and a solidarity fund for funerals. In the 1970s it ran a funeral society, a textile company, and a printing company, having recuperated failing enterprises for workers.[6] It now runs a funeral fund and a cultural centre and provides social health care services at prices lower than those of the national health service through two clinics: Clínica Médica Povo Portuense and the Clínica Médica do Povo Portuense-Gaia. The clinics offer consultations with health professionals for cardiology, dermatology, gynaecology, traditional Chinese medicine, dentistry, neurology, ophthalmology, ORL, orthopaedics, paediatrics, psychological and psychiatric care,

podiatry, and urology. It counts 18,000 members.[7] Members pay a monthly fee to access health care from the two clinics.

The cooperative practices social health care by making its services available at low prices. General medical consultations cost $3.35 USD (2.50 EUR) and consultations in specialized medicine $46.75 USD (35 EUR). The membership fee varies according to age, with seniors paying a lower membership fee. To help keep costs to patients low, a number of the health professionals associated with the clinics volunteer their time or charge low rates. Additional finance is through members and donations.

In March 2013 the cooperative signed an agreement with the government of Senegal, which enables Senegalese immigrants to enjoy access to its affordable health services. The agreement is to facilitate the integration process of the Senegalese community in terms of access to health care.

PHARMACY COOPERATIVES

Bulk purchasing and distribution of pharmaceuticals is organized through cooperatives. The first such cooperative was founded in 1935. A number of pharmacy cooperatives (at least eight) existed until 2007 when the sector experienced market concentration and cooperatives began merging. Four such cooperatives remain today. Up until 2011 there was a federation of pharmacy cooperatives, Fecofar. It was dissolved by decision of its members.

Pharmacy cooperatives are important actors in the pharmaceutical sector. In 2009, pharmacy cooperatives held nearly 43% of the market.[8] Today, the four remaining cooperatives continue to have a large market share. They engage in bulk purchasing, marketing, and distribution of pharmaceuticals for their member pharmacies. Some also operate laboratories. They are listed below in order of date of foundation:

- **Udifar Cooperativa de Distribuição Farmacêutica,** established in 1935, was the first pharmacy cooperative. In November 2007 it merged with two other pharmaceutical distribution cooperatives, CODIFAR Cooperativa Distribuidora Farmacêutica CRL and UNIÃO dos Farmacêuticos de Portugal CRL.[9] In addition to wholesale marketing and distribution, it has operated its own laboratory, Udifar II, since 2009. It was ranked the 951st largest enterprise in Portugal in 2009.[10]
- **Cooperativa dos Farmacêuticos do Norte, C.R.L. (Cofanor)** was established in 1967 and is based in Oporto. It operates two outlets, in Oporto and Montemor-o-Velho. It is 85th largest enterprise in Portugal.[11]
- **Cooperativa dos Proprietários de Farmácia, C.R.L. (Cooprofar)** was founded in 1975. It operates three subsidiary companies (Mercafar, Dismed, and Medlog) which deal in distribution and international representation, transport, and logistics.
- **Plural - Cooperativa Farmacêutica, C.R.L.** is a marketing cooperative for pharmaceutical products. It was established in 2006 and services 1,000 pharmacies. It has distribution centres and warehouses throughout the country.[12] In 2009, it was ranked the 144th largest enterprise in Portugal.[13]

New legislation was passed in 2011 regarding price margins for wholesalers and pharmacies. This new legislation also introduced changes in the reimbursement policies of the national health system. This led to a temporary drop in turnover as the pharmacy cooperative sector adjusted.

Pharmacy Cooperative Data

Cooperative	Members[14]	Employees	Market share	Turnover (USD)
Cooprofar	1,200+ (2014)[15]	267 (2012)[16]	18.9% (2011)[17] 8.52% (2009)[18]	$355,378,000 (2012)[19]
Cofanor	950 (2014)[20]	171 (2009)[21]	10% (2014)[22] 8.32% (2009)[23]	$334,471,000 (2011)[24]
Plural	1,000 (2014)		7.9% (2009)[25]	
Udifar			18.6% (2009)[26]	

SOCIAL COOPERATIVES

The Special Rehabilitation Centres for Children with Disabilities (Centros Especiais de Reabilitação de Crianças Inadaptadas, CERCIs) emerged in the second half of the 1970s as an initiative of parents and caregivers who were concerned with the problems of people with intellectual disabilities. These cooperatives filled a void for those services. Initially they focused their activities on school-aged children. This has led to the recognition of the CERCIs as pioneers in the creation of schools for special education.

Today CERCIs provide services complementary to those which the state provides. Their objectives are to promote the development of children, youth, and adults with disabilities and enable their inclusion in society. They provide social care to persons of all ages and various degrees of disability. They operate vocational training centres, centres for occupational support, residential units, units of

early intervention, sheltered employment centres and family support units, home care, and therapy services.

Due to the CERCIs, the 1998 revision of the Cooperative Code recognized a twelfth cooperative sector, social solidarity cooperatives. Previously, for lack of an alternative, CERCIs were considered part of the education sector.[27]

It is noteworthy that the new law enables cooperatives which provide employment to register as social solidarity cooperatives. Statistical information about the subsector therefore includes not only cooperatives that provide social care, but those formed by the unemployed as well. The latter may be young people without physical or mental disability who live in circumstances of severe economic hardship or lack professional integration opportunities.

Social Cooperative Data

Cooperativa António Sérgio para a Economia Social (CASES) reports that nearly 250 social solidarity cooperatives were active in 2010.

The **National Federation of Social Solidarity Cooperatives** (Federação Nacional de Cooperativas de Solidariedade Social, Fenacerci) brings together cooperatives that specifically provide services to persons with disabilities and their families. Fenacerci currently counts as members 53 CERCI cooperatives, or 25% of social cooperatives which serve disabled persons. In 2012, Fenacerci counted 22,000 individual members. The 53 CERCI cooperatives employed another 2,700 workers.[28]

Fenacerci reports that there are a total of 209 CERCI cooperatives[29] of which 150 are recognized by the State as Private Social Solidarity Institutions (Instituições Particulares de Solidariedade Social, IPSS).[30] This recognition must be requested from and granted by the State. It entitles them to a special tax regime and access to financial support, subject to their compliance with reporting and regulations.[31]

	Fenacerci (2012)	**Total** (2014)
Number of cooperatives	53	209
Number of members	22,000+	N/A
Number of employees	2,700	N/A

MUTUALS

According to the Ministry of Social Security, there were 103 registered mutuals in Portugal in 2014.[32] These mutuals provide a variety of social protection services, including health care. In terms of the latter, they provide limited coverage for medical consultations, pharmaceuticals, and (more rarely) inpatient care.

In 2011, approximately 7% of the population was covered by a mutual funded through voluntary contributions. However, mutuals do not just provide health benefits to members. Consequently, according to a recent publication of the European Observatory on Health Systems and Policies, it is difficult to calculate the health component of their contributions.[33]

Nonetheless there have been some attempts to measure mutuals' contributions to health care. For example, the pilot project of the Satellite Account of Social Economy (SASE) reported that in 2010, approximately six (5.1%) of Portugal's 119 mutuals were involved in activities related to health and well-being.[34]

Also worthy of note is that mutuals recently have launched a new network to share and expand their services, particularly in health and well-being. **RedeMut**, a network founded by 12 mutuals, was formally launched by the Association of Portuguese Mutuals (Associação Portuguesa de Mutualidades) on April 22, 2013. Its aim is to enable their more than 700,000 members to access health care services in any of the network's mutuals.[35] The 12 founding mutuals are:

- A Benéfi ca e Previdente - Associação Mutualista - Porto
- A Benefi cência Familiar - Associação de Socorros Mútuos - Porto
- A Lacobrigense - Associação de Socorros Mútuos - Lagos
- A Mutualidade da Moita - Associação Mutualista
- A Previdência Portuguesa – Coimbra
- A Vilanovense - Associação Mutualista - Gaia
- CSC - Associação de Socorros Mútuos dos Empregados de Comércio de Lisboa
- Associação de Socorros Mútuos dos Empregados do Estado
- Associação de Socorros Mútuos de Ponta Delgada
- Associação de Socorros Mútuos Nossa Senhora da Nazaré – Torres Novas
- Montepio Abrantino "Soares Mendes" – Abrantes
- Montepio Geral – Associação Mutualista

Members have access to basic and specialist medical consultations, surgery, hospitalization, nursing, and continuous care in their own installations and through other providers with whom the network has partnered.

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REPUBLIC OF KOREA[1]

2014

HEALTH SYSTEM

Population (in thousands): 49,003

Population median age (years): 38.85

Population under 15 (%): 15.25

Population over 60 (%): 16.58

Total expenditure on health as a % of Gross Domestic Product: 7.5

General government expenditure on health as a % of total government expenditure: 13.6

Private expenditure on health as a % of total expenditure: 45.6

Universal health care coverage was successfully established in the Republic of Korea (RK) in 1989. Despite the increase in public expenditure on health care and social welfare, individual households still play a major role in tackling social risks. At present, health care delivery relies heavily on the private sector. Given the trend of population aging, there are some tremendous challenges in the health care sector. Social problems remain in the delivery of high quality health care to citizens at affordable costs, and in the reduction of health disparities between the rich and the poor. However, RK's strong social movement and the original and innovative approaches introduced to its local health care system all warrant attention.

In the Republic of Korea, universal health insurance was realized in 12 years. The process started in 1977, when mandatory social health insurance was first introduced to large corporations with more than 500 workers. It then was extended to employees in firms with more than 300 workers in 1979, then to firms with more than 100 workers two years later, and finally to those with more than 16 workers in 1983.[2] Meanwhile, starting in 1981, the government implemented a series of pilot programmes in order to extend health insurance to the self-employed. Once rural self-employed and urban self-employed were covered by health insurance schemes in 1988 and 1989 respectively, universal coverage of health care had been established across the country. Even at that time, employees and the self-employed were covered separately by various insurance societies. Since 2000, in a major change to the structure of the health insurance schemes, all societies have been merged into a single national health insurer, the National Health Insurance Corporation (NHIC).[3] By 2012, 99% of the RK population were covered by a health insurance program.[4]

From 1991 to 2011, the ratio of total health expenditure to GDP rose 3.7% to 7.4%. During the same period, the public share of total health spending increased from 36.9% to 55.3%.[5] Nevertheless, due to the high co-payment rate and limited benefits offered by the national health insurance programme, the private share of health spending (including insurance contributions and out-of-pocket payments) remains among the highest in the OECD, at 36%.[6]

In RK, health care services are highly market-driven. Health care delivery has relied heavily on the private sector, which provides about 90% of the hospitals and medical services.[7] By comparison, the public health sector has relatively poor infrastructure. In particular, primary care in medical services is reported to be less accessible in RK than in the other OECD countries.[8]

Like other advanced economies, the RK population is undergoing a process of aging. In 2013, the proportion of older persons (60+ years) and that of the very old (80+ years) accounted for 17.1% and 2.4% of the total Korean population, respectively. Population aging poses tremendous challenges to the country's health and social services. To address the elderly, in 2008 RK introduced the Long-term Care Insurance programme as a social insurance scheme separate from national health insurance. While the aforementioned challenges have led to a broad consensus on the need to reform national health and social care policies,[9] the Korean government has not carried out "progressive health policies" and "has not promoted the participation of citizens in medical and public health areas."[10]

In light of government's unsatisfactory record, RK's civil society has played a driving role, not only in addressing social care problems and promoting diversity in health care service delivery, but in the policy-making process. As pointed out by J.-C. Lee,[11] "given the strong interest group influence, NGOs remain the only sector that can empower the public to demand a financially stable national health program in Korea," and "many Korean NGOs [...] aggressively called for government intervention in health care reform in response to the failure to regulate the supply side of the market." Such an influence "represented a new conception and a new scope for national solidarity."[12]

HEALTH COOPERATIVES[13]

The cooperative movement in RK represents an innovative model in public health delivery. The **Korea Health Co-operative Federation** (KHCF) is a national network which began with seven member health cooperatives in 2003. Currently the network has 16 member organizations and another 10 prospective members. Since health cooperatives used to be designated "consumer cooperatives," KHCF was formally incorporated in 2011 under the Consumer Co-operative Act.

KHCF's main activities are staff training, health promotion in the community, providing support for new cooperatives, and international exchanges. In response to the aforementioned health care delivery problems, KHCF, on behalf of the Korean health cooperative movement, "is always asking the RK government to expand the public health care system."[14]

According to the KHCF, the South Korean health cooperative movement began in 1994, when the first health cooperative was set up in Anseong at the initiative of Farmer's Association and Association of Christian Students. Since then, 16 more health cooperatives have been established: Incheon, Ansan, Daejeon, Wonju, Seoul, Walking-together, Jeonju, Seongnam, Suwon, Youngin, Cheongju, Siheung, Allbarun, Sallim, Mapo, and Happy-village health cooperatives. The number of KHCF family members reached 30,000 in 2012 and is rapidly increasing. Of them, four major cooperatives (Anseong, Daejeon, Ansan, and Incheon) represent 75% of the movement's total output. (They also have 75% of the total membership.) It is noteworthy that the establishment of all these organizations relied upon the involvement of civil society groups, such as consumer cooperatives, credit union affiliated groups, community and local residents groups, religious groups, associations advocating citizen's rights to health or serving the disabled, etc.[15]

Table 1: Health Cooperative Data

Number of cooperatives	17
Types of cooperative	N/A
Number of members	＞30,000 (2012)
Number of employees	N/A
Users	N/A
Facilities	N/A
Services offered	Primary care (western medicine, oriental medicine), dental care, health promotion Illness/accident prevention Wellness and health promotion
Annual turnover	approx. $88,391,280 USD (90 billion KRW 2010[16])

OTHER COOPERATIVES[17]

RK is a pioneer in the development of social cooperatives in Asia. The development of cooperative provision of social care services got a further boost from the Korean Co-operatives Fundamental Law which came into effect in December 2012. This law recognizes two types of cooperative: general and social. Social cooperatives are non-profit organizations with at least 40% of the business designated for the "public good." That means they need to observe much stricter criteria than general cooperatives. The new law is intended to facilitate community development and social welfare and to activate cooperative development in the public interest sector, such as health cooperatives.

Prior to the enactment of the new law, cooperatives providing social care services were registered under the legal framework of consumer cooperatives and administrated by the Fair Trade Commission (FTC).[18] According to FTC statistics, the number of consumer cooperatives active in the health domain has been steadily increasing, from 108 in 2009 to 225 in 2011, a pace comparable to that of consumer cooperatives active in such domains as local retail and university education.[19] With the new law, many health cooperatives are changing their legal status to that of social cooperatives. In the meantime, consumer cooperatives remain active in fostering health care delivery in local communities. For example, the **Seed Foundation of iCOOP** (a consumer co-operative federation) has organized activities to deliver free medical services to the public, with the collaboration of three local health cooperatives.[20]

Among the 3,944 co-operatives registered under the new law (3,816 as general cooperatives, 128 as social cooperatives), 43 are currently providers of care services for patients, the elderly, and postnatal mothers and children (40 as general cooperatives, 3 as social co-operatives; see Table 2). Of these, 12 are multistakeholder cooperatives (9 general cooperatives, 3 social cooperatives), 24 are producer-owned and 7 user-owned. One is a consumer cooperative and 6 are worker cooperatives. (See Table 3, next page.)

Table 2: Co-ops registered under the 2012 Co-operative Law[21]

	Number of co-ops	Number of social co-ops
All	3,816	128
In "human health and social work activities"	164	21
Co-ops providing care services	40	3

Table 3: Types & Numbers of Other Cooperatives

		# of co-ops	# of founding members[22]
Social cooperatives[23]		3	188
General Cooperatives	Multistakeholder	9	87
	Independent producer	24	208
	Consumer cooperative	1	26
	Worker cooperative	6	94

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[5] Ministry of Health and Welfare 2013:415.
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[7] Kwon 2009:66.
[8] Korean Health Co-operative Federation (KHCF). 2014. "Brief Introduction of Korean Health Co-operatives." Internal document supplied via email.
[9] For example, Lee 2003; KHCF 2014.
[10] KHCF 2014.
[11] Lee 2003:51.
[12] The role played by civic movements has "led to the extension of the different social insurance schemes and above all the introduction in 2000 of the National Basic Livelihood Security System." Bidet, E. 2010. "Social economy and health care in South Korea: The emergence of new actors." Retrieved August 13, 2014 (http://www.inhcc.org/english/data/2010-Health-coops-in-SK.pdf). P. 5.
[13] We express our deep appreciation to the Korea Health Co-operative Federation for supplying a brief introduction to the development of health cooperatives in this sector.
[14] KHCF 2014.
[15] Bidet 2010:6.
[16] Bidet 2010:6.
[17] We would like to express our sincere thanks to Hyungsik EUM (Centre d'Economie Sociale - Université de Liège, Belgium) for providing information on Korean cooperatives which offer social care services.
[18] Regarding the development of general cooperatives in South Korea, the Ministry of Strategy and Finance is in charge of planning frameworks and policies for such cooperatives and oversees their performance.
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[20] iCOOP Korea. 2012. *Ethical Consumerism: A most beautiful practice - iCOOP KOREA 2012 Annual Report*. Retrieved August 14, 2014 (http://www.icoopkorea.coop/en/report.html). P. 5.
[21] As of February 2014. We used two selection processes to analyze the data provided by Hyungsik EUM regarding total registered cooperatives. The first selection, based on industrial classification, identified 185 cooperatives as active in "human health and social work activities." The second selection was made by checking the actual, declared activities of these 185 cooperatives through the portal site for Korean cooperatives (http://www.co-operatives.or.kr). That process identified 42 cooperatives to be providers of social care services.
[22] Only the number of founding members is available in the registration data.
[23] According to the law, "social cooperatives" should be classified as "multistakeholder cooperatives."

RWANDA

2014

HEALTH SYSTEM[1]

The 1994 genocide in Rwanda destroyed much of the socioeconomic fabric of the country as well as its health infrastructure. The health care system is still suffering in the aftermath. Although the health status of the Rwandan population has improved significantly in recent years, it remains inadequate. Training health workers to advanced levels has taken time and has not been rapid enough to meet the needs of the Rwandan population.

In 2000, the Rwandan government adopted a plan, Vision 2020. The key idea was to transition into a middle-income country over the next two decades. The cornerstone of this development was to be health. As Rwanda's Minister of Health, Dr. Agnes Binagwaho, explained, "health is a key pillar of our development" and without improving health, they will never alleviate the country's poverty.[2]

The health system in Rwanda is a decentralized, multi-tiered system. It is composed of the following tiers and associated packages of health services: 18 dispensaries (primary health care, outpatient, referral); 16 prison dispensaries; 34 health posts (outreach activities – immunizations, prenatal care, family planning); 430+ health centres (prevention, primary health care, inpatient, maternity); 39 district hospitals (inpatient and outpatient); and 4 national referral hospitals (specialized inpatient and outpatient). The 4 referral hospitals are: Centre Hospitalier Universitaire de Kigali, Centre Hospitalier Universitaire de Butare, King Faisal Hospital, and the Kanombe Military Hospital.

Population (in thousands): 11,458

Population median age (years): 18.05

Population under 15 (%): 43.56

Population over 60 (%): 3.94

Total expenditure on health as a % of Gross Domestic Product: 10.7

General government expenditure on health as a % of total government expenditure: 22.1

Private expenditure on health as a % of total expenditure: 42.7

Rwanda's health system is financed both by state funds and by individuals' contributions through health insurance and direct fees for services. Health insurance is provided through a variety of programmes. The largest is the Community-Based Health Insurance Scheme which is primarily comprised of the social health insurance programme Mutuelles de Santé. Members pay annual premiums of approximately $6 USD per family member (increased in 2011 from $2 USD per person) with a 10% service fee paid for each visit to a health centre or hospital.

