



Cooperative health report

Assesing the worldwide contribution of cooperatives to healthcare

2018

International Health Cooperative Organisation



This report refers to the first edition of “The cooperative health report 2018: Assessing the worldwide contribution of cooperatives to healthcare”, an exploratory study conducted by Euricse in partnership with the International Health Co-operative Organization (IHCO), a Sector of the International Co-operative Alliance.

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To the memory of † José Carlos Guisado.

EXECUTIVE SUMMARY

The transformation of health care systems: Main trends and challenges

To address people's health needs, many nations have developed diverse types of health care systems. Country variations largely depend upon the level of public regulation of the related health activities, the financing mechanism and the degree of coverage for sickness and health problems. Furthermore, the nature and governance of the organizations managing the delivery of health services also impact the shaping of health care systems.

The nations covered by this stage of our research exclude low-income countries, i.e. most African and some Asian countries, which lack health care systems altogether. Although the present research explores different types of well-structured health care systems, organizations supplying health services are significantly diverse; they include public, private non-profit, mutual, cooperative or private for-profit organizations.

When considering the roles played by the different service providers, four typologies of health care systems have been identified. This way of classifying health care systems is meant to shed light on the complexity of the health care supply, particularly on the role played by health cooperatives and mutual aid societies.

The systems identified are the following:

- Almost exclusively public health care systems with private actors, for-profits, non-profits and cooperatives covering a marginal function;
- Universal health care systems where public actors have integrated the pre-existing private mutual and non-profit organizations;
- Health care systems conceived to ensure public universal coverage, which have, however, failed to ensure access to health services to all population groups; and
- Mixed health care systems where only basic health services are ensured by public policies targeting low-income groups.

In each health care system identified, the role of mutual aid societies and cooperatives tends to increase in importance over time. There is nonetheless a progressive shift from the first towards the fourth type, which can be interpreted as a reaction to the mounting difficulties all these systems are facing.

Key problems and challenges faces by the health sector

All systems analysed share a number of problems, which can be regarded as a consequence of the evolution of both the demand for and supply of health services. These include, among others, an increase in health expenditure to meet pressing health demands, i.e. demand for long-term care services due to longer life expectancy, which leads to increased rates of morbidity; the difficulties of most health systems to organize preventive care; long wait times for healthcare; and the general

difficulty to contain rising health costs.

These common problems have, in turn, four main implications:

- A progressive and relatively selective reduction in health care coverage and increasing inequality among individuals and groups and between urban and rural areas;
- Increased user resource withdrawal through ticket imposition in the public health care systems and through the increased cost of private coverage and out-of-pocket expenditures in both public and private systems;
- More intense pressure on health care workers (especially medical doctors) to increase their productivity; and
- A growing gap between the demand for personalized services and standard health care provision, which calls for innovative organizational developments.

Policy makers have so far been unable to propose clear and long-term solutions. The most widespread policy responses have been the decentralization from national to regional authorities and the growing valorisation of private providers as a consequence of the privatization of health care service delivery. However, the privatization of health care has primarily been implemented by favouring for-profit providers, while health cooperatives have been largely disregarded by policy makers.

Overall, the potential of health cooperatives is still far from fully harnessed. Based on our research, there are three main reasons that help explain why their potential has been underestimated:

- The tendency not to differentiate among private providers and the assumption that for-profit actors perform better than public, non-profit and cooperative organizations—often assimilated by the public one—due to their higher efficiency.
- The complexity of the non-profit and cooperative supply of health care—particularly, the different forms, activities, sizes and features exhibited by this varied organizational landscape across the globe. This complexity makes it difficult to extrapolate and quantify the weight of non-profit health care-oriented organizations separate from generic ‘private’ organizations.
- The lack of reliable and complete data on the true relevance of these actors, especially on the capacity of health cooperatives to perform health services and address health needs.

The progressive revival of health cooperatives

If one considers the pressing need to counteract mounting difficulties faced by health care systems worldwide and the several market failures faced by the health domain, i.e. the inability to pay for services and the information asymmetry between insurers and the insured and between patients and physicians, neither the key role of health care cooperatives, nor their revitalization are surprising. Despite having been downsized during the construction of public health care systems, mutual aid societies and cooperatives never disappeared altogether, even in countries with universal public health systems. Meanwhile, in countries with mixed universal health care systems (consisting of public and private providers) health cooperatives have continued to serve their members over the past two centuries without interruption.

However, for a health cooperative revival to happen fully, health care authorities and related workers need to better understand the role, relevance and potential of health cooperatives. This was precisely the main goal pursued by the research project ‘Health care cooperatives and mutual aid societies worldwide: Analysis of their contribution to citizens’ health’, commissioned by the IHCO.