Membership is voluntary and payment of premiums is based on economic status. The program was first introduced in 2004. By 2010, 91% of the Rwanda population was insured through Mutuelles de Santé. Rwandans can access health care at all public and non-profit health centres in Rwanda. The Mutuelles de Santé member's package does not include coverage at private health centres, however.

Rwanda's experience illustrates the value of universal health insurance. In the view of Peter Drobac, the director in Rwanda for Boston-based Partners in Health, "Its health gains in the last decade are among the most dramatic the world has seen in the last 50 years."[3]

MUTUAL HEALTH ORGANIZATIONS

With Law No. 62/2007 of December 30, 2007, membership in a health insurance plan is mandatory for every Rwandan citizen.[4] Rwanda has pioneered major programmatic, organizational, and health financing reforms aimed at improving the quality of care and, ultimately, the health status of the population with a particular focus on its most vulnerable segments. From only one initiative in 1998, these schemes have expanded to cover virtually the entire country. MHO schemes are part of the national programme for the promotion of access to health care.

MHOs in Rwanda are autonomous organizations, administered freely by their members. MHOs determine their benefit packages, annual premiums, and periodicity of the subscriptions. They establish conventions on care and health services, service providers, and reimbursement modalities, according to the terms of the contract. In addition, they sensitize the population and ensure the recruitment as well as development of customer loyalty among members. MHOs ensure the day-to-day management of the resources they collect and maintain transparency and traceability in their various bank and cash operations.[5]

Following the reintroduction of the policy for health care payment in 1996, multiple pilot initiatives for the implementation of MHOs have been undertaken. In 2004, with the adoption of the "Policy for the Development of Mutual Health Organizations in Rwanda," the government reiterated the importance of the MHO funding mechanism in order to generalize and to improve financial access to health care.

After the pilot implementations, MHOs were adapted to fit within the decentralization model that was being developed in Rwanda, specifically involving the Ministry of Decentralization and Local Affairs (MoDLA) and its agencies. This adaptation anchored them in the community and facilitated the mobilization of local authorities in the various administrative districts and district subdivisions. This involvement also resulted in the involvement of non-governmental organizations (NGOs) and religious leaders, which raised the population's awareness of the importance of enrolling in MHOs. Leadership at the central level was also mobilized to ensure the backing of the highest authorities in government.

In mid-2006, benefit packages were expanded, and coverage for the indigent, vulnerable groups and for people living with HIV was institutionalized by the government and foreign partners. The benefit packages now cover primary health care, secondary care, and tertiary care, which dramatically improved the price-quality ratio for MHO services.

Recognizing the potential problems involved in small risk pools, Rwanda established a National Guarantee Fund (FNG) and a District Solidarity Fund (FSD) to bolster financing mechanisms for MHOs. The FNG/FSD system[6] harmonizes MHO benefits with those received by the beneficiaries of other social health insurance systems and by providing care for indigents.

The percentage of the population contributing to MHOs continues to increase. At the end of 2008, national coverage was estimated at 85%. Another 6% of the Rwandan population was estimated to be covered by other mandatory insurance schemes, such as the RAMA, MMI, or other private insurance plans.

Summary of Health Financing Methods[7]

Method	Formal public sector	Formal private sector	Poor	Informal urban	Informal rural/farmers
Prepayment	RAMA and MMI	MHO or RAMA	MHO (*Mutuelles*) schemes		
Coverage (number of citizens)	297,000 (2006)	7.6 million (2008)			
Coverage (% of population)	3.3	85			
Source of revenue	RAMA: 15% (shared equally); MMI: 22.5% (17.5% government)	Member contribution of $7.60 USD per year for up to seven per family, plus contributions from government and donors for those who cannot afford this amount			
Revenue collection	Payroll deduction	Collected by MHOs			
Number of risk pools	One each for RAMA and MMI	One per district (approximately 392), but a National Guarantee Fund and District Solidarity Fund have been created to provide equalization and reinsurance support			
Payment methods	Fee-for-service	Some capitation and fee-for-service; output-based payment methods have been also implemented for some services			
Benefit package	Full range of services	Preventive and curative services, prenatal care, delivery care, laboratory exams, drugs on the MoH essential drug list, ambulance transport to hospital, limited district hospital services			
Facility coverage	Own facilities plus contracts with public/FBO	Contracts with district health centre and surrounding hospitals; recent changes have allowed subscribers to obtain service at any health facility			
Regulatory	RAMA/MHI Boards oversight	MHOs that are non-profit, self-administered organizations; policy direction from MoH			

CASE STUDY

The **Public Health Building Program** (PHP), funded by the Swiss Agency for Development and Cooperation-Switzerland, began in Rwanda in August 2002. To date five phases of intervention have been completed. The areas covered by the programme include the districts of Karongi and Rutsiro in the country's Western Province. The population of the project area was estimated in 2010 at 617,000 inhabitants, served by 41 health centres.

One of the interventions of the PHP was to support the establishment of a national policy for health financing by supporting the development of MHOs in the intervention area. The programme has provided direct support to a total of 45 health

facilities partners. Since 2008 in Karongi, and since 2009 in Rutsiro, the PHP has also supported the establishment of a system of grouping 30-50 households into Community Solidarity Associations (Ikimina). In each Ikimina members urge one other to pay MHO premiums. Each Ikimina agrees to use the services of the MHO only when all its members are up-to-date in their dues. This has enabled the District of Karongi to increase population adherence, which now reaches 99%. Plainly, the commitment and solidarity of people in small groups who share the same realities are important when promoting adherence to MHOs.[8]

The utilization of health services in Karongi and Rutsiro (see tables, below) demonstrate the degree to which the population, including the poor, sees the advantage in the use of health services.

Mutual Health Indicators 2005-2009 - District of Karongi[9]

Indicators	2005	2006	2007	2008	2009
Membership rate in MHOs (relative to total population)	58%	87%	74%	85%	99%
Number and % of poor people enjoying free membership cards	-	40,000 21% of total population	59,855 21% of total population	65,178 23% of total population	73,904 23.5% of total population
Rate of utilization of services by the population	-	0.50 contact/ inhabitant	0.52 contact/ inhabitant	0.79 contact/ inhabitant	0.72 contact/ inhabitant

Mutual Health Indicators 2005-2009 - District of Rutsiro

Indicators	2005	2006	2007	2008	2009
Membership rate in MHOs (relative to total population)	8%	94%	75%	87.62%	87%
Number and % of poor people enjoying free membership cards	-	35,000 13% of total population	72,115 27% of total population	67,826 24% of total population	67,826 23.1% of total population
Rate of utilization of services by the population	-	0.43 contact/ inhabitant	0.46 contact/ inhabitant	0.7 contact/ inhabitant	0.69 contact/ inhabitant

CONCLUSION

The experience of Rwanda shows that in a context of political will and opportunities for external funding, it is possible to institutionalize and generalize the approach of MHOs at the national level.

MHOs have proven an effective mechanism for increasing financial access to curative health care and consequently increasing the use of these services. The compulsory nature of public support to MHOs is certainly a way to achieve universal coverage, although it imposes regular health costs on family budgets. That said, it is important to continue to increase the quality of care in order to deal with increasing demand for health care. It also is important to continue to motivate public support for MHOs.

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[6] The FNG is sponsored through contributions from RAMA, MMI, private insurance systems, and foreign partners, including the Global Fund. The FSD is funded by the contributions of MHOs, administrative districts, transfers from the FNG, and contributions from development partners are involved at the district level.

[7] Abbreviations: FBO = Faith-Based Organization; MHI = Medical Health Insurance; MHO = Mutual Health Organization; MMI = Military Medical Insurance; MoH = Ministry of Health; RAMA = Rwanda Health Insurance Company (Rwandaise d'Assurance Maladie). Source: World Bank, Human Development Department Africa Region. 2011. *Making Health Financing Work for Poor People in Tanzania: A Health Financing Policy Note*. Retrieved August 19, 2014 (http://p4h-network.net/wp-content/uploads/2013/10/WB_TanzaniaHealthFinancingPolicyNoteFinal.pdf).

[8] Savadogo et al. 2011.

[9] Savadogo et al. 2011.

SENEGAL

2014

HEALTH SYSTEM

Until 1970, Senegal, like other African countries, experienced economic growth. A health system financed exclusively with public funds was considered a positive legacy of the French colonial period. Then, in the early 1970s, economic decline set in, to which several factors contributed: the oil crises, poor rainfall, low industrialization, and a peanut monoculture. In 1990, foreign debt service reached 66.5% of GDP. The budget for health went in the opposite direction. In 1970 nearly 10% of the national budget was allocated to health, against 5.2% in 1992.

Along with this economic crisis, structural adjustment programmes increased the constraints on the country. The health sector has been hit hard by "political donations." To this must be added a health system that was highly centralized and poorly distributed geographically. All these factors lead to an alienation of health facilities from the population.

It was in 1987 that African health ministers met in Bamako, Mali to adopt a strategy of health system reform. The Bamako Initiative aimed to strengthen community-based primary health care in order to increase access to health for all. It also sought to promote greater resource mobilization, including the adoption of cost recovery (for both consultations and drugs), in order to improve the management of health facilities and to decentralize the public health system.

Population (in thousands): 13,726

Population median age (years): 18.01

Population under 15 (%): 43.54

Population over 60 (%): 4.57

Total expenditure on health as a % of Gross Domestic Product: 5.0

General government expenditure on health as a % of total government expenditure: 9.6

Private expenditure on health as a % of total expenditure: 44.1

In Senegal, the Initiative was accompanied by a drug policy reform that reorganized and decentralized the National Medical Stores. Promoting essential drugs in their "generic" forms became generalized across the country. Alongside these structural reforms to the public health sector, the private sector has been mobilized and has contributed significantly to the improvement of health care delivery, especially in urban areas. The private sector falls into two categories – religious institutions and non-profit – and benefits greatly from external grants and from the for-profit sector.

MUTUAL HEALTH ORGANIZATIONS

Senegalese MHOs have had to carry on despite great legal uncertainty.[1] Since 2011, they have been governed by West African Economic and Monetary Union (WAEMU) Community Regulation.

A recent survey of Senegal's MHOs[2] identified 149 community MHOs and 15 professional MHOs. Nearly half (48%) are located in the regions of Dakar and Thiès, and most of their members (57%) are women. Reportedly, 122 MHOs (74% of the total) benefit from the support of a structure or organization, and 39% have no office. In addition, only 5% offer their members a local health care unit and/or a pharmacy.[3]

Senegal's MHOs are highly flexible organizations which can be readily adapted to the experience, needs, and abilities of their members. MHO contribution systems are generally suitable and affordable in communities. Indeed, microhealth insurance is important to extending health coverage to the maximum number of people. (Lalane Diassap MHO covers more than 80% of the village. See "Case Study.")

Studies show that the ability to pay is not the key factor for success of MHOs. Some manage to offer significant benefits with very low fees. The adjustment of the level of benefits to available resources must be rigorous, however. Other factors essential to MHO performance are the dedication and proximity of managers, so that their integrity and their rigor with respect to mutual principles encourage a like commitment on the part of the population. Again, the Lalane Diassap MHO is a good example of success in this area.

That said, MHOs in Senegal must contend with many operational and institutional weaknesses, quite apart from the aforementioned regulatory transition between Senegalese law and the WAEMU Community Regulation.

Member retention is a serious issue. Losses occur as a result of resignation, suspension, cancellation, or self-exclusion. Other causes are automatic suspension of members for failure to pay their contributions on time, mismanagement, lapses in care in case of illness, and a lack of flexibility, understanding, and real solidarity.

The basic package of services is often inadequate, but so is the collection of contributions: At best, 60% of members are up to date with their contributions. (Aggravating the situation is distrust regarding the use and practical impact of contributions. Popular belief has it that payment of contribution actually invites disease.)

Daily operations suffer for lack of management infrastructure (office, vehicle, records, computers, training, etc.). Essentially, accounting and record keeping are manual. This does not jeopardize MHO viability, but it does hinder their development and efficiency.[4]

Case Study

In Senegal, MHOs are numerous. In Thiès alone, 42 MHOs cover 18,500 families (100,000 beneficiaries) or 10% of the region's total population of 1 million. The GRAIM (Groupe de Recherche et d'Appui aux Initiatives Mutualistes/Research and Support Group for Mutual Initiatives/Enda Graf Sahel) supports the coordination of 40 of these organizations and 25 in the rest of Senegal (as well as six district unions).

Like many village MHOs in Thiès, the **Lalane Diassap MHO** was established in 1994 at the initiative of a village association, the association of young Lalane.[5] It is the current performance benchmark for rural MHOs in Senegal.

Lalane Diassap MHO started its health insurance operations in February 1996. The MHO has 568 members, and covers 2,809 beneficiaries or 82% of the vicinity's total population (1,200). This attests to the credibility, effectiveness, and awareness of the campaigns which the MHO has conducted. In the village of Lalane only two families are not affiliated.

The membership fee is $2.00 USD (1000 FCFA). The contribution, originally set at $.31 USD (150 FCFA), is now double that due to the MHO's extensive service package. The rate of collection of contributions (60% of participants) needs to improve but it is quite high for a rural MHO. The proximity of members is essential to the collection of contributions. Beneficiary documentation, including contribution payments, is in order.

The financial condition of the MHO is satisfactory. The contribution/expenditure ratio is 1.8 in 96 and 1.45 in 974, if one excludes advances on hospital bills which are not MHO expenses. (Taking these advances into account – in which case no refund is payable – the ratio is slightly greater than 1.) Even in the worst case scenario, the MHO can still meet its expenses.

Data on operating costs was not available but they must be close to zero: the MHO has no office, no phone, and managers receive no compensation. However, Lalane Diassap MHO must improve its rate of contribution collection and quickly set up regular evaluation and monitoring procedures. The negotiation of preferential rates with health care providers is also critical, for it allows the MHO to offer significant benefits while taking an acceptable fee.

SOURCES

[1] MHOs in Senegal were to be governed by a law adopted in 2003 (Law n° 2003-14 of June 4, 2003), followed six years later by an implementing decree (Decree n° 2009-423 of April 27, 2009). According to the Law of 2003, an MHO is a non-profit group which proposes (mainly through membership fees) "to exercise foresight, action, solidarity, and of mutual assistance in the interest of the members and their families." A few years later, a draft modification of this legal framework was introduced in 2009, then, in 2011, the entire framework was repealed when Senegal adopted the WAEMU Community Regulation.

[2] The survey was carried out by Hygea consulting firm, at the initiative of the Senegalese Ministry of Health and Medical Prevention in partnership with the University of Montreal. For more details, see: Mané, Jean-Pierre. 2010. "Étude sur les Mutuelles de santé au Sénégal : 43% des membres quittent les structures pour radiation ou suspension." *Senetoile.info*, July 2. Retrieved September 2, 2014 (http://senetoile.info/component/content/article/61-sante/7285-etude-sur-les-mutuelles-de-sante-au-senegal-43-des-membres-quittent-les-structures-pour-radiation-ou-suspension.html).

[3] The survey also indicates that growth in the MHO network has long been slow. The first MHO was created in 1989. The period 1993-1999 saw the creation of 23 new MHOs, and during the years 2000-2008, another 140. Mané 2010.

[4] Institutionally, MHOs are often hampered by isolation from other health authorities. They may lack a contractual relationship with health care providers. Low involvement of MHOs in the definition of health policies, with public health institutions and health committees, or with supporting development organizations are other serious disadvantages. For more information about the strengths and weaknesses of MHOs in Senegal, see: IWPAR. 2014. "Le projet IWPAR." Enda Tiers-Monde. (http://www.iwpar.org/accueil.html).

[5] IWPAR 2014.

SINGAPORE

2014

HEALTH SYSTEM

Population (in thousands): 5,303

Population median age (years): 37.88

Population under 15 (%): 16.48

Population over 60 (%): 15.13

Total expenditure on health as a % of Gross Domestic Product: 4.7

General government expenditure on health as a % of total government expenditure: 11.4

Private expenditure on health as a % of total expenditure: 62.4

Singapore has a universal health care system with multiple layers of protection. This system is generally referred as the "subsidies plus 3M framework." As a first tier of protection, universal health coverage is provided by tax-financed government subsidies available to all citizens in public hospitals and government polyclinics. The 3Ms (Medisave, MediShield, and Medifund) constitute the second, third, and fourth tiers of medical protection to Singaporeans. Medisave is a compulsory individual medical savings account scheme which allows them to pay their share of medical treatment without financial difficulty. MediShield is a catastrophic medical insurance scheme allowing them to effectively risk-pool the financial risks of major illnesses (i.e., it covers hospitalization bills for the treatment of catastrophic illnesses). Medifund is a financial assistance scheme serving as "the ultimate safety net for needy Singaporean patients who cannot afford to pay their medical bills despite heavy subsidies, Medisave and MediShield."[1]

Thus, Singapore has a mixed financing system based on the combined philosophies of individual responsibility and affordable health care for all. A key principle of Singapore's national health scheme is that no medical service is provided free of charge, regardless of the level of subsidy, even within the public health care system.[2] The government subsidizes up to 80% of the bill in public sector hospitals, where 80% of acute care services are provided.[3] As regards primary care services, 80% are provided by private general practitioners and the rest by public polyclinics.[4] Patients visiting the clinics of private general practitioners do not receive subsidies and have to cover the full cost of treatment.[5] As the health care financing system in Singapore is "skewed towards supporting the acute sector .... high levels of out-of-pocket payment are required for primary care."[6] This is regarded as a "major failure of Singapore's healthcare financing system."

Furthermore, a 2010 study[7] revealed that "the increased affluence, higher life expectancy and the ageing of the population have further raised household expenditures on healthcare over time." Like other countries, Singapore faces the challenges of an aging population. By June 2013, 10.5% of Singaporeans were over 65 years old and 16.3% were over 60.[8] According to a report prepared by National University of Singapore, population aging "is producing a new set of policy and political challenges. As the population ages, the national health care spending (both public and private) will increase since older persons consume more health care than the young."[9]

HEALTH COOPERATIVES

Health cooperatives have the potential to address the problem of primary care delivery and increased health care spending. Two health cooperatives were identified in Singapore, NTUC Unity Healthcare Co-operative Ltd (founded in 1992) and the Good Life Co-operative Ltd (2012). Both are user-owned organizations.

NTUC Unity Healthcare Co-operative Ltd is the largest health care co-operative in Singapore. It was set up by the National Trade Union Council (NTUC) about 20 years ago in response to workers' concerns over rising health care costs. Nowadays it aims to empower the community to care for its health and wellness, with the support of its pharmacists, dentists, and other professional staff.[10] It currently operates more than 50 Unity Pharmacies and 15 Unity Denticare clinics nationwide.[11] Moreover, in collaboration with the National Healthcare Group, the cooperative runs a family medicine clinic. Working with three doctors and supported by a team of nurses and allied healthcare professionals, the clinic provides preventive and primary care services to the community.[12] Because the clinic encourages patients to make appointments in advance, patients can expect to have a shorter waiting time in the clinic.

Apart from offering affordable and easily accessible health care products and services to the public, NTUC Unity Healthcare Co-operative works with NTUC Eldercare to provide free health checks to the elderly. It operates self-help health check stations in five NTUC Eldercare Silver ACE centres. The stations provide basic equipment that allows users to check their blood pressure and body mass index. More than 1,200

seniors living in the vicinity of the centres are estimated to benefit from this initiative, which enables them to care for their own health and wellness.[13] Moreover, since many seniors suffer from such chronic diseases as hypertension and diabetes, a group of Unity pharmacists visit five NTUC Eldercare Silver ACE centres on a regular basis to conduct health checks and monitor individuals' health conditions. On top of the health checks, pharmacists spend time to explain the purpose of the medications to prevent harmful drug conflicts. This medication review enables the elderly to stay informed about the various types of medication they consume daily. Finally, every Tuesday, the cooperative provides seniors aged 50 and above with a 5% discount on regular priced items at all Unity pharmacies.[14]

The purpose of establishing **The Good Life** is to provide an alternative type of health care system which focuses not simply on treatment but on prevention. It works by partnering its members' needs with medical professionals and creating suitable programmes.[15] In other words, it offers a network of doctors as medical providers. As one of the benefits, its members can profit from discounts for services and products purchased from affiliated providers. Currently there are 19 affiliated providers working in the private sector. These doctors are specialized in a wide range of fields, such as ENT (ear, nose, throat), dermatology, general surgery, orthopedics, ophthalmology, and endocrinology.[16] Besides, members gain access to information on health care and the health care financing framework, and can get involved through activities like public forums.[17]

SOCIAL COOPERATIVES

In Singapore, six healthcare-related social cooperatives were identified. Together they provide a wide range of services and activities from daycare, elder care, home care (e.g., nursing, home physiotherapy, home dementia care) and travel services to medical or clinical care and active rehabilitation, etc. (See Table 2.)

Table 1: Health Cooperative Data[18]

Number of cooperatives	2
Type of cooperative	User-owned
Number of members	18,518[19]
Number of employees	about 500 (2012)[20]
Dentists and specialists	>100[21]
Users	N/A
Facilities	56 pharmacies, 15 denticare clinics, 1 family medicine clinic
Services offered	Retail pharmacy, wholesale distribution, dental services, medical services, organic food distribution Illness/accident prevention Wellness and health promotion Treatment and cure
Annual turnover	N/A
Revenue sources	Sales of goods (81.6%), dental services (11.2%), others (7.2%)[22]

HEALTH MUTUAL ORGANIZATIONS

In Singapore, there is one cooperative insurance enterprise, NTUC Income, that provides health insurance. It was established in 1970. Nowadays, it provides health, life, and general insurance products and services at affordable rates to two million customers across all segments of society.[23]

PHARMACY COOPERATIVES

In Singapore, NTUC Unity Healthcare Co-operative Ltd. operates 56 cooperative pharmacies, providing both medical and health care products and a comprehensive range of professional services at affordable prices. Those services include advice on drug interaction, chronic disease management, diabetic care, dispensary service, information on travel medication and first aid, medication for minor ailments, and medication review.[24]

Table 2: Social Cooperatives in Singapore[25]

Name (Year)	Type	Member #	User #	Staff #[26]	Services	Other information
NTUC Eldercare Co-operative Ltd (1997)[27]	P	N/A	N/A	N/A	Daycare, home care, basic clinical care, home nursing, home physiotherapy, home dementia care, sheltered home, senior activity centres, active rehabilitation, caregiver training	9 daycare centres, 6 seniors activity centres
Singapore Amalgamated Services Co-operative (SASCO LTD) (1933)[28]	P	N/A	N/A	15	Elder care, daycare, rehabilitation, childcare	A second-level cooperative union with 14 cooperative affiliates
Silver Horizon Travel Co-operative Ltd (2012)[29]	U	117 (2013)	N/A	5	Travel services	
Methodist Co-operative Society Ltd (1995)[30]	U	800[31]	N/A	18	Child care, educational, legal, medical, welfare, recreational, housing, and transport services	

SOURCES

[1] Ministry of Health Singapore. 2014. "Costs and Financing." Webpage. (http://www.moh.gov.sg/content/moh_web/home/costs_and_financing.html). Note that another component of the health care financing framework is called ElderShield, a severe disability insurance scheme. It provides basic financial protection to the elderly in need of long-term care due to severe disabilities.
[2] Wikipedia. 2014. "Healthcare in Singapore." Wikipage. (http://en.wikipedia.org/wiki/Healthcare_in_Singapore).
[3] Ng, T. L. T. 2013. "Enhancing Universal Health Coverage through Public-Private Partnerships in Primary Care: The Case of Community Health Assist Scheme in Singapore." Lee Kuan Yew School of Public Policy, National University of Singapore. (http://www.economistinsights.com/sites/default/files/legacy/ecasia/uploaded-resources/CHAS-Sinagapore.pdf.)
[4] Ng 2013; also see Gill, Alisha. 2013. "Healthcare Financing: How should Singapore's Ministry of Health shift costs from private pockets to the public purse?" Lee Kuan Yew School of Public Policy, National University of Singapore. (http://lkyspp.nus.edu.sg/wp-content/uploads/2013/07/csu_healthcare-financing-final_2207.pdf). P. 3.
[5] Tan, N.C. 2014. "PAIR UP for primary care excellence: Perspectives from a primary healthcare provider in Singapore." *Singapore Medical Journal* 55(3):110-116.
[6] According to Ng (2013:2), "Singaporeans rely extensively on out-of-pocket payments to finance their healthcare, with at least 50 per cent of total healthcare expenditure being borne by out-of-pocket payments."
[7] Gan, L., and J. Frederick. 2010. "The willingness to spend on health care: evidence from Singapore." *Review of Applied Economics* 6(1-2):13-27. (http://www.lincoln.ac.nz/Documents/Commerce/RAE/2010/2-Lydia%20L%20Gan.pdf).
[8] Department of Statistics Singapore. 2014. *Yearbook of Statistics Singapore 2014*. Department of Statistics, Ministry of Trade and Industry, Republic of Singapore. (http://www.singstat.gov.sg/publications/publications_and_papers/reference/yearbook_2014/yos2014.pdf).
[9] Gill 2013:8.
[10] Unity Healthcare. 2014a. "Vision, Mission, Values." NTUC Health Co-operative Ltd. Webpage. (http://www.ntuchealth.com.sg/unity_healthcare/).
[11] The data is as of the end of 2013. See: Unity Healthcare. 2014b. "Your Caring Partner In Lifelong Health: Unity Healthcare Annual Report 2013." NTUC Health Co-operative Ltd. (http://www.ntuchealth.com.sg/pdf/Unity-Healthcare-AR13-Fullset.pdf). P. 11.
[12] For more information about clinic services, go to: Unity Family Medicine Clinic. 2014. Website. (http://unityfmc.com.sg/services/).
[13] Unity Healthcare. 2014c. "Corporate Social Responsibilities." Webpage. (http://www.ntuchealth.com.sg/unity_healthcare/corporate_social_responsibilities.php).
[14] Unity Healthcare 2014c.
[15] The Good Life. 2014. "Who We Are." The Good Life Co-operative Limited. Webpage. (https://www.thegoodlifecoop.org/index.php/about-us/who-we-are).
[16] The Good Life. 2014. "Doctor Directory." The Good Life Co-operative Limited. Webpage. (https://www.thegoodlifecoop.org/index.php/member/benefits/doctor-directory).
[17] Xinmsn.com. 2014. "Healthcare co-operative to encourage a more hands-on approach." March 28. (http://news.xin.msn.com/en/singapore/healthcare-co-operative-to-encourage-a-more-hands-on-approach-1).
[18] Since the data from the Good Life Health Co-operative is currently unavailable, the data provided here only refers to one cooperative, NTUC Unity Healthcare Co-operative.
[19] Including 11 institutional members and 18,507 individual members (Unity Healthcare 2014b:77).
[20] Microsoft. 2012. "Singapore Health Co-operative Uses the Cloud to Scale with Growth." Microsoft Office 365 Customer Solution Case Study. (http://www.microsoft.com/casestudies/ServeFileResource.aspx?4000031278).
[21] They are dentists and specialists working in 15 Unity Denticare clinics (Unity Healthcare 2014b:12).
[22] Figures are as of the year ending March 31, 2013. Other revenue sources include advertising income, dividend income, government grant, interest income, rental income, and others. (Unity Healthcare 2014b: 64).
[23] NTUC Income. 2014. NTUC Income Insurance Co-Operative Limited. Website. (http://www.income.com.sg/aboutus/index.asp).
[24] For more information, consult: Unity Healthcare. 2014d. "Pharmacy Services." NTUC Health Co-operative Ltd. Webpage. (http://www.ntuchealth.com.sg/services/pharmacy_services.php.)
[25] Note that this table list is not meant to be exhaustive. Organizations were selected from: SNCF Singapore National Co-operative Federation. 2014. "Affiliates." Webpage. (http://www.sncf.org.sg/web/affiliates-directory/affiliate-directory). The following sectors were searched: Health; Aged Care & Welfare Affiliates; NTUC co-operative sector Affiliates; and Service Co-operatives Sector Affiliates. Two more social cooperatives in Singapore are Silver Caregivers Co-operative Ltd and REVERSE Co-operative Ltd. Neither was included in the table owing to a lack of information. The website of Silver Caregivers Co-operative Ltd (http://www.silvercaregivers.org.sg/) is currently not working. Very little figure-based information seems available from the website of REVERSE Co-operative Ltd (http://reverse.org.sg/web/).
[26] Figures obtained for this column all refer to management staff.
[27] NTUC Eldercare. 2014. Website. (http://www.ntuceldercare.org.sg/wps/portal/eldercare/home).
[28] SASCO. 2014. "Formation of the Co-Operative Union (SASCO LTD) in 1933." Singapore Amalgamated Services Co-operative Organisation Limited. Webpage. (http://www.sasco.org.sg/).
[29] Silver Horizon Travel Co-operative Ltd. 2014. Website. (http://silverhorizontravel.com/index.php).
[30] Methodist Co-operative Society Ltd. 2014. Website. (http://www.methodistcoop.org.sg/).
[31] Methodist Co-operative Society Ltd. 2013. "Annual Report 2012-2013." (http://www.methodistcoop.org.sg/Downloads/AnnualReportEnded31July2013.pdf). P. 3.

SOUTH AFRICA[1]

2014

HEALTH SYSTEM[2]

Health care in South Africa varies from the most basic primary health care, offered free by the State, to highly specialized, high-tech health services available in the both the public and private sector.

However, the public sector is stretched and under-resourced in places. While the state contributes about 40% of all health expenditure, the public health sector is under pressure to deliver services to about 80% of the population. The private sector, on the other hand, is run largely on commercial lines and caters to middle- and high-income earners who tend to be members of medical schemes. It also attracts most of the country's health professionals.

This 2-tiered system is inequitable and inaccessible to a large portion of South Africans. Moreover, institutions in the public sector suffer from poor management, underfunding, and deteriorating infrastructure. While access has improved, the quality of health care has fallen. The situation is compounded by public health challenges, including the burden of diseases such as HIV and tuberculosis (TB), and a shortage of key medical personnel.

The South African government is responding to this situation with a far-reaching plan to revitalize and restructure the country's health care system:

- Fast-track the implementation of a National Health Insurance scheme,[3] which eventually will cover all South Africans.
- Strengthen programmes against HIV and TB, non-communicable diseases, as well as injury and violence.
- Improve human resource management at State hospitals and strengthen coordination between the public and private health sector.
- Deploy health teams to communities and schools.
- Regulate costs to make health care affordable to all.
- Increase life expectancy from 56.5 years in 2009 to 58.5 years in 2014.

Population (in thousands): 52,386

Population median age (years): 25.7

Population under 15 (%): 29.53

Population over 60 (%): 8.44

Total expenditure on health as a % of Gross Domestic Product: 8.8

General government expenditure on health as a % of total government expenditure: 12.9

Private expenditure on health as a % of total expenditure: 52.1

TYPES OF HEALTH & SOCIAL CARE COOPERATIVE

Three types of cooperative were identified and studied: 1) Health Cooperative - a cooperative whose business goals are primarily or solely concerned with health care; 2) Social care cooperative - cooperatives whose original and current sole function is to provide social care services to users, i.e., persons in need of that care. 3) Multipurpose Cooperative – which provides both health services and social care services.

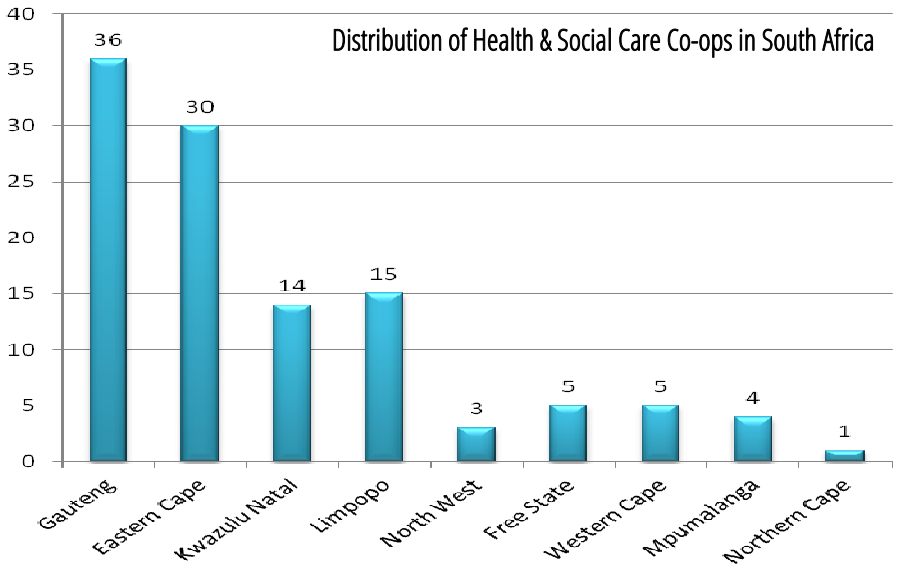
Of these three types, we have identified 113 health cooperatives and social care cooperatives in South Africa. (See Table at right, and the graphic presentation on the next page.)

Distribution of Health & Social Care Co-ops in South Africa

Province	Number of co-ops	% of total
Gauteng	36	31.9
Eastern Cape	30	26.5
Kwazulu Natal	14	12.4
Limpopo	15	13.3
North West	3	2.7
Free State	5	4.4
Western Cape	5	4.4
Mpumalanga	4	3.5
Northern Cape	1	0.9
Total Co-ops	113	100.0

HEALTH COOPERATIVES

At least 70 of the 113 cooperatives identified under this survey are health cooperatives. These cooperatives provide services like illness/accident prevention, wellness and health promotion, and treatment and cure. Within this group, detailed information is available for three cooperatives located in Limpopo. Sources of revenue for these three cooperatives are consultation fees, sales of health products, consortium funding, loans from the land bank, and grants from the Department of Rural Development and Land Reform, etc.



Health Cooperatives (in Limpopo)

Name of cooperative	Type	Number of members	Number of customers	Product/Service	Employees	Annual turnover (2013)
Sedikong Organic Farming	MS	15		Medicinal Plant		$2,813 USD (30,000.00 ZAR)
NTL Baraka Eco Farming & Tourism	MS	6		Medicinal Plant	27	$23,466 USD (250,000 ZAR)
Dibolane Cooperative	MS	18	1,836	Advice and cure	18	$18,773 USD (200,000 ZAR)

Case Study

The **South African Medical Care Co-operative** (SAMCC)[4] was formed after two significant events in 1995.

From 1992 to 1995, various groups across the country organized themselves into Independent Practitioners Associations (IPAs). For the most part these were isolated groups working independently with many functions and much duplication of effort. There was an attempt to create a National Association of IPAs, which included the Orange Free State, Pretoria, the Eastern Transvaal, and parts of the Western Transvaal.

In 1995, Dr. Morgan Chetty, saw the need to unite the existing IPAs. With the sponsorship of Adcock Ingram (a leading South African pharmaceutical manufacturer), and using their infrastructure, Dr. Chetty convened a meeting of some 75 leaders from most parts of the country. At this meeting, a steering committee was formed to discuss the need for a national body.

At a second meeting later that year, a national body was established and Dr. Dennis Dyer and Dr. Morgan Chetty were elected chair and deputy chair. It was decided that SAMCC members would be groups of doctors organized as IPAs. The expertise and resources within these groups would be utilized for the good of the whole group. The integrity and autonomy of each region would be respected.

The organization has developed over the years. In response to changes in the private sector demanding a national solution to health care issues, SAMCC has been more conspicuously branded and its central structure strengthened. The SAMCC is proudly representative of modern South Africa. It is a registered cooperative with a voluntary membership of 3,500 doctors, and is part of a national network of general practitioners which is fully BBBEE (Broad Based Black Economic Empowerment) compliant. Of its members, more than 60% are Historically Disadvantaged Individuals.

It is SAMCC's vision is to be South Africa's premier BBBEE general practitioner organization involved in network management, health care solutions, and investments. Its mission is to deploy all the strategies necessary to create:

- a truly representative national footprint of accredited general practitioners.

- the operational capacity necessary to provide quality, affordable, accessible, appropriate, sustainable health care to as many people in South Africa as possible by engaging stakeholders in both public and private sectors.
- value-adding BBBEE business initiatives.
- better conditions for the health care consumer and general practitioner.

To achieve this vision and mission, SAMCC recognizes three key elements:

- **The Health Care Provider**. As coordinators, general practitioners are the crucial element in containing downstream healthcare costs. SAMCC will work with all interested parties to ensure that GPs are integral to Primary Health Care delivery, to Public Private Partnerships (PPPs), and to private ventures.
- **The Healthcare Consumer**. SAMCC fully supports consumerism in medicine at the level of the patient as well as that of the caregiver.
- **National and Regional Health Care Policy**. SAMCC is fully competent to service government contracts and subscribes to the philosophy of the Health Charter,[5] PPPs, BBBEE, and the Low-Income Medical Scheme.[6]

SOCIAL CARE COOPERATIVES

We found two kinds of social care cooperative in South Africa: Multistakeholder and Producer. They number in total approximately 43. Their fields of activity are services to elderly persons, fitness associated to care and health, massage, home-based care, and assistance to people living with disabling diseases, etc.

SOURCES

[1] A more detailed version of this case is available upon request. For more information on Health cooperatives in South Africa, contact: Ursula Titus, Tessera Development Solutions, Tel: +27 82 7788674 Email: ursula.c.titus@gmail.com Skype: ursula_sa.

[2] The next section has been drawn from SouthAfrica.info. 2014. "Health care in South Africa." Retrieved August 19, 2014 (http://www.southafrica.info/about/health/health.htm#.U_Ov-GNOvoI).

[3] NHI is a 10-point plan to improve service provision and health care delivery. It includes major investments in health facilities (nursing colleges and tertiary hospitals) as well as stricter regulation. The NHI is to be phased in over 14 years, commencing 2012. In 2012/13, the government earmarked $94m USD (1b ZAR) to its pilot projects. (SouthAfrica.info 2014.)

[4] SAMCC South African Medical Care Co-operative. 2014. Website. Retrieved August 19, 2014 (http://www.samcc.co.za/).

[5] In 2005, a Health Charter was drafted for purposes of "improving access to and quality of healthcare in the country, as well as raising black economic empowerment in the sector." See Modisane, Tumelo. 2005. "Charter to improve healthcare." *SouthAfrica.info*, July 12. Retrieved August 27, 2014 (http://www.southafrica.info/about/health/health-charter-120705.htm#.U_4VBmMQM1I).

[6] The Low-Income Medical Scheme (LIMS) was developed to deliver low-cost medical care to employees who previously could not afford coverage. "So far, finding the correct balance between the cost of LIMS for employers and the amount of benefits offered by providers has proven difficult, due mainly to the increasing costs of medical care and the lack of young, healthy employees to balance out the benefits." Oxford Business Group. 2008. *The Report: South Africa 2008*. South Africa Department of Trade and Industry. P. 165.

SPAIN

2014

Barcelona Hospital. Photo: Instalaciones Asistenciales Sanitarias (SCIAS)

HEALTH SYSTEM

The Spanish national health system provides universal coverage, is funded from taxes, and operates predominantly within the public sector. Provision of health care is free of charge with the exception of pharmaceuticals prescribed to people under 65 years of age, which generally require a 40% co-payment. At the end of 2002, health competencies were decentralized to the regional level in recognition of Spain's political system. The 17 regional health ministries are responsible for the organization and delivery of health services within their respective regions. A commission comprising the national level and 17 regional health ministries coordinates health policies. However, their decisions (which must be made by consensus) can only take the form of recommendations.