IHCO research aims and outcomes

IHCO and the European Research Institute on Cooperative and Social Enterprises (Euricse) agreed to jointly develop a multi-annual research initiative on the contribution of health care cooperatives to improve people’s health and wellbeing across the world. They aimed to publish an annual report containing—for a progressively growing number of countries—both quantitative and qualitative analyses of health care cooperatives and mutual organizations as well as the systems in which they operate.

The first year of the research study focused on 15 countries, selected among those that have a structured health care system. These include Argentina, Australia, Belgium, Brazil, Canada, Colombia, France, Italy, Japan, Malaysia, Singapore, Spain, Sweden, the United Kingdom (UK) and the United States. For each of these countries, Euricse developed a profile focused on the main features of health care cooperatives vis-à-vis the health care system. In-depth case studies of these cooperatives’ main features were delivered in Belgium, Brazil, Canada, Italy, Spain and Japan. The research initiative investigated various types of cooperatives: cooperatives of health practitioners, mainly doctors; user/patient cooperatives; and multi-stakeholder cooperatives, but also other types of co-operatives, like agricultural cooperatives, which provide different types of health services.

Research Methods

The present research project was based on quantitative and qualitative methodologies. Data analysis was based on the collection, aggregation and synthesis of already existing data obtained through available statistical and research reports, scientific papers and online databases. We also relied on data directly provided by the selected organizations. The quantitative research was integrated by a case study analysis focused on six country studies, which allowed for a more in-depth analysis of both the universe of health cooperatives in each country studied and the cooperative models. The case studies, which were based on a common protocol, included a detailed description of the socio-economic context of each country and the role played by health cooperatives and mutual societies in the healthcare system.

Research findings

Health cooperatives are widespread and on the rise in most studied countries

The research confirms that health cooperatives exist in all of the health care systems surveyed, although large country variations are noticeable. They deliver a wide range of services, covering risk protection, prevention and soft healthcare service delivery, pharmaceutical product distribution and healthcare clinic management.

Country variations depend on several factors: the degree of coverage provided by the public health care system; the degree of freedom granted to private providers; cooperative traditions and cultures (social orientation); the ability of cooperative movements to self-organize to address new challenges; and the way cooperatives are recognized, regulated and supported by national laws. Such differences have helped shape the role of cooperatives within the health care domain in different ways across countries.

Table 5, found in Part 1 of the present study and included below, summarizes the number of health cooperatives, turnover, employees and users in 12 of the countries studied¹. It should be considered that data might have been under-estimated in some countries due to a lack of data on specific typologies of health cooperatives/mutual aid societies or employees, along with the fact that, in some countries, organizations similar to cooperatives, i.e. associations, are not counted. We can therefore conclude that the size of health cooperatives is underestimated in most of the countries reported in the table.

Table 5: Number of cooperatives, turnover, employees and users in the studied countries.

Country	Year	Organisation	Turnover (million)	Currency	Employees	Users* (million)	Users*(as % of the population**)
Australia	2016	175	9,244	AUD	15,653	3.6	14.9%
	2014-2015-						
Belgium	2016	785	1,002	EUR	19,702	13.2	116.3%
Brazil	2015	1,933	-	-	96,023	24.0	11.6%
Canada	2013	130	63	CAD	1,132	0.4***	1.1%
Colombia	2013-2015	152	9,872,594	COP	17,383	8.6	17.7%
France	2014	1,832	-	-	36,344	12.3	18.4%
Italy	2014	6,756	9,235	EUR	233,397	5.5	9.1%
Japan	2014-2015	145	1,359,320	JPY	91,969	12.2	9.6%
Singapore	2015	4	114	SGD	2,271	1.7	30.3%
Spain	2016	507	14,449	EUR	52,006	6.4	13.8%
Sweden	2015	298	149,411	SEK	19,367	13.6	137.3%

* Estimates

** Source: World Bank

*** Data refer to the users of cooperatives strictly in the health and social services. Data on the insurance sector are not available.

The case study analysis confirms that health cooperatives have grown in importance over the past 20-30 years in all studied countries. Their increase has been dramatic, especially in countries where they

¹ The complete version of the same table can be found in Annex 2

were previously weakly developed or did not exist altogether. Their growth has been a clear reaction to the increase in the demand for health services and the rising difficulties faced by public authorities to support expanding health care expenditures. Interesting examples are provided by health cooperatives targeting the needs of elderly populations, namely Italian social cooperatives, Canadian health cooperatives and Japanese agricultural cooperatives (*Koseiren*). Also worth noting are community-based cooperatives and mutuals in France, which are becoming increasingly relevant in collective care, i.e. targeting low-income patients. There are also community-based cooperatives working with indigenous peoples in Canada.