The cooperative sector is similarly regulated with a national cooperative law and 15 regional laws on cooperatives. At the end of 2013, it numbered 21,257 cooperative societies with the majority (over 60%) providing services, followed by industrial, agriculture, and construction cooperatives.[1]

Both national and regional laws define a significant number of sectors of activity in which cooperatives can be active, including health and social care. The national cooperative law (Ley General de Cooperativas 1999) allows cooperatives to provide health care services and any health-related activity. Health cooperatives (cooperativas

Population (in thousands): 46,755

Population median age (years): 40.99

Population under 15 (%): 15.2

Population over 60 (%): 22.86

Total expenditure on health as a % of Gross Domestic Product: 9.6

General government expenditure on health as a % of total government expenditure: 15.0

Private expenditure on health as a % of total expenditure: 26.4

sanitarias) can take the following forms: worker cooperatives (cooperatives of health professionals); consumer cooperatives (users, and includes the provision of insurance through companies owned by cooperatives); integrated cooperatives (users and producers in a cooperative with multiple activities); and health service cooperatives.[2] Regional laws also provide for cooperatives to be active in the provision of health and social care and are generally more specific regarding the form or activity they can undertake.

Numerous cooperatives that provide health and social care exist. The first pharmacy cooperative was established in 1927, the first health cooperative of users and producers in 1974, and the first cooperative of health professionals (doctors) in 1976. Cooperatives today run hospitals and clinics, provide a wide range of medical services, offer home care, run residential facilities to the disabled and elderly, distribute pharmaceuticals, provide ambulance services, and provide health care insurance.

HEALTH COOPERATIVES

Health cooperative development can be traced back to 1934 and the igualatorias, which are considered precursors of modern cooperatives. Families made arrangements with doctors, each paying the same fee (same = "igual") for services which they would receive at no further cost were they to fall ill, i.e., a producer-managed, user-prepaid insurance arrangement. As cooperatives were unable to engage in insurance activities with third parties, these igualatorias were established as limited companies.[3]

Health cooperatives had the most significant development in Catalunya under the leadership of Dr. Josep Espriu and later the Espriu Foundation. Health cooperatives are found in other regions too, however.

Espriu Cooperative Model

In 1957 the Barcelona-based igualatoria Asistencia Sanitaria Colegial was established. Under the leadership of its president, Dr Josep Espriu, it founded and financed the interprovincial igualatorio, **Asistencia Sanatoria Interprovicional S.A. (ASISA)** in 1962, bringing together prepaid health care in 35 municipalities. It was also Dr Espriu that led a large group of colleagues from Asistencia Sanitaria Colegial to establish **Instalaciones Asistenciales Sanitarias (SCIAS)** in 1974. This, the first consumer health cooperative, was a response to the shortage of facilities and to the desire to bring together producers and users to define and manage health care. Today, it counts over 160,000 members and owns the 337-bed Barcelona Hospital.

Cooperatives of health professionals soon followed. In 1977 a group of doctors working with ASISA founded the Madrid-based cooperative, Lavinia Sociedad Cooperativa. In 1978 Asistencia Sanitaria Colegial transferred its shares in ASISA to Lavinia at no cost.[4] Lavinia thus became the sole proprietor of ASISA and combined medical care and insurance. Lavinia's membership totals over 12,000 health professionals and ASISA gives coverage to more than 1.8 million people.

ASISA's Moncloa Hospital, Madrid

The worker cooperative Autogestió Sanitària was founded in 1978 by a group of doctors from Asistencia Sanitaria Colegial who also made up the majority of shareholders of an insurance company, Assistència Sanitaría S.A. Autogestió Sanitària is a service cooperative. Its 5,500 health professionals provide both medical and insurance services to more than 200,000 policyholders. It is important to note that, by law, it may not offer insurance to consumers directly; Autogestió Sanitària therefore provides insurance through Assistència Sanitaría.

These four entities form the cooperative network of the Espriu Foundation. They have a total membership of 179,437, including 17,835 medical professionals. (Note: the number of attending physicians exceeds 31,500.) They provide health services to approximately two million people through 14 hospitals, 13 dental clinics, 48 medical centres, and 110 medical offices. They also run three hospitals in collaboration with the government. Care of private patients represents 54% of their portfolio. Their combined turnover in 2012 was $1.825 billion USD (1.366 billion EUR).[5]

Other Initiatives

There are however other worker cooperative initiatives, notably Cooperativa Sanitaria de Galicia (COSAGA) and CES Clinicas in Madrid.

COSAGA was established in 1985 by a group of health professionals who were convinced that the best way to provide quality service to their patients was to work as a team. Under the

value proposition "Team Medicine," the cooperative takes a human approach, focusing on the patients, their families, and their needs with professionalism, honesty, integrity, and respect. It seeks efficiency and excellence through participation and innovation while reinvesting its surplus to improve service delivery. It also cares for the community in which it operates. With 12 members and 120 employees, it offers services through four clinics[6] for ambulatory and non-ambulatory surgery, a non-surgical intensive care unit, and emergency services. Most of its users are people covered by SERGAS, the publicly-funded health care system of Galicia. Considered one of the best medical centres in the region of Ourense, COSAGA was the first medical centre in Galicia to obtain the 300+ level Seal of Excellence from the European Foundation for Quality Management.[7]

CES Clinicas was founded in 1980 by a group of dentists as a worker cooperative. It provides a wide range of dental care and more recently has added women's health services (gynaecology). Its membership has reached 80 health professionals who care for over 80,000 patients in its five clinics.

During a recent debate over the privatization of the health system in the autonomous region of Madrid, the proposal was made, based on the Catalunya experience, to convert 10% of clinics into health cooperatives. In April 2014, however, the government reversed its decision to privatize the health system.

Health Cooperative Data[8]

	Espriu Foundation	CES Clinicas[9]	Cooperativa Sanitaria de Galicia (COSAGA)[10]
Number of cooperatives	2 cooperatives and 2 cooperative groups	1	1
Types of cooperative	User and Producer	Producer	Producer
Number of members	179,437	<80	12
Number of employees	33,338	N/A	120 (including 54 doctors, 19 nurses, 22 auxiliary nurses, 3 pharmacists)
Users	2,000,000	80,000	
Facilities	14 hospitals, 13 dental clinics, 48 medical centres, 110 medical offices. Also runs 3 hospitals in collaboration with the government	5 clinics	4 clinics
Services		Orthodontia, gynecology	General medicine, internal medicine, general surgery, traumatology; vascular, neuro, maxilla-facial and plastic surgery; cardiology, otolaryngology, pediatrics, anesthesiology, oncology, gastroenterology, urology, psychiatry, endocrinology, dermatology, allergology, physiotherapy, imaging, ophthalmology, clinical analysis, pneumology, sleep medicine, hematology, and rehabilitation.
Annual turnover	$1.825 billion USD	N/A	$10.4 million USD

Case Study[11]

The **Espriu Foundation** is a private non-profit umbrella organization, established February 17, 1989 to promote, disseminate, and develop comprehensive, cooperative health care. The Espriu Foundation brings together institutions in Spain that apply the health cooperative model created by Dr. Josep Espriu. The model envisions a health service provision system based on cohesive and shared management and a social concept of health care whose focus is the welfare of the patient, not the pursuit of profit.

The Foundation monitors, promotes, and defends the health cooperative movement and has established a knowledge platform to improve health protection systems. It engages in representation at the national and international level, undertakes research, and provides health cooperative management and training.

The cooperative network of Espriu Foundation employs 33,338 people and provides health services to approximately two million users. The cooperatives have a total membership of 179,437 of whom 17,835 are medical professionals and the rest are users. Its income is derived primarily through premiums paid by health care users. Its turnover in 2012 was $1.825 billion USD. According to the World Cooperative Monitor 2013, this makes

it the third largest health cooperative network in the world in terms of turnover.

The Espriu Foundation network has 14 clinics and hospitals, 13 dental clinics, 48 medical centres, and 110 service offices. It also runs three hospitals in collaboration with the government.

The Espriu cooperatives provide all kinds of medical services in all medical specializations, excluding those that, under Spanish law, must be provided through the national health system.

The development and success of cooperatives within the Espriu Foundation are the result of two important factors: collaboration with the national health system and shared management between physicians and users.

Collaboration with the national health system (i.e., with government) takes two forms. The first is an agreement to deliver health services to public civil servants. Through an agreement with the Civil Service Mutual Association, ASISA provides health care coverage for employees of various national public administrations. Approximately 900,000 people are thus covered, accounting for 49% of ASISA's portfolio. The second form is the management of some health facilities belonging to the national health system. This has led to cost savings for the national health system and to higher satisfaction among users.

Shared management between producers and users – physicians and patients – is also at the heart of the success and performance. A transparent governance system balances the interests of health professionals and users, so the cooperative can guarantee the health professional the freedom to provide the patient with the best possible care.

PHARMACY COOPERATIVES

Cooperatives formed by pharmacists to purchase and distribute pharmaceuticals are particularly strong in Spain. A 2011 World Health Organization report on Spain noted, "The drugs distribution system is organized mainly by wholesalers (who distribute roughly 85% of all medicines), chiefly made up of pharmacy cooperatives, accounting for 75% of total sales, the remaining 25% corresponding mainly to purchase by hospitals."[12]

The first pharmacy cooperative, **Federació Farmacèutica**, was established in 1927 with the objective of providing distribution and credit services to its members. Today, pharmacy cooperatives provide a wide range of services to members, including bulk purchasing, warehousing, distribution, credit, software for ordering and managing inventory, marketing services, and training. They bring together 19,000 of Spain's 22,500 pharmacies into the 32 pharmacy cooperatives of the Association of Cooperative Pharmacies (Asociación de Cooperativas Farmacéuticas, ACOFARMA).[13]

The importance of pharmacy cooperatives as distributors is apparent in their substantial market shares. (See tables, below.)[14] COFARES, the largest distributor (23.51% of the market in 2013), has a membership of 9,723 pharmacies, a turnover of $3.389 billion USD (2.535 billion EURO) and employs 2,006 persons.[15]

Rank	Enterprise	2013 Market Share %
1	COFARES	23.51
2	Farmanova Group[a]	13.67
3	Hefame & Centro Farmacéutico Valenciano	12.70
4	Alliance Health care	11.65
5	UNNEFAR Group	9.2[16]
6	CECOFAR Group	8.52
7	FARUN+[b]	7.20
8	Federació Farmacèutica	5.72

[a]: 9 member cooperatives [b]: 6 member cooperatives

Pharmacy Cooperative Data (2013)[17]

Number of cooperatives	32
Types of cooperative	Purchasing and distribution
Number of members	19,000+ pharmacies
Annual turnover	$4.859 billion USD (3.635 billion EUR) COFARES and Farmanova Group only

SOCIAL COOPERATIVES

As with health cooperatives, cooperative legislation defining social cooperatives exists at the national level and in 15 of the 17 autonomous regions. These laws define the forms (generally consumer or worker cooperatives) and activities of what are variously defined as social interest, social integration, social initiative, social service, or public interest cooperatives. The Spanish Confederation of Workers' Cooperatives (Confederación Española de Cooperativas de Trabajo Asociado, COCETA) provides a summary of the laws and their contents in 2010 publication, *Cuando se trata de personas, las cooperativas llevan la iniciativa*.[18]

According to COCETA, as of September 30, 2010 there were an estimated 508 worker cooperatives in the social sector, of which 78.5% were found to carry out social care activities. The majority of these worker cooperatives (over 50%) provided home care, followed by those providing senior residential care (25%). However,

there were also cooperatives operating day or night care centres for persons with disabilities and seniors, as well as those providing employment (sheltered work, labour insertion).[19]

The largest social care cooperative in terms of business volume is Claros Sociedad Cooperativa Anduluz, a worker cooperative founded in 2001 through a merger of five existing social care cooperatives in Andalucia. Claros manages and provides a wide range of social care services under contract with a number of public entities. It also owns and operates its own centres. In 2012 it provided home care services to 7,500 persons, managed 14 residential centres for foundations and public entities, operated 3 of its own residential facilities and 2 of its own daycare centres for seniors. With a membership of 44 persons, Claros employs over 4,000 workers and had a turnover of more than $60.15 million USD (45 million EUR) in 2010.[20]

In the Basque country, GSP, a Mondragón Corporación affiliate, manages senior residences, home care services, day centres, community housing, and sheltered housing. It operates 13 senior residences and 12 daycare centres, and 2 assisted living centres.[21]

Consumer cooperatives also provide social care. One recent example is Cooperativa CONVIVIR, a seniors care residential facility. It is a multistakeholder consumer cooperative whose members include persons near retirement or retired, as well as an association and another cooperative. The latter owns the residential facilities and organizes services for elder care. Members having the right to use the facilities, to transmit usage rights to their family, and to select the services which they wish to receive.[22]

Social Cooperative Data 2010

The only data available for social care cooperatives relates to those which take the form of worker cooperatives.

Number of cooperatives	399[23]
Types of cooperative	Producer (worker cooperatives)

MUTUALS

In Spain there are 30 mutuals which play a role in health care provision, particularly with regard to accidents and occupational health.[24] They are financed through contributions to social security and operate their own health centres.

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SWITZERLAND

2014

SOCIAL CARE COOPERATIVES

There are few cooperatives in Switzerland related to the subject of this survey: Two social care cooperatives, four pharmacy cooperatives, and one pharmacy-related cooperative have been found in the course of research.

Coopérative de Soins Infirmiers (CSI) and **IDP Medical** are both social care cooperatives in Switzerland. Coopérative de Soins Infirmiers brings together independent nurses who provide domiciliary care. It is a producer cooperative and is based in Geneva. IDP Medical is a producer cooperative that offers domiciliary care and hospitalization services at home. It has four branches throughout Switzerland and is based in Geneva.

Population (in thousands): 7,997

Population median age (years): 41.85

Population under 15 (%): 14.79

Population over 60 (%): 23.25

Total expenditure on health as a % of Gross Domestic Product: 11.3

General government expenditure on health as a % of total government expenditure: 20.6

Private expenditure on health as a % of total expenditure: 38.3

SOCIAL CARE COOPERATIVES DATA

Number of cooperatives	2
Types of cooperative	Producer
Number of members	Over 317
Number of employees	N/A
Users	Over 1,470
Facilities	N/A
Services offered	Illness prevention; Wellness and health promotion; Treatment and cure; Rehabilitation
Annual turnover	N/A

COOPERATIVE PHARMACIES

Four cooperative pharmacies were identified in Switzerland: Coop Vitality and Pharmacies Geno (both retailer cooperatives), and two second-level cooperatives, Ofac and Apodata. Coop Vitality is part of the large Coop Société Coopérative Group and counts 55 pharmacies as members throughout Switzerland. Pharmacies Geno is a locally-based cooperative with three pharmacy members. Two-thirds of Switzerland's pharmacies are members of Ofac, which provides them with administrative and IT support. Apodata collects and sells the sales data of its pharmacy members. They numbered 250 in 2005.[1]

PHARMACY COOPERATIVES DATA

Number of cooperatives	4
Types of cooperatives	4 User
Number of members	N/A
Installations	Over 1,338 pharmacies

SOCIAL CARE COOPERATIVES

Name of co-op	Type			Members	Employees				Types of service						Annual turnover
	User	Producer	Multistakeholder		NB	Doctors	Nurses	Other health prof	Others	Illness & accident prevention	Wellness & health promotion	Treatment and cure	Rehabilitation		
Coopérative de Soins Infirmiers[2]		X		317	N/A		X			X	X	X	X		N/A
IDP Medical[3]		X		N/A	N/A		X	X	X	X	X	X	X		N/A

PHARMACY COOPERATIVES

Name of cooperative	Type			Members	Annual turnover	Field of activity
	User	Producer	Multistake holder			
Coop Vitality/ Coop Société Coopérative[4]	X			2,537,859 members (Coop Société Coopérative)	$35,636,400 USD (26,967,000 EUR)	Coop Vitality has 55 pharmacies in Switzerland and is part of one of the country's largest retailer cooperatives, Coop Société Coopérative. It employs 650 people.
Pharmacies Geno[5]	X			N/A	N/A	Pharmacies Geno count 3 pharmacies based in Bienne and Lengnau.
Second-level cooperatives						
Ofac[6]	X			Over 1,280 pharmacies (2/3 of all pharmacies in Switzerland)	N/A	Ofac provides Swiss pharmacies administrative and financial services (e.g., billing, IT support).
Apodata[7]	X			N/A	N/A	Apodata is a pharmacist cooperative. It collects and sells its members' sales data.

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TURKEY

2014

PHARMACY COOPERATIVES[1]

In Turkey, pharmacy cooperatives are well developed. Pharmacy constitutes the unique activity of cooperatives within the health and social care sectors. In the late 1970s, a time when economic conditions became very serious, Turkish drug supplies were heavily dependent on overseas sources. Commercial wholesalers acted arbitrarily, and put pharmacists at risk of having to close their places of business. To safeguard their pharmacies, some of them organized themselves as cooperatives.

Nowadays, the **Association of All Pharmacists Cooperatives (TEKB)**, founded in 1989, is the meta-association of the country's pharmacist cooperatives. TEKB aims at tracking and responding to all events and developments in the global and Turkish industry. It takes actions which encourage the development of cooperatives and their membership bases. It also implements projects and programmes in the realm of pharmaceuticals and pharmaceutics, thus providing the pharmaceutical and health industries with new products and services.

Under TEKB, five wholesaler pharmacist cooperatives serve 13,000 pharmacies across the country: Bursa Pharma.Coop. (1979), Çekoop Pharma. Coop. (2010), Edak Pharma. Coop. (1979), Güney Pharma. Coop. (1989), and Istanbul Pharma. Coop. (1989).

TEKB has designed three main services:

- **The Farmaofis Service** involves products to meet the office supply and equipment needs of the TEKB and its member pharmacy cooperatives. Thanks to this service pharmacies can readily secure office materials to facilitate their operations and to relieve their busy agendas.
- **Farmavizyon** - TEKB organizes a pharmaceutical fair every year in order to help pharmacists to keep up with events and developments in the global as well as in the Turkish pharmaceutical industry. In this venue, they can examine new products, projects, and activities regarding all aspects of the industry, and contribute to the development of cooperative membership bases. The Farmavizyon Pharmaceutical Fair aims to convene participants who share the ethical values of the health industry and are committed to introducing them to colleagues. In addition to pharmacist cooperatives, the trade fair is supported by other pharmacist organizations and the Chambers of Pharmacists (the professional pharmacist associations).
- **Farmayakıt** is a service which offers advantages to TEKB members when they use the fuel products of British Petroleum (BP). It uses the combined the power of pharmacist cooperatives, arising from consumption, to leverage advantages for the members in terms of fuel supplies. In return, BP Taşıtmatik enjoys particular advantages when accessing the services of member pharmacists. Farmayakıt, grounded in a signed agreement between TEKB and BP, is a service available exclusively to the cooperative's member pharmacists.

"We now have a network of 13,000 pharmacies all over Turkey providing jobs to 40,000 people. Our reputation comes from the quality of our service, especially when delivering drugs that are urgently needed," explained Abdullah Özyiğit, the head of TEKB.[2]

Population (in thousands): 73,997

Population median age (years): 29.04

Population under 15 (%): 26.0

Population over 60 (%): 10.56

Total expenditure on health as a % of Gross Domestic Product: 6.3

General government expenditure on health as a % of total government expenditure: 12.8

Private expenditure on health as a % of total expenditure: 26.1

Pharmacy Cooperatives Data

Number of cooperatives	5
Types of service	Providing drugs
Workers	Over 40,000
Facilities	Pharmacies (13,000)
Annual turnover	N/A

The mission of pharmacy cooperatives is:

- To modernize the drug procurement and supply service, which is the primary requirement of the members (the pharmacists).

- To carry out new service projects in line with the mission of and in cooperation with TEKB.
- To provide the members with new services, to increase their efficiency and to generate new resources for reinvestment in the membership.
- To make the cooperative member pharmacies the first choice of end users.
- To allocate the additional resources obtained from projects to realize new service designs in line with technological, financial, organizational, and administrative regulations.

Pharmacist cooperatives are governed by such principles as:

- Equal Participation: Each member/partner has a single vote and equal rights to elect and be elected.
- Transparency and Independent Audit: Pharmacist cooperatives are audited every year by independent audit companies.
- Dividend: The cooperatives distribute the difference between annual income and expenditure as a dividend to the partners according to the proportion of their purchases (as per the Cooperation Law and the Articles of Association).

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UGANDA

2014

HEALTH SYSTEM

In Uganda, health services are provided by the public and private sectors. Each covers about 50% of the reported outputs.[1]

In 1999 a new National Health Policy was inaugurated and to implement it, the first phase of a Health Sector Strategic Plan. This plan put in place a Minimum Health Care Package – 12 health programmes to address the most common or debilitating conditions for which relatively cost-effective interventions are available:

1. Control of communicable diseases (malaria, STD/HIV/AIDS, tuberculosis)
2. Integrated management of childhood illness
3. Sexual and reproductive health and rights
4. Immunization
5. Environmental health
6. Health education and promotion
7. School health
8. Epidemic and disaster prevention, preparedness and response
9. Improving nutrition
10. Interventions against diseases targeted for elimination or eradication (includes polio, guinea worm, and neonatal tetanus)
11. Strengthening mental health services
12. Essential clinical care

Implementing the Minimum Health Care Package requires a responsive health system that provides timely, appropriate, and affordable interventions.

Mama Co-op. Photo: HealthPartners.

Population (in thousands): 36,346

Population median age (years): 15.68

Population under 15 (%): 48.54

Population over 60 (%): 3.72

Total expenditure on health as a % of Gross Domestic Product: 8.0

General government expenditure on health as a % of total government expenditure: 10.2

Private expenditure on health as a % of total expenditure: 76.1

HEALTH COOPERATIVES IN UGANDA[2]

The birth of health cooperatives in Uganda is an interesting example of the power of international inter-cooperation. When dairy producers in Uganda saw the benefits of cooperating to secure veterinary care for their cattle, they began to wonder if the same approach could be used to secure health care for their children. Health care emergencies often place families in very precarious situations, forcing them to sell off assets in order to pay for the costs of care.

The producers talked it over with **Land O'Lakes**,[3] a USA-based dairy cooperative which has been supporting the development of dairy cooperatives in Uganda since 1994. Land O'Lakes reflected on the issue and approached the giant health cooperative **HealthPartners** of Minnesota about the feasibility of setting up health care cooperatives in Uganda using the foundations of existing dairy co-ops. HealthPartners elected to get involved.

In 1997, HealthPartners[4] and Land O'Lakes helped form the Uganda Health Cooperative (UHC). It originally had worked with dairy cooperatives but then expanded to other groups (e.g., coffee and tea cooperatives, microfinance groups, schools) in order to offer affordable, prepaid health care plans to members. UHC would meet with members of these cooperatives and their families to explain the programme and assess their support and readiness to participate.

Once a group was selected, it became the owner of its health care plan and did not need to register it as a separate legal entity. Some positive outcomes have been lower health care costs for members due to preventive care and earlier treatment of diseases, fewer employee absences, regular incomes, and greater savings for health providers.[5]

CASE STUDY

Affordable access to prenatal care, labour and delivery with a skilled health professional, and support within 72 hours of birth is critical to mitigating maternal and child morbidity and mortality. In 2013 the **Mama Co-op** project[6] was launched to enable pregnant women in Uganda's Buhweju district to recognize, demand, and access quality health care through a member-owned and -operated health cooperative:

> "HealthPartners participated in a competition for the most innovative ideas to Save Lives at Birth .... Out of over 500 applicants, HealthPartners cooperative development strategy was one of 65 finalists and one of 15 winners! As a result, HealthPartners received a one year US$250,000 seed grant to make the Mama Co-op a reality that saves lives for women and children in Uganda. HealthPartners International development projects promote cooperative development for all, but the Mama Co-op focuses on the most vulnerable population at the most vulnerable time, women of reproductive age and newborns. Supporting women is a high-yield investment, resulting in stronger economies, more vibrant civil societies, healthier communities and greater stability."[7]

The Mama Co-op project is based on the model of a HealthPartners Cooperative in another district of southwest Uganda. The project addresses the quality, accountability, and accessibility of health care through the development of a community-owned health co-op that will serve at least 900 pregnant women and newborns (6,000 people in total).

Mothers in rural areas face two challenges: 1) lack of access to accurate information on healthy preventive and treatment-seeking behaviours; and 2) lack of access to quality health services. The absence of demand for health services is due to a lack of financial resources, cultural beliefs, and practices that discourage seeking care. The care which is available is often poor in quality. HealthPartners supports the efforts of local stakeholders to overcome these challenges sustainably, by building their capacity to start and manage their own health cooperative.

HealthPartners' scalable co-op model is designed for resource-poor settings with roles and responsibilities filled by local stakeholders, especially pregnant women, women of reproductive age, and the poor. A member-elected board of directors approves benefit packages selected by groups. Factors ranging from low administrative costs to inclusion of large family sizes are key to health insurance plans driven by local stakeholders. Members pay inexpensive quarterly premiums and co-payments at the time of health care service. The board also supports negotiations with providers for annual Memorandums of Understanding (MOU). Premiums and membership lists are turned over to group leaders who deliver them directly to the provider. Volunteer Village Health Teams, trained by the Ministry of Health, sensitize the community (employers, other co-ops, women's groups, burial societies, etc.) to encourage preventive and treatment-seeking behaviours and to recommend health co-op membership. In exchange the volunteers receive discounted co-op membership rates.

Health care providers participate in the co-op model, too. Member premiums secure providers a consistent, reliable source of revenue, enabling them in turn to recruit and retain quality staff and keep a stock of supplies and drugs. The health co-op increases members' ability to seek treatment early. This reduces treatment costs for providers and improves health outcomes. If the provider does not administer services at the level of quality specified in the MOU, members are free to select a different provider. This motivates providers to give the best care possible. They employ data entrants to check member identification cards and current member lists before delivering services and to track premiums and treatment costs.

Health insurance schemes already exist in Uganda. The problem with most donor-funded health insurance models is their lack of sustainability. Implementers use donor dollars to reinsure providers, subsidize premiums, or introduce technology. Beneficiaries eagerly embrace these options and donors are pleased with the results. But when these projects conclude, beneficiaries cannot afford to pay premiums and have not developed the skills to maintain or update the technology.

Unsustainable projects such as these can create dependency that is a disservice to beneficiaries and donors. The sustainability of the HealthPartners model is its most critical innovation. Through a member-owned and -operated health co-op, members continue to receive quality health care and providers continue to profit even after the project has ended.

The Mama Co-op project is very new. As yet there is insufficient data on which to base a discussion of its progress, activities, etc.

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[1] Much of the information for this case originates in the following study: Republic of Uganda, Ministry of Health. 2010. "The Second National Health Policy: Promoting People's Health to Enhance Socio-Economic Development." Kampala. (http://www.usaid.gov/sites/default/files/documents/1860/National_Health_Policy_July_2010.pdf).

[2] See the book which has been released on this project: Halvorson, George C. 2007. *Health Care Co-Ops in Uganda: Effectively Launching Micro Health Groups in African Villages*. Oakland, CA: Permanente Press.

[3] "Since 1981, Land O'Lakes International Development has applied an integrated approach to international economic development that capitalizes on our company's 90 years as a leading farm-to-market agribusiness. We use our practical experience and in-depth knowledge to facilitate *market-driven business solutions* that generate economic growth, improve health and nutrition, and alleviate poverty." Quoted from: Land O'Lakes Inc. 2014. "Innovative Solutions for Global Prosperity." Webpage. (http://www.idd.landolakes.com/).

[4] HealthPartners is an independent, private, member-owned and democratically-governed business, created with member equity. It has been active in Uganda since 1997 as part of the company's commitment to global social responsibility. (For more information on the HealthPartners family of health care companies, see the United States national case, p. 172.) HealthPartners. 2014. Website. (https://www.healthpartners.com/public/).

[5] For more details, see: Girard, Jean-Pierre, and Geneviève Bussière. 2007. "Health co-ops around the world: Uganda." International Health Co-operative Organisation (IHCO). (http://www.usherbrooke.ca/irecus/fileadmin/sites/irecus/documents/ihco_jeanpierre_girard/coops_world_anglais/uganda_anglais.pdf).

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UNITED KINGDOM[1]

2014

HEALTH SYSTEM

Health care in the United Kingdom is a devolved system, meaning that England, Northern Ireland, Scotland, and Wales have their own systems of publicly-funded health care. Even if there is some variety in these systems, each country provides public health care free of charge to all UK permanent residents. The system has been paid from general taxation since its implementation in the 1940s (based on the Beveridge Report). The private health care sector is smaller than the public one. Over the last years, however, a huge top-down reorganization has altered the way the National Health Service (NHS) in England organizes service. New organizations have been established, like the Clinical Commissioning Groups (CGGs), which oversee the delivery of most of the hospital and community NHS services in the local areas for which they are responsible.

Prior to the establishment of the NHS, health care and social services were provided by a combination of philanthropic organizations, State poor-law institutions, and working class self-help and mutual aid (mainly friendly societies, cooperatives, and trade unions).[2] Friendly societies, the most widespread type of organization, provided mutual insurance and in some cases, medical coverage.

The first cooperatives and trade unions appeared over two centuries ago and often used friendly societies as a legal structure. Their impact on health care provision was minimal, however.

Population (in thousands): 62,783

Population median age (years): 40.07

Population under 15 (%): 17.54

Population over 60 (%): 23.06

Total expenditure on health as a % of Gross Domestic Product: 9.4

General government expenditure on health as a % of total government expenditure: 16.1

Private expenditure on health as a % of total expenditure: 17.5

In the UK, cooperatives do not have a single legal structure. Co-operatives UK, the leading trade association for cooperatives there, defines the cooperative as a form of mutual aid association: "Mutuals are organisations majority owned and controlled by their members on a fair and equitable basis. Co-operatives are part of this family of businesses alongside building societies, mutual insurers, and employee owned businesses. What distinguishes co-operatives is their adherence to a set of internationally agreed [International Co-operative Association, ICA] values and principles]."[3] The recent rise of social business, public service mutuals, and employee-ownership, due to David Cameron's "Big Society" program, and the historic lack of a single legal structure for cooperatives, has contributed to the emergence of a diverse landscape of cooperatives and mutuals in the UK.

Six legal forms have been used to register cooperatives:[4] Society (Co-operative Society or Community Benefit Society), Company Limited by Guarantee (typical form for the non-profit sector), Company Limited by Shares, Community Interest Company Limited by Guarantee, Community Interest Company (CIC) Limited by Shares, or a Limited Liability Partnership. A significant number of health care and social care organizations are registered as Community Interest Companies. This legal form, introduced in 2004, is designed for social businesses. It imposes an asset lock and a requirement to confirm and report upon a community-driven purpose. Membership and representation are not mandatory in a Community Interest Company, but they can be implemented.

In 2012, health and social care cooperatives (including daycare, nurseries, foster care, and other types of social care services not included in this study) represented 1.8% of the total turnover of the cooperative economy and 5.5% of the total number of cooperatives in the UK.[5] Whereas the UK health and social care economy increased by 19.2% 2008-2010, the cooperative health and social care sector slightly decreased over the same period (-0.7%).[6]

HEALTH COOPERATIVES

Health care and social care cooperatives did not emerge in the UK until the second half of the 20th century. Producer-owned cooperatives were the principal organizational form of cooperatives that developed in the 1980s and 1990s. The emergence of health cooperatives was a response to health care reforms and a desire on

the part of general practitioners (GPs) to join together and share their out-of-hours (OOH) duties. (Until 1995, GPs were responsible for providing care to their patients around the clock.) Beginning in 1995, it became increasingly common for OOH GP practices to be based on the model of the worker cooperative.

GP Practices are family doctors who join together to create a practice contracted for its services by the National Health Service. OOH GP Practices provide primary health care services in the evenings and weekends as well other community health care services. They can also offer telephone advice, home visits to patients, and primary care centres with or without walk-in services. By the late 1990s, OOH GP cooperatives had become a popular form of self-organization for doctors, with about 300 organizations across the UK and 30,000 doctors in the early 2000s.[7] However, in 2004 a reform shifted the out-of-hours services away from doctors to Primary Care Trusts that commissioned services locally.[8] With this transfer of service responsibility to diverse providers (including the private sector), GP cooperatives declined. Many physicians opted to relinquish the responsibility of 24-hour care; some GP cooperatives found themselves underpriced by the private sector.[9]

This new context led to a transformation of the sector: some GP cooperatives remained or joined other cooperatives to create bigger entities (e.g., Local Care Direct, which formed from the merger of seven GP cooperatives in 2004).[10] Other GP cooperatives expanded to include a wider range of provision. The majority either disappeared or consolidated. Social enterprises specializing in OOH services and other community health services emerged as well.[11]

A social enterprise is an organization with social aims which reinvests its financial surplus in the enterprise. Some social enterprises in the health care sector follow the membership and governance model of cooperatives, and for this reason were included in this survey. The recent rise of social enterprises in the health care sector is due mainly to the NHS' reform agenda to use the private and third sectors to deliver public services.[12]

One interesting initiative promoted by the NHS in 2010 gave Primary Care Trust staff the option to set up social enterprises and favour community-based approaches to health care. This initiative (presented through the programme "The Right to Request") was a way to encourage staff creativity and local community responsibility.[13] It enabled NHS staff to create mutuals and spin out of the public sector. The government's support of independent, employee-owned enterprises led to a rapid expansion of public service mutuals which follow some of the principles of cooperativism (e.g., user/producer ownership, reinvestment of surplus).

This study identified 20 health cooperatives in the UK. A majority are member-based and -governed social enterprises or non-profits and put a strong emphasis on the role of the members in governance. Eleven of these organizations are producer-based cooperatives (either individual workers or GP practices are members) while nine are based on multistakeholder memberships (e.g., workers, GP practices, users, other local organizations).

The cooperatives provide and combine a diversity of health and social care services: out-of-hours services, emergency care, primary care, minor surgery, dental care, NHS 111 service,[14] and preventive primary care (vaccinations, prenatal care, weight loss, tobacco use, etc.). Nine organizations provide out-of-hours services along with other medical care.[15] Some cooperatives possess their own facilities, like primary care centres, GP-led centres, and walk-in centres (which do not require appointments). One cooperative operates a wholesale pharmacy business.

With 187,000 to 1,500,000 potential users in their respective areas, the cooperatives included in this study vary greatly in size. The oldest organizations are also the largest: usually GP cooperatives that expanded and consolidated into broader social enterprises after 2004. Some of these organizations are public health mutuals or former NHS Primary Care Trusts, like Central Surrey Health and SeQUol.

Health Cooperative Data

Number of cooperatives	20
Types of cooperative	Producer (11) Multistakeholder (9)
Number of members	Over 3,320 members, according to the data collected for 10 out of 19 cooperatives
Number of employees	About 6,280 employees, according to the date collected for 11 out of 19 cooperatives
Users	About 9,484,652 potential users, according to the data collected for 16 out of 19 cooperatives
Facilities	27 Primary Care Centres, 3 walk-in centres, 6 GP-led Practices, 4 community hospitals, 1 pharmacy, according to the data collected for 16 out of 19 cooperatives
Services offered	Illness prevention Wellness and health promotion Treatment and cure Rehabilitation
Annual turnover	About $330,579,000 USD (198,010,914 GBP) according to the data collected for 16 out of 19 cooperatives

Case Study

The mission of **Willow Bank Partnership CIC** is "to promote and improve for the public benefit the health, life-chances and economic and social well-being of people living and working in areas where the Company operates." Its main activity is the delivery of health care services in the community, delivering care which addresses the determinants of health, often in partnerships with other organizations which share Willow Bank's values and social purpose.

Willow Bank was formed in 2006 in response to the Department of Health's Social Enterprise Pathfinder initiative. At that time the team were employed by the NHS to deliver primary care services to vulnerable people: the homeless, substance misusers, and others who had difficulty engaging with traditional GP practices, for example. Under the Pathfinder scheme, the staff, together with two partners, Stoke-on-Trent Gingerbread (a local charity specializing in supporting homeless single parents) and Change Through Partnership (UK) Ltd (former NHS senior managers) formed the social enterprise using cooperative principles. Over 9,000 patients are registered at Willow Bank in 2014 – a significant growth since 2006 when 2,500 patients were using its services.

Willow Bank's governance structure reflects staff and community interests. A majority of board members are staff directors, elected on 2- or 3-year cycles. There is a director position reserved for patients and founding partners. (At the moment the organization is even chaired by a patient.) All profits are reinvested in the organization or to benefit local communities. Unlike other primary care organizations, which usually are established under a for-profit partnership model, all Willow Bank staff are salaried, including the GPs.

Willow Bank invests a good deal of its time in developing partnerships with other organizations, which in turn makes it possible to trial innovative service delivery models. For example, with partners in the community and with the support of the chair, Willow Bank has been the first in the UK to implement a screening and treatment program for South Asian communities at risk of hepatitis C.

Willow Bank recently won a prestigious grant to explore how services can be commissioned to support the efforts of families to achieve better health and social care outcomes. It is one of the highest achieving GP practices in the city of Stoke-on-Trent in terms of health outcomes.

SOCIAL CARE COOPERATIVES

Although social care can also be provided by health cooperatives (e.g., prevention services, palliative care, etc.), some cooperatives specialize in social care and focus on a target population (e.g., the elderly or people with disabilities) or specific services (e.g., alternative therapy, palliative care).

At the beginning of the 1990s, health and social care services in the UK started shifting away from care in large institutions to community-based services.[16] The NHS and Community Care Act, passed in 1990, stated that local authorities were responsible for assessing and providing social care needs for their populations by purchasing services from the independent sector, rather than by providing care themselves.[17] This legalization "diversified the provision of a wide range of social care services from the public sector to the third sector and the private sector,"[18] which led to the creation of a number of social care cooperatives. According to a recent study on care services in the UK, social care cooperatives represent under 1% of the social care market.[19]

Recently, Scotland and Wales and initiated projects and policy changes to support the growth of social care cooperatives. In 2013, a cooperative development programme was set up in Edinburgh to support Scotland's sector of health and social care co-operatives.[20] In Wales, the Social Services and Wellbeing Act was passed in 2014 to promote and support social enterprises, the third sector, and cooperatives.[21]

This study identified 26 social care cooperatives. About half are producer-based. The other half is characterized by multistakeholder membership (staff, users, and their families can become co-op members). They are organized as social enterprises or non-profits. A majority of social care cooperatives provide domiciliary services to seniors and the disabled: health-related assistance, help with domestic chores, shopping, and washing, for instance. Two of them also provide nursing homes. Therapy services (e.g., alternative therapy targeting children) and acupuncture are two other types of service which these cooperatives provide. They range in size from small organizations with less than 10 members to larger cooperatives with 300 or as many as 800 members.

Social Care Cooperatives Data

Number of cooperatives	26
Types of cooperative	Producer (12), Multistakeholder (14)
Number of members	Over 2,347 members[22]
Number of employees	Over 2,022 members[23]
Users	N/A
Facilities	N/A
Services offered	Illness prevention; Wellness and health promotion; Treatment and cure; Rehabilitation
Annual turnover	Over $56 million USD (34 million GBP)[24]

Case Study

Care Plus Group is a social enterprise that provides adult health and social care services for the communities of northeast Lincolnshire, a "densely populated area but geographically isolated."[25] Care Plus offers nursing services, specialist nursing, palliative care, domiciliary care, psychological services, meals on wheels, employability, and other social care services. It was set up in 2011 as a Community Benefit Society (a form of a cooperative business) and employs over 800 staff.[26]

Care Plus is a multistakeholder cooperative, owned by its staff and stakeholders. Every worker has a vote as do community members. It has an innovative governance structure that reflects the culture change that has seen some public organizations, namely mutuals, shift over to the third sector under the "Right to Request" law: "The culture change [...] involves becoming aware that there is not simply an entitlement to an annual pay increase for continuing to do the same job. If the business is to prosper, pay increases need to be based on an element of performance, cost and efficiency savings."[27] Quality care, cost efficiency, growth, governance and leadership, and an engaged workforce are the six strategic goals of the cooperative.

Pat Conaty describes the governance of Care Plus Group in his recent study of social care cooperatives:

> "Care Plus Group has a two-tier board comprising a Council of Governors responsible for the strategy of the mutual and a board of directors responsible for the operations. [The workers] elect eight staff governors. Two further governors are appointed by the local authority, two governors by GPs and three governors by community group members. The board of directors includes four non-executives (one of whom is the chair) and three executive directors including the chief executive of the mutual. The Council of Governors is the body that both appoints and removes the chair of the board and the other non-executive directors as well. A Community Forum recruits members from service users, carers, volunteers and other local health community people."[28]

PHARMACY COOPERATIVES

Social pharmacies, organized as cooperatives, exist in the UK. The four organizations identified in this study are all part of wider retail groups: The Cooperative Group, The Midcounties Co-operatives, East of England Co-operative Society, and Lincolnshire Co-operative. At the time of writing (May 2014), The Cooperative Group is selling its pharmacy branch, The Co-operative Pharmacy (the largest cooperative pharmacy), due to recent poor financial results.

The four pharmacies are user-based cooperatives. Three of them operate on a mid- to large-scale, with 45 to 750 shops in the UK. The fourth cooperative operates on a smaller scale with eight pharmacies. Over 851 pharmacy cooperatives are active throughout the UK. Two of the cooperatives have an online retail website. Two pharmacies offer their customers private consultation rooms.

Pharmacy Cooperatives Data

Number of cooperatives	4
Types of cooperative	User (4)
Number of members	N/A
Users	N/A
Facilities	Over 851 pharmacies
Annual turnover	Over $1.344 billion USD (805 million GBP)[29]

HEALTH MUTUAL ORGANIZATIONS

Six major health insurance mutuals were identified in the UK. Five are registered as mutual friendly societies, and the sixth is registered as an Industrial and Provident Society. They provide complementary health plans and insurance to 5-6 million customers. They also offer a range of products for individuals and businesses: health cash plans, dental insurance, health plans for the elderly, and personal health insurance. The services covered include in-patient and day-patient treatment, out-patient treatment, cancer treatment, private ambulance, home nursing, therapy, or physiotherapy.

Health Mutual Organizations Data

Number of cooperatives	6
Types of insurance	Complementary (6)
Users	5-6 million
Facilities	1 hospital trust
Annual turnover	About $1.012 billion USD (606 million GBP) in 2012

Case Study

Benenden Health is a not-for-profit business with a membership of around 900,000 people across the UK. It offers health care services that complement rather than replace the care offered by the NHS. In 2013, Benenden Health provided more than $105 million USD (63 million GBP) in health care services to its members. Monthly subscriptions cost only $13.67 USD (8.19 GBP) per person, and

members can request a range of health care services and treatments. There are no exclusions for pre-existing medical conditions and no upper age restrictions.

Benenden Health was founded in 1905 by a post office worker, Charles Garland, in order to help post office employees affected by tuberculosis. Almost immediately, 30,000 fellow workers joined the scheme. In 1907 Benenden Hospital was opened in Kent. In May 2014, a $75.13 million USD (45 million GBP) redevelopment of the same hospital was launched. In January 2013 Benenden Health opened up its membership to any UK resident aged over 16. Previously, members of Benenden Health had to be current or former public sector workers, or members of a range of other eligible organizations.

Being a mutual makes Benenden Health a different kind of health care provider: Benenden Health is not a private medical insurer but a not-for-profit health care organization that provides members with health services that are complementary to the NHS. Members are at the center of Benenden Health and can have a say in how the mutual is run. Benenden members elect delegates at the branch level to represent them at the organization's annual conference, at which the Society's major policies must be approved.

Whenever waiting times in the NHS are too long, members can instead request quicker treatment or diagnosis via Benenden Health. As well as serving its members well, this means that Benenden Health is helping to relieve the rising pressure on the NHS.

SOURCES

[1] A more detailed version of this case is available upon request. Thanks go to the following for their collaboration: Marc Bell, Blandine Cassou-Mounat, Pat Conaty, Geraint Day, Mo Girach, Karen Hassell, Ed Mayo, Martin Shaw, Liz Watson, and the UK Health and Social Care Information Center.

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[14] This is a telephone medical counselling service provided on behalf of the NHS.

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[20] Conaty 2014.

[21] Conaty 2014.

[22] According to the data collected for 10 out of 27 cooperatives.

[23] According to the data collected for 7 out of 27 cooperatives.

[24] According to the data collected for 10 out of 27 cooperatives.

[25] Conaty 2014.

[26] Care Plus Group. 2014. "About us". Webpage. Retrieved May 31, 2014 (http://www.careplusgroup.org/pages/about-us).

[27] Conaty 2014.

[28] Conaty 2014.

[29] According to the data that was collected for two out of four cooperatives.

UNITED STATES OF AMERICA[1] 2014

HEALTH SYSTEM

The United States' health system is a cluster of health systems of diverse complexity. Federal, state, and local governments have their defined roles. Responsibility for individual health care issues is decentralized. As a rule, direct health care services including primary, secondary, and tertiary care are primarily provided by thousands of private sector agencies (for-profit or not-for-profit).

Most persons acquire private health insurance coverage through their employers or on their own. There are two major federally-funded health insurance programs: Medicare is health insurance coverage for people 65 and older, or for people under 65 with disabilities; whereas Medicaid is health insurance coverage for low-income people.

According to 2012 data, 15.7% of Americans were covered by Medicare and 16.4% by Medicaid. Close to 30% of African and Hispanic Americans use Medicaid.[2]

Finally, there is a dedicated plan, TRICARE. It is the health care programme for more than 9.6 million active duty service members, National Guard and Reserve members, retirees, their families, survivors, certain former spouses, and others worldwide.[3]

Data from 2012 show that 15% of the population were uninsured, which means up to 45 million persons. There is important variation from state to state: at the bottom there is Massachusetts with 4% of the population uninsured and at the top, Texas with 24%.

There is a growth trend in health care expenses in the USA, the total health expenditure in 2012 being 17.9% of GDP, up from 15.2% in 2004. Public health spending was 46.4% in 2012 and private was 53.6%.

Population (in thousands): 318,000

Population median age (years): 37.3

Population under 15 (%): 19.63

Population over 60 (%): 19.31

Total expenditure on health as a % of Gross Domestic Product: 17.9

General government expenditure on health as a % of total government expenditure: 19.9

Private expenditure on health as a % of total expenditure: 53.6

Cooperatives do not have a uniform status across the United States. The legislation to incorporate cooperatives depends on each state's legislation. Some allow cooperatives to incorporate as cooperatives whereas others require cooperatives to register as nonprofit corporations. Some cooperatives are also "incorporated under other statutes not specific to cooperatives."[4] Throughout the USA, cooperatives are thus registered under a diverse number of legal statutes. In some states, they are also allowed to perform a specific function, such as "purchasing health care for small employers or controlling access to medical marijuana."[5]

Second-level cooperatives, such as purchasing cooperatives (hospitals, independent pharmacies, or business owners), are also a widespread organizational model. They allow their members to "lower costs, improve competitiveness and increase their ability to provide quality services."[6] Again, their legal status depends on each state's legislation.

Interest for cooperatives arose during the recent debate over the Affordable Care Act, also known as "ObamaCare," a project launched by President Obama to insure a greater number of American citizens. As part of the reform and as an alternative to a federal public option, the Affordable Care Act provides for the creation of non-profit, consumer-driven health insurance organizations, called Consumer Operated and Oriented Plans (CO-OPs). The idea behind the creation of CO-OPs was to offer more choice and provide low-cost options to customers, as well as to tackle the lack of competition between health insurance providers in most states.[7]

In 2013, 23 CO-OPs were operating in 23 states and benefiting from federal funding. A $6 billion USD federal fund was set up to support the creation of CO-OPs, but was reduced by law in 2011 to $3.4 billion USD, and in 2013 to $2 billion USD after debates in Congress.[8] Start-up, low-interest loans and grants are available to CO-OPs as funding options. Although CO-OPs must be registered as non-profit corporations, they must be governed by their members, reinvest their surplus revenue in the organization, and have a strong consumer focus. They offer their services through state exchange marketplaces. In an attempt to reach more clients, some of them also sell insurance outside the exchange marketplace.[9] CO-OPs are subject to the same laws and regulations that apply to issuers and must be

licensed as such in the state where they operate. In May 2014, the National Alliance of State Health CO-OPs announced that 400,000 people had enrolled in CO-OPs health plans.[10] However, membership to CO-OPs differs widely from state to state.[11]

CO-OPs represent an innovation in the USA's health care landscape and an attempt to provide coverage to a larger portion of the population. However, they face major challenges: the enrollment rate in some states has not reached the expected level; securing funds is still a challenge for some CO-OPs; the competition with established private insurers could threatened their viability; and, finally, the need to build and retain competent staff who can provide a range of quality services, as well as provide appropriate care, such as preventive services.[12]

HEALTH CARE COOPERATIVES

Health care cooperatives have a long history in the United States: "from the late 19th century to the beginning of the New Deal, various mutual-aid societies were formed to provide medical care."[13] In the early 1930s, as part of the New Deal, health cooperatives were promoted to help families support health costs in rural areas. Cooperatives provided an efficient solution to bring "quality health care with a limited role of the government"[14] to those areas which had limited access to health care. Their numbers mushroomed. The highest numbers were recorded in 1942 with "1,200 cooperatives in 41 states that served more than 650,000 members."[15] Although they were successful in a number of states, health cooperatives were opposed by the American Medical Association which succeeded in forbidding consumer-controlled health plans in 26 states.[16] Most of those cooperatives no longer exist, although some have prospered. Group Health (founded in 1947) and HealthPartners (1957) are today the largest consumer-governed health organizations in the United States. They are recognized as "centers of innovative and high quality health care, with a strong preventive emphasis."[17]

In the 1970s and 1980s, health cooperatives and member-owned non-profits emerged in rural areas and formed health networks. Those organizations provided medical and non-medical services (e.g., human resource-related services) as the numbers of doctors and hospitals dwindled in rural areas.[18] In 1990, out of 30 networks of health care providers (mostly rural hospitals), six were organized as cooperatives.[19] Health care centres can also be found in inner-city neighbourhoods.[20]

Some cooperatives that provide health care are health maintenance organizations (HMOs). HMOs appeared in the 1950s when employers were obliged to finance their workers' health plans.[21] HMOs are owned by users and provide both health insurance and primary and preventive care. HMOs cannot incorporate as cooperatives in many states and have to register under non-profit or mutual insurance law. As a consequence, few HMOs are genuine cooperatives.[22]

In the United States, health care cooperatives include both cooperatives which operate clinics and cooperatives which provide insurance at lower costs. (The latter are identified as "health mutual organizations" in this survey.)

Three health care cooperatives were identified. All are user-based. They operate in both rural and urban areas. Group Health and HealthPartners are the largest and serve over two million members. Group Health operates in Washington State and North Idaho. HealthPartners operates in Minnesota, western Wisconsin, South Dakota, and North Dakota and is able to provide a national network through its partners. Group Health Cooperative of South Central Wisconsin (1974) has over 70,000 members and operates mainly in Wisconsin. The three cooperatives provide health plans as well as a wide range of services: primary care, urgent care, specialized care (e.g., eye care, mental care, dental care), and online care services. Almost half the cooperatives operate in Wisconsin, a state where cooperatives are very widespread.

Two other cooperatives aim at strengthening and facilitating the operations of networks of regional hospitals. Rural Wisconsin Hospital Cooperative (1979) serves 39 hospitals in Wisconsin. The Hospital Cooperative operates in southeast Idaho and west Wyoming and serves 14 hospitals. It combines purchasing services and shared resources.

Health Care Cooperatives Data

Number of cooperatives	3
Types of cooperative	3 User
Number of members	approx. 2,180,000 members
Number of employees	approx. 23,300 employees[23]
Users	Over 2,180,000 users[24]
Facilities	6 hospitals, 75 primary care clinics, 5 medical clinics, 24 urgent care locations, 15 pharmacies, 6 eye care centres, home care, 22 dental locations, online care services, 4 outpatient surgery centres
Services offered	Illness prevention; Wellness and health promotion; Treatment and cure; Rehabilitation
Annual turnover	Above $7,888,359,000 USD

Cooperatives Supporting Regional Health Networks Data

Number of cooperatives	2
Types of cooperative	1 User, 1 Producer
Number of members	53 hospitals
Number of employees	71[25]
Users	10,000[26]
Facilities	53 hospitals
Services offered	Illness prevention; Wellness and health promotion; Treatment and cure; Rehabilitation
Annual turnover	N/A

Case Studies

Group Health (1947) is a consumer-governed, non-profit health organization. It is based in Washington State and northern Idaho. Group Health is one of the oldest and largest health care providers to operate in a cooperative manner in the USA. Although it is not incorporated as a cooperative, it has adopted a cooperative philosophy since its creation.

Members elect a board of eleven trustees, who are all health plan members.[27] The board of trustees hires the chief executive officer and sets the strategy and direction of the organization. It works collaboratively with the physician group practice, deliberately separating management functions from medical decisions, and ensuring consumer oversight. Members further participate with their ability to propose and approve bylaw changes and advisory resolutions. They advise management through grassroots activities, member councils, and interest groups. Volunteer activities also constitute an important part of members' involvement in Group Health's governance (e.g., volunteering at health centres, transporting needy seniors to their medical appointments, or serving as companions in hospices).[28]

Group Health's mission is to "enrich people's lives by improving health" and to provide high-quality and affordable services. Group Health serves more than 600,000 members and generated more than $3.6 billion USD in 2013. It operates 25 primary care clinics, 3 urgent care centres, 4 outpatient surgery centres, and 1 hospital. It works in collaboration with more than 1,000 physicians.

Group Health manages plans for families, individuals, businesses, and federal and state employees. It provides health plans for major USA companies such as The Boeing Company, Comcast Corporation, Macy's, and Microsoft Corporation. Group Health also offers several Medicare plans. Group Health's membership is composed of commercial groups (53%), Washington state employees (15%), Medicare members (14%), individual and family members (14%), and federal employees (9%).[29] Most users are members of Group Health although some non-members can use the services in cases of emergency.

In 1983, Group Health opened a medical research institute, which has published more than 2,400 articles. The institute constitutes a major source of innovation and improvement of Group Health's services and positions the organization as a leading health care provider. Group Health also supports a foundation that funds health care and community-based programmes, like school-based health centres, or programmes for abused women and children.[30] The foundation runs a large immunization programme in the state of Washington to increase childhood immunization rates, which have dropped over the years. The institute and the foundation partner with Group Health on an innovative research programme, Partnership for Innovation, to improve care-based research into patients' needs and the proposals of the medical staff.

The **Rural Wisconsin Health Cooperative (RWHC)** serves as a catalyst for statewide collaboration as a progressive, creative force on behalf of all rural health constituencies. Owned by 39 non-profit, rural, acute, and general medical-surgical hospitals, RWHC's mandate is twofold: advocacy for rural health at the state and federal levels, and shared service development for member hospitals as well as external customers.

Incorporated in 1979 as a member-owned co-op, RWHC has received national recognition as one of the United States' earliest and most successful models for networking among rural hospitals. Programs and services have evolved over time to include shared staffing, quality improvement, patient satisfaction surveys, clinical and managerial educational offerings, financial and HIT (health care information technology) consulting, public- and foundation-based grant initiatives, as well as dozens of collaborative projects amongst its members. RWHC employs 71 people and works and supports more than 10,000 individuals working in rural health organizations throughout Wisconsin and the USA.

The core values of trust, collaboration, creativity, excellence, pride, openness, individual development, productivity, and responsibility continue to define the work of RWHC and its members. Through collaboration, RWHC is able to deliver services that are innovative and reliable, yet affordable for the smaller hospital. These offerings help to improve the quality of the patient experience, improve the health of the local population, and reduce the operating expense of providing care.

SOCIAL CARE COOPERATIVES

Social care cooperatives, mostly home care cooperatives, first appeared at the beginning of the 20th century. In 1970s, producer-owned cooperatives that offered care services to the elderly and disabled expanded. **Cooperative Home Care Associates**, the first worker-owned social care cooperative, was founded in New York in 1985 and is one of the largest and most influential of its kind today. The experience of Cooperative Home Care Associates provided an alternative to traditional care providers, which mainly employed temporary and untrained personnel. In the 1990s, similar cooperatives began to operate throughout the United States to provide home care for the elderly.[31]

"Human services" cooperatives have also emerged as a means to offer mutual support to families caring for individuals with disabilities. Initiated by families and people with disabilities, these cooperatives provide, for example, care services, therapy, professional training, and help finding jobs for disabled individuals. Cooperatives that offer social care services (therapy, home care) are the only ones that were included in this survey.

Twenty-one social care cooperatives were identified. Home care services for the elderly and the disabled, and acupuncture and massages are the types of service these cooperatives provide. Three cooperatives have multistakeholder memberships, 16 cooperatives are producer-based, and two more are user-based. Few data are available on their membership, turnover, and staff, but the data collected shows that the cooperatives differ widely in size. Cooperative Home Care has the largest staff with about 2,000 employees. Staff ranges from two to 500 people in the other cooperatives. Three cooperatives are "human services cooperatives": Arizona Autism United, Freedom Co-op, and Inspire.

There has been a resurgence of interest in "home health care" cooperatives through the growth of the worker cooperative sector in the United States. The HomeCare Coop Foundation, established within the past five years, is an example of the re-emergence of cooperatively based home health care services. The Foundation provides in-home care cooperatives with an array of capacity-building resources to optimize their impact and improve the lives of caregivers and ultimately, their clients. The U.S Federation of Worker Cooperatives supports the development of home care worker cooperatives as well.

2.1. Social Care Cooperatives Data

Number of cooperatives	21
Types of cooperative	2 User, 16 Producer, 3 Multistakeholder
Number of members	N/A
Number of employees	N/A
Facilities	N/A
Services offered	Illness prevention; Wellness and health promotion; Treatment and cure; Rehabilitation
Annual turnover	N/A

Case Studies

The **People's Organization of Community Acupuncture** (POCA) is a rapidly growing cooperative of people involved in the community acupuncture movement: acupuncturists, patients, clinics, and supportive organizations.[32] It is a multistakeholder cooperative and counts 1,684 members. POCA's stakeholders are patients, organizational members, clinic, and acupuncture members. Between 2012 and 2014, the number of its new members almost doubled.

Membership services differ for POCA member groups. Patient members benefit from free birthday treatment, three free referral coupons, a newsletter, and access to a website discussion forum, "POCA TV." Acupuncture and clinic members benefit from all the above as well as additional forum discussion areas with posts on thousands of topics, several wikis, peer mentoring, and a microloan programme. Organizational members have the same benefits as patient members as well as the ability to market products, services, and POCA member discounts for free in the e-Circular.

Member benefits/services grew exponentially in the first three years. They now include a resource-rich website with open-source clinic and business materials plus a free video channel, and free and low-cost CEUs (Continuing Education Units) for practitioners. There is also the option of an affordable community acupuncture school that connects graduates directly with existing community acupuncture jobs and advice for starting and running community acupuncture clinics.

POCA was incorporated in 2011 as the successor organization to the Community Acupuncture Network (CAN). CAN was a non-profit business league for acupuncturists who were using a high-volume, low -cost, group treatment model designed to make acupuncture accessible to people on ordinary incomes. Unfortunately, it did not have a formal role for community acupuncture consumers. POCA's history is short but the year 2014 provided several milestones. The annual survey confirmed that clinics using its model delivered over 900,000 affordable treatments in 2013. POCA counts more than 1,000 patient members, and an acupuncture school is expected to open in the very near future.

Most people do not have insurance that covers acupuncture, especially enough acupuncture to adequately treat chronic conditions. POCA's clinics have enhanced the delivery of acupuncture so that patients are part of the delivery systems clinically and can contribute social capital (volunteering, marketing) and financial capital (membership dues, donations to POCA) towards clinics and the POCA Co-op. This ability to contribute to the systems that deliver the care is linked to another sense of wellness for the individual, for the community to which s/he belongs, and for the clinic community itself. POCA could be described as a non-capitalist franchise owned by patients who need acupuncture and acupuncturists who need jobs.

PHARMACY COOPERATIVES

In the United States, pharmacy cooperatives are mainly second-level cooperatives. In the 1990s, independent pharmacies were facing increasing competition from "chain drugstores, mass merchandisers and supermarkets." To stay in business, they started forming purchasing cooperatives to leverage costs and to compete with larger retail companies. They serve several thousand members.[33]

Five pharmacy cooperatives were identified in this survey, four of which are second-level purchasing cooperatives. The five cooperatives are user-based cooperatives and their consolidated membership represents over 7,385 pharmacies.[34] Compliant Pharmacy Alliance Cooperative (1993), American Pharmacy Cooperative, Inc. (1984), Partners in Pharmacy Cooperative, and Independent Pharmacy Cooperative offer purchasing services to lower the operating costs of pharmacies. Independent Pharmacy Cooperative also supports advocacy efforts. The fifth cooperative, Care Pharmacies Cooperative Inc., is an independent retail chain and counts over 85 members nationwide.

Pharmacy Cooperatives Data

Number of cooperatives	4 second-level purchasing cooperatives and 1 first-level cooperative
Types of cooperatives	5 User
Number of members	N/A
Users	N/A
Facilities	Over 7,385 pharmacies
Annual turnover	N/A

HEALTH MUTUAL ORGANIZATIONS

In the 1970s, many businesses started forming member-owned cooperatives to purchase health insurance for their employees.[35] The cooperative model allowed them to negotiate the best services and rates for their employees instead of paying expensive health insurance costs. In the late 1990s, these cooperatives operated on behalf of about 10 million employees. These purchasing cooperatives are regulated under a specific legal status in many states, such as in Texas and California.[36]

Only two health care cooperatives offering health plans were identified in this study. Both offer supplementary coverage. Farmer's Health Cooperative offers health plans to about 2,600 farmers and agribusinesses in Wisconsin. Group Health Cooperative of Eau Claire (1976) serves 70,000 members in western and central Wisconsin. They are both Health Maintenance Organizations (HMOs).

The Obamacare Consumer Operated and Oriented Plans (CO-OPs) are a new form of health mutual organization. Although they are not registered as cooperatives, they must be governed by their members, reuse their surplus revenue in the organization, and be registered as non-profits. Since most of them were launched fairly recently (2013), it is not yet clear if they all operate under those principles. (For example, one will open its board to members in 2015.[37]) CO-OPs are still evolving and working to find a sustainable business model.

National cooperative leaders in the United States have been engaging with CO-OPs in an effort to better understand their role in the marketplace and explain the differences between them and registered cooperatives to avoid confusion and encourage the application of cooperative principles in their governance.

Health Mutual Organizations Data

Number of cooperatives	25
Types of insurance	25 supplementary
Users	About 477,600
Facilities	N/A
Annual turnover	N/A

SOURCES

[1] A more detailed version of this case is available upon request. Thanks to the following for their collaboration: Liz Bailey, Margaret Bau, Michael Beall,Thomas Bowen, Eric Bowman, Amy Coghenour, Diane Gasaway, Vanessa Hammond, Amy Johson. Dave Johnson, Martin Lowery, Margaret Lund, Jane McNamee, Cris Monteiro, Bruce Reynolds, Lisa Rohleder, and Tim Size.
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URUGUAY

2014

HEALTH SYSTEM

In 2007 Uruguay established the National Integrated Health System (Sistema Nacional Integrado de Salud, SNIS) to ensure citizens access to comprehensive health services through public and private insurers and insurer-providers of comprehensive health care services.[2] The SNIS has made it possible to offer the same benefit plan to approximately 95% of the population.[3]

The public system includes the Public Health Services Administration (Administración de Servicios de Salud del Estado, ASSE), the University Hospital, and care units of the Armed Forces and Police, which together cover just over 40% the population. The private sector is made up of non-profit Institutions for Collective Medical Attention (Instituciones de Asistencia Médica Colectiva, IAMCs), most of which are health cooperatives, and mutuals. Together they provide health care to the majority of the population.

> "The Institutions for Collective Medical Attention (IAMC) may be any of the following: (a) health care associations, inspired by the principles of mutualism, which provide their members with medical care through mutual insurance, and their resources are dedicated exclusively to this purpose; (b) cooperatives of professionals, in which medical care is provided to their members and the social capital is contributed by the professionals who work in them; (c) health care services created and financed by private or mixed companies to provide non-profit medical care for their employees and sometimes their family members; (d) other private professional medical care institutions that provide non-profit medical care to their members and the social capital contributed by the professionals, who are required to work in them."[4]

Population (in thousands): 3,995

Population median age (years): 34.16

Population under 15 (%): 22.05

Population over 60 (%): 18.59

Total expenditure on health as a % of Gross Domestic Product: 9.0

General government expenditure on health as a % of total government expenditure: 21.9 (2011 data)

Private expenditure on health as a % of total expenditure: 32.1

In 2008, IAMCs provided health services to 1.8 million people, with cooperatives providing services to 583,025 people or 32.3%. The majority of these were in the interior of the country (outside the capital city). In 2014, the number of people choosing to be covered by health cooperatives grew to over one million people.[5] IAMCs are the largest providers of integral health care.

The ASSEs and IAMCs receive per capita payments in accordance with the risk of the covered population and care goals set by the Ministry of Public Health from the National Health Fund (Fondo Nacional de Salud, FONSA), constituted by obligatory deductions from salaries and general taxes.[6] They must at minimum provide the obligatory health services defined by the Ministry, with adherents paying monthly fees and co-payments for treatments. In 2014, there were 41 IAMCs, of which 28 were cooperatives and 9 were mutuals. However, cooperatives are also prominent in the provision of specific health care services, particularly dentistry and social care.

Although cooperatives are important providers of health care, the cooperative law (Ley Nº 18.407 of 2007)[7] does not include specific mention of health cooperatives. It provides for the following cooperative types: agriculture, consumer, housing, insurance, mutual guarantee, savings and credit, social worker, artist, and other related trade cooperatives. The National Institute of Cooperatives (Instituto Nacional de Cooperativismo, INACOOP), however, reports that a significant number of "medical cooperatives" (i.e., cooperatives made up exclusively of health professionals) are becoming "Institutional Private Health Care Professionals," a new legal form that is considered part of the social economy and partially governed by the General Cooperative Law. This new form has the advantage of not limiting the number of contracted workers, whereas the law limits the number of non-members that a worker cooperative may employ.

HEALTH COOPERATIVES

The 2008 Second Cooperative Census (II Censo Nacional de Cooperativas y Sociedades de Fomento Rural) categorized cooperative activity as per the statistical indicators designated by

the United Nations ISIC.[8] Health care is covered under the ISIC's definition of "human health activities" (division 86).[9]

The census report prepared by INACOOP indicated there were 80 cooperatives carrying out human health activities. These cooperatives can be described as both health and social care cooperatives. They employed 46.5% of all heath workers and were responsible for 22.6% of total turnover in the sector.[10]

In 2014, 28 health cooperatives were IAMCs and thus recognized as providers of national health system services (in this case, ambulatory and inpatient services).[11] Persons with a minimum of three years of IAMC affiliation are entitled to change providers during a set period of time, on a yearly basis. In 2014, 4.1% of the more than 1.3 million people entitled to change providers did so. This was less than in previous years (6.4% in 2011, 4.6%, in 2012, 4.4% in 2013), suggesting that affiliates are in general satisfied with their providers. Cooperatives in 2014 have all had a net increase in affiliates.[12]

The list of cooperative IAMCs as of February 2014 indicates how many of their affiliates are covered by FONSA (1,053,648) and provides information related to their facilities (201 ambulatory and 33 inpatient).[13] By comparison, 9 mutuals provide health care to more than 880,000 FONSA affiliates.

There are 112 other medical cooperatives and 36 dentist cooperatives which also provide health care services. Dentist cooperatives have national coverage and provide health services to more than 10% of the population. They are worker cooperatives that aim to improve dental care coverage and accessibility, and to generate quality employment opportunities for orthodontists.

Health Cooperative Data

Statistical data on cooperatives is collected using a variety of indicators that do not coincide with the types set out in the Cooperative Law. The 2008 Second Cooperative Census collected data using the United Nations ISIC, Revision 4[14] as well as indicators that describe their activities in more detail. The census showed that cooperatives in variety of sectors (including housing, worker, and savings and credit) were active in providing health services.[15] The data in the following table reflects those cooperatives which fall under ISIC divisions 86 and 88.

	2008[16]	**2013**[17]**/2014** (see notes)
Number of cooperatives	86 cooperatives • 40 medical cooperatives (ISIC R.4 class 861 and 862) • 36 dentist cooperatives • 10 involved in other human health activities (ISIC R.4 class 8690) including ophthalmologists', psychologist and psychiatrist cooperatives, ambulance services, and home care	88 cooperatives (categorized as 46 medical, 53 worker, and 2 social cooperatives) • 28 involved in hospital activities (ISIC R.4 class 861) • 31 involved in medical and dental practice activities (ISIC R.4 class 862) • 29 involved in other human health activities (ISIC R.4 class 869) 27 of 88 cooperatives were IAMCs – recognized providers of the national health care system.
Types of cooperative	Producers (majority), Users	
Number of members	1,826 • 1,047 for medical cooperatives • 593 for dentist cooperatives • 186 for other cooperatives	1,690 for medical and dental cooperatives
Number of employees	12,823	
Users	796,453 for medical and dental cooperatives • 17.5% of population cared by medical cooperatives • 6.4% of population cared by orthodontist cooperatives	• 120,000 dental patients reported by Cooperativa Odontológicas Federadas del Interior COFI[18] cooperatives only (2014)[19] • 151,000 dental patients estimated by Cooperativa Odontológica de Montevideo de la Asociación Odontológica RedDentis (2014)[20]
Facilities	Hospitals, polyclinics, sanatoria, infirmaries, laboratories, blood banks, orthodontic clinics and dental offices, pharmacies, rehabilitation centres	
Services offered	Ambulatory and hospitalized health care – including medical, dental, mental health; elderly and home care, ambulance and medical transport	
Annual turnover	$7,726,962 USD (December 2008)[21] – 22.6% of market share	
Sources of financing	Transfers (national health insurance for medical cooperatives only), members, direct payments	

Noteworthy is the 2014 Members Directory of the Federation of Worker Cooperatives (Federación de Cooperativas de Producción, FCPU). It has its own categories of sectoral activities, some which are more detailed (leather workers, chemical workers etc.) while others are more general, such as social or health services. These include worker cooperatives involved in such services as ambulance services and social care (home care cooperatives).[22]


Photo: RedDentis

Case Study

RedDentis, Cooperativa Odontológica de Montevideo de la Asociación Odontológica Uruguaya, is a dentist (worker) cooperative located in the capital city, Montevideo. RedDentis was established in September 1999 at the initiative of the Dentists Union to address the issue of reduced labour opportunities for orthodontists in private practice. The cooperative form was chosen because the National Health System provided opportunities for cooperatives in health care delivery. The government was expanding health care coverage to include dental care, due to substantial oral health problems among 90% of the population. It therefore was hoped that RedDentis would be in good position to engage in public-private partnerships or private partnerships.

RedDentis has established an innovative management model to provide both quality employment and better quality and more affordable dental heath care. It also engages in advocacy to protect the interests of its members. It provides professional training and cooperative education as well as marketing support, and implements quality control systems.

RedDentis has 268 dentist worker-members. Nearly all (260) have their own dental offices. Members must be certified orthodontists ("doctor en odontología") having graduated from a public or private university. They must be current with pension payments to their professional organization and be paid-up members of the Uruguayan Dental Association.

All RedDentis health professionals are co-op members. No dentists are contractors. The only employees (17) are administrative staff. According to the Cooperative Law, the number of contracted workers may be no more than of 20% of the total number of members in worker cooperatives.

Although officially categorized as a worker cooperative, RedDentis also provides shared services, including centralized administrative services (e.g, accounting, invoicing, bill collection, and audit services), while enabling decentralized delivery of dental care. Each member owns and manages his/her own office. The cooperative owns the administrative headquarters. Members benefit from a software package that provides joint calendar/appointment management, invoicing and payment functionalities, and the ability to consult and update patients' clinical records on-line and in real time. There are document treatment plans for education and training purposes. As there is no national collection of epidemiological information on dental hygiene, this data collection may prove useful for national health purposes in future.

RedDentis can attend to 5,000 patients daily, so patients can be served without delay, even for urgent care. To use RedDentis services, patients must be affiliated with the cooperative and pay it a monthly fee. This entitles them to dental consultations at no extra charge, exams and diagnostics, national coverage for 24-hour emergency care year-round, health education, fluoride treatments, teeth cleaning and access to all specialities.[23] Treatments are charged at a 40% discount off the treatment fee suggested by the Uruguayan Dental Association. Services outside Montevideo are provided by a network of 34 orthodontist cooperatives found across the country. They are members of the Federated Dentist Cooperatives of the Interior (Cooperativa Odontológicas Federadas del Interior, COFI), a RedDentis partner.

More than 150,000 people receive dental care through RedDentis. Many are covered through service agreements which their professional associations, unions, cooperatives, and employers contract with RedDentis.

In 2010 RedDentis collaborated with the Ministry of Social Development to assist beneficiaries of the Uruguay Trabaja programme (Uruguay Works, a job placement and training programme for marginalized groups). This was important as one of the aims of RedDentis has been to help address social inclusion. In

2011, RedDentis was also the recipient of a grant from the Ministry of Industry and Energy in recognition of its accomplishments as a worker cooperative and in support of it projects. RedDentis engages in health promotion for children and young people in schools, colleges, and other neighbourhood organizations.

SOCIAL COOPERATIVES

According to the Cooperative Law, social cooperatives are worker cooperatives which aim to provide members with both employment and economic development opportunities. Their ultimate purpose is to enable the economic and social integration of the heads of households of vulnerable populations, including youth, persons with disabilities, and ethnic minorities.

According to this definition, INACOOP identified 151 active social cooperatives as of June 2013.[24] Given ISIC division 87 (residential care),[25] ten of these cooperatives were involved in social care. They engage in the following activities: nursing facilities (class 8710), residential care for mental retardation, mental health and substance abuse (class 8720), and for the elderly and persons with disabilities (class 8730). These cooperatives are also categorized by their sector of activity, i.e., social, housing, and worker cooperatives.

Social Cooperative Data 2013

The data below reflects only those cooperatives in division 87 (residential care) that have a social care function. Note that data provided under health cooperatives also includes in part cooperatives providing social care. Social care cooperatives may also be included in the ISIC class 889 (other social work without accommodation). However, the information available indicates that the majority are social cooperatives promoting employment opportunities for vulnerable populations and do not fit the social care definition of this report.[26]

Number of cooperatives	9 (4 worker, 4 housing, and 1 social cooperative) • 1 providing general residential care (ISIC R.4 class 8700) • 1 providing residential care for the mentally retarded, the mentally ill, and those suffering from substance abuse (ISIC R.4 class 8720) • 7 providing residential care for persons with disabilities and the elderly (ISIC R.4 class 8730)
Types of cooperative	Users, Producers

SAVINGS & CREDIT COOPERATIVES

Uruguay counts over 100 savings and credit cooperatives. Based on a review of those with websites, an estimated 20% of these cooperatives facilitate access to health care. They offer health service benefits in the form of discounts based on agreements with health services providers. These benefits may also include reductions for medical treatments and exams, pharmaceutical and optical products. At least one also runs a blood bank for members.

Some offer medical services to members free of charge or at a small cost. These medical services include general medicine and orthodontist services, emergency medical transport, and house calls. For example:

- **Cooperativa Minuana de Ahorro y Crédito (COMAYC)** offers free emergency dental care to members, discounted rates at pharmacies and optical centres, and negotiated rates for psychological treatment, orthopaedic care, and non-emergency dental care.[27]
- **Cooperativa de Ahorro y Crédito del Personal Subalterno de las Fuerzas Arma (CACCSOE)** offers an emergency medical service for members and their families for a small monthly charge at locations in Montevideo and Durazno. Two doctors are available for house calls. It has agreements for member discounts for optical products and ambulance services throughout the country.[28]
- **Cooperativa de Ahorro y Crédito (COSSAC)** set up an orthodontist office at its head office where it provides members with orthodontic care. Over 80% of treatments are free of charge, and paid services cost less than market prices. It also provides a free social care service to its members (accompanying patients in clinics and hospitals) as well as discounted prices on other services.[29] It currently has over 32,000 members.[30]
- **Federación Uruguaya de Cooperativas de Ahorro y Crédito (FUCAC)**, the federation of savings and credit cooperatives, provides its 165,000 members with discounts on diagnostics and treatment at a private clinic (psychiatric and psychological consultation, including occupational and family therapies). It also offers to members who take out personal loans no-cost life, unemployment, hospitalization, and disability insurance coverage for the duration of the loan.[31]

Savings and credit cooperatives are not included in the statistical data on health and social cooperatives above since they are categorized by their primary area of activity.

OTHER COOPERATIVES

Similarly, many consumer cooperatives provide medical services to their members, but are not counted among the cooperatives providing health and social care since that is not their primary area of activity. The following are examples of the health services which some consumer cooperatives offer.

- **Cooperativa de la Previsión Social (CPS)** was created in 1954 to provide services to the employees of the Banco de Previsión Social. It provides access to a wide range of consumer products and services including financial and legal services. Among these are free general and specialist medical services including laboratory services for it members through both external providers and its own medical service. It also offers members a number of paid services, such as an extension of medical coverage to include their families, orthodontic care, emergency care, terms for membership in the medical and social care cooperative (Cooperativa de servicio cooperative de cuidados y compania, Caminos), and optician discounts. Members have access to consultations with specialists in cardiology, surgery, dermatology, physiotherapy, gastroenterology, nephrology, ORL, psychiatry and psychology, rheumatology, traumatology, urology, and ophthalmology.[32]
- **Cooperativa de Consumo Salud Pública,** a consumer retail cooperative for public health workers, provides a wide range of consumer food and non-food products to members. It also offers orthodontic care and discounts for ambulance, social care, and psychological services.[33]

INSURANCE COOPERATIVES

Sancor Seguros S.A., a private company, is a wholly-owned subsidiary of the Argentine insurance cooperative, Sancor Seguros. It operates nationally through five offices and offers life and non-life insurance products. Among these are health insurance products providing coverage for hospitalization and surgical interventions (up to $500-1,700 USD in value), organ transplants, and access to discounted pharmaceuticals. The insurance is of a complementary nature, to help defray costs not covered by the national health plan.[34]

MUTUALS

Numerous mutuals are active in Uruguay providing social protection, including pension plans, life insurance, and health care services. They do not have their own legal status but fall under the law governing civil associations.

As noted above, health care is also provided by mutuals known as IAMCs. Nine mutuals are recognized providers of national health system services, offering ambulatory and inpatient services in their own facilities. These mutuals provide health care to more than 880,000 FONSA affiliates.

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[22] FCPU 2014.
[23] Specialties include paediatric dentistry, orthodontics, implants, gerodontology, periodontics, and dental surgery.
[24] INACOOP 2013.
[25] "The division includes the provision of residential care combined with either nursing, supervisory or other types of care as required by the residents. Facilities are a significant part of the production process and the care provided is a mix of health and social services with the health services being largely some level of nursing services." United Nations 2008:254.
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VENEZUELA[1] (Bolivarian Republic of) 2014

Centro Integral Cooperativa de Salud in Pueblo Nuevo, Barquisimeto. Photo: CECOSESOLA.

Population (in thousands): 29,955

Population median age (years): 26.73

Population under 15 (%): 28.84

Population over 60 (%): 9.17

Total expenditure on health as a % of Gross Domestic Product: 4.7

General government expenditure on health as a % of total government expenditure: 5.5

Private expenditure on health as a % of total expenditure: 66.3

HEALTH SYSTEM

It is estimated that 68% of the population of Venezuela does not have access to health insurance coverage, despite the fact that the 1999 constitution entitles its citizens to health care.

The health system is comprised of a public and a private sector. The public sector includes the Ministry of Health (Ministerio del Poder Popular para la Salud) and several social security institutions, the most significant being the Venezuelan Institute for Social Security (Instituto Venezolano de los Seguros Sociales, IVSS). The Ministry of Health is financed with federal, state, and county contributions. The IVSS is financed with employer, employee, and government contributions. Both provide services in their own facilities. The private sector includes providers offering services paid for out-of-pocket and private insurance companies.[2]

Cooperatives engage in health care delivery as part of the private sector, to address issues of access, quality, and affordability. Neither cooperatives nor mutuals can undertake insurance functions, however.[3]

The Venezuelan government engaged in extensive cooperative promotion particularly under the Chávez regime. This resulted in over 306,000 cooperatives being formed, of which the great majority (267,000) were inactive by 2010. Few were formally registered and many were considered to be bogus cooperatives, formed and controlled by the State. No official statistics are available, however. It is estimated that in 2012 the movement counted 40,000 active cooperatives with 730,000 members.[4] Cooperatives are found in a variety of economic sectors, including agricultural production, savings and credit, transport, distribution of public utilities, and health care.[5]

HEALTH COOPERATIVES

Cooperative provision of health care essentially began in the 1990s in response to the inadequate and inefficient public health system and the high cost of private insurance. Services initially were provided by existing cooperatives in various economic sectors which then expanded services in response to the needs of their members.

In Venezuela health services are generally delivered by user-owned or user-producer cooperatives, although at least one producer-owned cooperative (formed by doctors) is known to exist. No updated information on the number or types of cooperative is readily available.

However, the public health administration has recognized two cooperative health care providers as primary care providers, requiring reasonable co-payments from those covered by public

health care.[6] These are secondary-level cooperatives (cooperative centrals) which own and operate hospitals and medical centres, namely Servicio Médico Cooperativo (SERMECOOP) of the Central Cooperativa de Barinas (CECOBAR) and Centro Integral Cooperativa de Salud of the Central Cooperativa de Servicios Sociales.

CECOBAR was founded in 1972, initially to provide funeral insurance to its member cooperatives. Today it provides health and financial services as well. In 1999 it established the Medical Service Cooperative (Servicio Médico Cooperativo, SERMECOOP), the first cooperative health care centre. It provides services to over 100,000 people: general medical consultations, gynaecology, paediatrics, obstetrics, and orthodontic care free of charge, and fee-based general surgery, hospitalization, radiology, and laboratory services.[7] It also has an ambulance that operates a mobile clinic.[8] Members pay a monthly fee of approx. $6.25 (40 VEB) to have access to health services at their clinic/hospital, open 365 days a year, 24 hours a day.[9] Non-members can also access services at affordable prices. The cooperative operates a clinic in Barinas, and has medical centres both in Barinas and the municipality of Rojas. It plans to build a new clinic in Libertad in the municipality of Rojas.[10]

The Central for Cooperative Social Services (Central Cooperativa de Servicios Sociales, CECOSESOLA) was established in the state of Lara in 1967 to provide services for its member cooperatives. Today it comprises 50 organizations which bring together a total of 20,000 members. It currently engages in agricultural production, small-scale agro-industrial production, funeral services, transportation, savings and loans, and health care services. It also manages mutual aid funds, the distribution of food and household items, and organizes important markets (ferias) at which small farmer-members can sell their products. (More than 600 tons of fruit and vegetables are sold annually to 60,000 families at prices 30% below those of local supermarkets.) In 2007 CECOSESOLA established an Integrated Health Cooperative Centre or hospital (Centro Integral Cooperativa de Salud, CICS). It also operates six clinics. CECOSESOLA provides quality health care services to 200,000 people a year at rates 60% less than other private health care providers.[11] (See "Case Study," below.)

Other multipurpose cooperatives also provide health care services. (See table below.)

Health Cooperative Data

	CECOSESOLA	SERMECOOP	Others
Cooperatives	1	1	1
Types	User and producer	User	Producer
Members	20,000	N/A	N/A
Employees	1,300,including 70 health professionals	42 (2002)	N/A
Users	200,000 (2013)	100,000 (2012)	N/A
Facilities	1 hospital, 6 medical clinics	1 clinic, 2 medical centres	N/A
Services	General medicine, gynaecology, paediatrics, internal medicine, general surgery, hand surgery, mastology, urology, gastroenterology, orthopaedics, paediatric endocrinology, ophthalmology, otolaryngology, psychology, psychology, dietetics and nutrition, acupuncture and alternative therapies, dentistry, endodontics, and orthodontics	General medicine, gynaecology, paediatrics, obstetrics, orthodontic care, general surgery, hospitalization, radiology, and laboratory services	
Revenue sources	Payment for services/Surplus	Payment for services	

CASE STUDY

CECOSESOLA is a cooperative central that catered initially to its member cooperatives, then to a wider group of associations which today number 50 and total 20,000 members. It currently engages in agricultural production, small-scale agro-industrial production, funeral services, transportation, savings and loans, and health care services. It manages mutual aid funds and the distribution of food and household items. It does not distribute its surpluses but reinvests them to better serve its members. In 2012-2013 CECOSESOLA's turnover in all activities was reported to be approx. $127 million USD (800 million VEF).

CECOSESOLA started building its Cooperative Health Network in the city of Barquisimeto (the capital of Lara State, located west of Caracas) in the 1990s. In 1994, members organized informal mutual aid funds – health funds – to which each member contributed a specific amount on weekly basis. It was managed by members and

was used to cover the cost of health care. In 2002, 13 health funds existed in CECOSESOLA member organizations. These local funds contribute to the CECOSESOLA Integrated Health Fund, a mutual aid or solidarity fund managed by those who contribute to it. Disbursements are not a function of contributions but a function of need.[12]

In the same period, members began accessing health care services through their own cooperatives. However, recognizing the greater need for public access to health care, CECOSESOLA members began to build a health service network. In 1997 they established a medical centre in the Pueblo Nuevo section of Barquisimeto to provide general medical services. By 2006, the centre was providing services to more than 150,000 people – members and non-members. The centre had overextended itself in order to provide quality care. Members expressed the need for more comprehensive health services. The idea of building a new centre was launched – one that would provide integrated health services.

To purchase the land and construct the new medical centre, members raised capital through member contributions, surpluses from cooperative activities, and community raffles and donations. Today, the 4-storey building (3,465 m^2) is valued at more than $11 million USD (70 million VEF).

The **Centro Integral Cooperativa de Salud (CICS)** was inaugurated in 2007 to engage in health promotion, prevention, curative care, and rehabilitation. It provides ambulatory care as well as hospitalization, surgery, paediatrics, gynaecology, obstetrics, radiology, and endoscopy. Alternative medical treatments are available, including acupuncture, hydrotherapy, massage, Tai Chi, and dance therapy. It also offers healthy eating seminars. Other health services, such as dentistry and laboratory services, are available in other locations. In total CECOSESOLA runs CICS and six other community medical facilities in its integrated network.

The CECOSESOLA is staffed by 1,300 worker members, including 70 health professionals, administrative staff, and other workers. All staff are members of the cooperative. Remuneration of health professionals is based on a percentage of their consultation fees. Remuneration of other staff is determined by salary scales and productivity. All member-workers receive a health plan that entitles them to free preventive health care at their clinics. The plan covers about 80% of medical consultations and offers significant discounts on other services at the health clinics (relative to the established community member rates). The health fund provides support when worker-members need large, expensive operations. They generally are asked to pay back one third of the total cost if they are able.[13]


CICS in Barquisimeto. Photo: CECOSESOLA

CECOSESOLA operates under a non-hierarchical management system. There are no individual managers, but teams to organize the work at the centre. The CICS holds weekly management meetings for those who wish to participate. An average of 60 persons attend. Quarterly meetings are also held to review and discuss activities and future directions.

The CICS and CECOSESOLA clinics provide health care to members and non-members. Members receive free health care for general medicine, paediatrics, and gynaecology, and pay a flat rate of $28 USD (175 VEF) for most of the other specialities (including traditional and alternative medicine) excepting consultations with an ophthalmologic or ORL specialist ($39.75 USD or 250 VEF).[14] Non-members access services at affordable fees. For example, on April 1, 2014, the fee for a paediatric consultation at CICS for a non-member was $27 USD (170 VEF) whereas other private clinics were charging an average of $63.50 USD (400 VEF). All other consultations for non-members in other medical specialities cost $35.75-47.70 USD (225-300 VEF) whereas private clinic consultations charge $95-127 USD (600-800 VEH), depending on the specialization.[15]

Below are statistics for patients treated at CICS in 2013 (exclusive of patients seen in other clinics in the network).

Types of consultation at CICS	Patients
General medicine	38,220
Paediatrics	38,969
Gynaecology	9,684
Other medical specialities and sonogram	28,342
Surgery, radiology, laboratory services, therapies, and acupuncture	43,393
TOTAL	154,608

The number of consultations is increasing, particularly in paediatrics, which is leading to overcrowding. For example, in 2013 CICS had eight paediatric doctors, three of them full-time, who attended on average 35 children during their respective shifts. There is concern that this volume may put the quality of service at risk. Overall the CICS and its network provide health services to more than 200,000 people.

OTHER COOPERATIVES

Multipurpose cooperatives are also known to provide health care services. For example:

- **Cooperativa La Florencia,** located in Rubio in the state of Táchira, has more than 6,700 members. It provides consumer and savings and credit services as well as operating a pharmacy.[16]
- **Cooperativa La Bermúdez** provides funeral, financial, and health services to 60,460 persons, covering nearly half the population of the municipality.[17] In 2002 it provided 14,000 people with health care.[18]
- **Asociacion Cooperativa Tucutunemo R.L.** initially was established as a savings and credit and consumer cooperative. It later added health care to its service offering.[19] Today its health services include gynaecology and obstetrics, traumatology, gastroenterology, otolaryngology, nephrology, psychology, physiotherapy, internal medicine, general medicine, ultrasound, clinical laboratory, general radiology, and emergency 24-hour service.[20]

MUTUALS

No information was identified regarding mutuals involved in the provision of health care.

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VIETNAM

2014

HEALTH SYSTEM

In Vietnam, the health care system has been largely transformed since the initiation of Doi Moi reforms in 1986 with the aim to create a "socialist-oriented market economy." In the health care sector, the goal of reform was to reduce government spending on health care by way of making user households responsible for their medical costs. As a result, major changes in the health care system occurred along with the privatization, deregulation, and decentralization processes. On top of those changes, user charges in public hospitals started to be introduced, and social insurance schemes were established in the country.

Before the launching of the Doi Moi reforms, People's Committees and cooperatively-run health centres formed basic Vietnamese health care networks and provided free health care services. The reforms have caused financial distress for these networks.[1] Facing this weakened public health system, private medical practices were legalized in 1986, and the pharmaceutical market started to be de-regulated in 1989. In the same year, public hospitals and health centres were allowed and even encouraged to collect service and drug charges to compensate for the reduction in public subsidies.[2] Later on, as a partial compensation, both compulsory State-funded and voluntary health insurance schemes were established in 1992.[3]

Population (in thousands): 90,796

Population median age (years): 29.41

Population under 15 (%): 22.87

Population over 60 (%): 9.32

Total expenditure on health as a % of Gross Domestic Product: 6.6

General government expenditure on health as a % of total government expenditure: 9.5

Private expenditure on health as a % of total expenditure: 57.4

The compulsory health insurance covers mainly employees (and retirees) in the formal sector, civil servants, and some social protection groups (such as the disabled and "meritorious" people). Since 2005, the poor and ethnic minorities have also been included in this insurance scheme. Voluntary health insurance in Vietnam was designed to cover specific occupational and age groups, such as school children and farmers.[4] But it was only with aggressive promotion by the government in the mid-2000s that voluntary health insurance grew more successful. The total percentage of insured people has increased from 13.5% in 2001[5] to 60% in 2010.[6] But a large proportion of the Vietnamese population still receives no health insurance benefits.[7]

It is estimated that 82% of all employment in Vietnam is informal.[8] Informal workers constitute a great part of the population without health insurance coverage. Moreover, the expansion of coverage during the past decade was not accompanied by a deepening of coverage. For example, when more than 50% of the population was covered in 2008, social insurance accounted for only 17.6% of Vietnam's total expenditure on health.[9]

As the bulk of health expenses has shifted from the state to households, an estimated one-third to one-half of the population has suffered from a lack of regular access to health services.[10] As a result, Vietnam has witnessed increasing health inequalities and gaps.[11] The dominate mode of paying for health care is fees-for-service, which is regarded as "the root of the problem of rising expenditures in Vietnam", because it "offers providers opportunities to pursue their material self-interest at their patients' expense."[12]

For policymakers, how to ensure access to health services at an affordable cost has become a tough issue. In particular, despite the legalization of private hospitals since 1989, public hospitals still own more than 90% of all hospital beds.[13] Now that public hospitals seek to generate revenues from users, they are "public" in name only.[14] Indeed, out-of-pocket payments account for more than half of total health expenditures in Vietnam.[15] Public hospitals derive nearly 60% of their revenues from out-of-pocket payment, compared to 29% from the government budget and merely 11% from social insurance schemes.[16]

Currently in Vietnam, people seem to have little understanding of the nature of cooperatives as member-based organizations operating in the market economy. For a long time, Vietnam did not have a specific state entity responsible for cooperative development. In 2005, with the establishment of the Department of Cooperatives in the Ministry of Planning and Investment, the encouragement of cooperative development commenced at the central level. Still, at

the local level, there is a lack of a relevant official body for cooperative promotion.[17] As a non-governmental organization, the Vietnam Cooperative Alliance (VCA) is an apex body for cooperative movement in Vietnam. It is organized both at the central and provincial levels.

HEALTH CO-OPERATIVES[18]

In Vietnam, the emergence of cooperatives in the health care sector is a very recent development. The model was first introduced after the example of best practices in Japan. The Vietnam Cooperative Alliance organized delegates for a number of study visits to Japan. Later, introductory seminars were organized in Hanoi, Hai Phong, and Ho Chi Minh City. The support from the Asia-Pacific Health Co-Operative Organization (APHCO), and especially from the Japanese Health Co-operatives Association (JHCA), has facilitated the establishment of several pilot organizations in such provinces as Yen Bai, Hanoi, and Bac Giang.

Currently, three health cooperatives (Minh Thanh, An Phuoc, and Hop Luc) are operating in different parts of Vietnam. (See Table 2.) In total, they have more than 770 members, employing more than 50 staff members and serving more than 224,000 people per year. They provide a wide range of services, from primary care and dental care, health checks, and home treatment, through rehabilitation and recuperation.[19]

Two of the latter cooperatives (An Phuoc and Hop Luc) are running successfully. An Phuoc cooperative, established in 2011, is reported not only to provide health care services but to create jobs in the community. Following its success, a project aiming to establish a pharmacy cooperative in the province is also in the works. However, Minh Thanh, active in health promotion in small villages and an initial success, has recently encountered financial difficulties, particularly after the economic crisis. As a result, they are reported to have shifted their focus from health promotion, disease prevention, and consultancy to sales of nutritional medicines.

Table 1: Health Cooperative Data

Number of cooperatives	3
Types of cooperative	1 User, 1 Producer, 1 MS
Number of members	>770 (estimated)
Number of employees	>50 (estimated)
Users	224,000-233,000 (estimated)
Facilities	N/A
Services offered	Primary care, dental care, health checks and disease prevention, home treatment, rehabilitation, recuperation, personal advice Illness/accident prevention; Wellness and health promotion; Treatment and cure; Rehabilitation
Annual turnover	approx. $6 million USD (estimated)

Table 2: Health Cooperative Details

Name of cooperative	**Minh Thanh**	**An Phuoc**	**Hop Luc**
Location	Yen Bai province	Quang Nam province	Thanh Hoa province
Type			
User	X		
Producer			X
Multistakeholder		X	
Members	165	?	487[20]
Employees	8	30[21]	?
Doctors	2	8	
Nurses	3	15	
Other health professionals	2[22]		
Others	1[23]		
Users[24]	32,759[25]	120- 150 people/day[26]	155,086
Facilities			
Types of service			
Illness & accident prevention	X	X	X
Wellness & health promotion	X	X	
Treatment and cure		X	X
Rehabilitation			X
Annual turnover		$377,360 USD (8 billion VND)	$5,306,625 USD (112.5 billion VND)[27]

PHARMACY COOPERATIVES

At the same time as health cooperatives were being established, the pharmacy cooperative model was being introduced in Vietnam. Currently, there are three pharmacy cooperatives in operation. The first one is located in Yen Bai, providing traditional and oriental medicines to its 10-15 members and the local community. The other two (Chua Boc and Ba Vi), situated in Hanoi, are also small in scale and basically offer traditional medicines. Chua Boc cooperative has 14 employees and an annual turnover of $103,752 USD (2.2 billion VND).

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[18] We would like to express our sincere thanks to the Vietnam Cooperative Alliance, and particularly to Ms. Tran Thi Ngan, for providing updated information on health and pharmacy cooperatives in Vietnam.
[19] In particular, Hop Luc is reported to provide specialized services including dermatology, venereology, paediatrics, dentistry, otorhinolaryngology, ophthalmology, toxicology, tuberculosis and tumour cure, burn treatment, anaesthetics, X-ray, rehabilitation, recuperation, and so on.
[20] Of these, 364 members are doctors, nurses, and technicians. The other 123 are government staff from such departments as planning, administrative, and accounting.
[21] Of 30 employees, 23 are cooperative members.
[22] One is pharmacist, the other a surgeon.
[23] This is a cadre serving as professional consultant with good knowledge of disease prevention, health care, and protection.
[24] Potential users – area of coverage.
[25] Including 31,559 people in Yen Binh district and 1,200 people in surrounding provinces.
[26] The services provided by the cooperative are open to both its members and local communities.
[27] Of the total annual turnover of $2,523,595 USD (112.5 billion VND), $1,200,110 USD (53.5 billion VND) come from other services.

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