Besides enabling estimations of the size, relevance and trends of cooperatives in most of the countries studied, the case study analysis has also allowed for the identification of two distinct criteria to explain country variations related to the role played by health cooperatives. These are the degree of integration of cooperatives and mutual aid societies into the public health systems and the degree of centralization versus decentralization of the health systems.

Based on these criteria, three groups of countries have been identified:

- Countries where health cooperatives and mutual aid societies are highly integrated into the public health system, i.e. a high degree of institutionalization. Examples include Belgium and France, where mutuals have a longstanding history. These types are highly regulated, although recent health system reforms have helped grant them growing autonomy.
- Countries where cooperatives and mutual aid societies were downsized by publicly funded universal healthcare systems established during the 20th century, as part of the process of constructing European welfare states. This situation changed gradually as the traditional welfare regimes started to show their first difficulties and cooperatives re-emerged as welfare and health care providers, especially to meet those needs that public health systems were unable to meet, as well as to address new needs arising in society. Italy and Spain are included in this group of countries.
- Countries where health cooperatives have continued to operate autonomously or with limited connections with public health suppliers. This happens in health systems that have been designed to ensure a universalistic reach but fail to do so because of their inability to deliver services in peripheral areas and/or a lack of financial resources, e.g. Brazil and Colombia. In this group are also mixed health systems where public health services are ensured only to individuals without social security benefits who cannot afford to pay. This is the case in Argentina, Malaysia and the United States.

Health cooperatives are extraordinarily able to adjust to national and local conditions

The presence and widespread diffusion of health co-operatives in all three groups of countries enable us to state that health cooperatives are highly adaptable to the typical features of any health care system. They have traded an ability to reinvent themselves over time; they have evolved their membership, governing bodies and service delivery to better fulfil unmet needs. Likewise, health cooperatives help overcome coordination failures that arise from asymmetric information that typically characterises health care services. Moreover, rather than competing with public providers,

health cooperatives tend to fill gaps left by other actors.

Essentially, health cooperatives can adjust to changing economic, social and political conditions and can assume various forms consistent with their surrounding cultural and socioeconomic environment more readily than conventional corporations.

Furthermore, unlike other economic sectors, which are typically populated by one predominant type of cooperative, the health care sector is distinguished by a rich variety of cooperative forms. Depending on the type of problem addressed, members may include patient-users, medical doctors and nurses, customers of medicines, volunteers (not present in traditional co-ops) or a combination of these stakeholders. The choice of one cooperative type over another depends upon the problem addressed. This may include the inability of users to pay for services, which is typically not a problem addressed by conventional, for-profit enterprises. Other objectives of health care cooperatives include: improving the working conditions and valorising the ethical commitment of medical doctors, nursing staff and paramedics; encountering the diversified needs of users; and striking a balance between the advantages provided by advanced technologies and the need to provide personalized services.

The most popular types, by far, are health care worker cooperatives and mutual aid societies. Other cooperative forms identified include: user cooperatives, producer (including agricultural) cooperatives and multi-stakeholder or community-based cooperatives.

Mutual aid societies

Mutual aid societies are widely developed across the studied countries. Their rationale is to pool different kinds of risks, including illness, job loss and old age, across their member associations. Mutual aid societies are voluntary groups of natural or legal persons whose main purpose is to meet the needs of their members rather than achieve an investment return target (Grijpstra et. al., 2011). They are based on the principles of solidarity and reciprocity; mutual membership is free and there is no discrimination between members. They are non-profit organizations; all income from mutual societies is reinvested to improve the services provided to members.

The country where mutual societies plays the most central role in the national health system is Belgium, where 99% of the population is covered by mutual protections, the sole provider of compulsory health insurance. It should be noted that mutual societies began to develop independently of the Belgian national health system in the 19th century and they were subsequently integrated into the public system when it was built. Mutual societies are also present in Spain, though they have not been integrated into the public system; since 2012, universal health insurance coverage has been partially restructured and mutual societies have become an important point of reference for those who see their rights challenged.

Worker and producer cooperatives

Like in any other sector, the aims of health worker cooperatives are to enable more effective organizations. These cooperatives monitor the medical profession; improve the conditions of

workers, like medical doctors, who are often put under pressure to increase their productivity; and increase efficiency and effectiveness of the services delivered.

Examples of worker cooperatives include cooperatives that bring together professionals operating in different areas of the health sector: doctors, dentists, nurses, pharmacists and paramedics. Worker cooperatives are widespread in most of the countries studied (except Singapore and Japan), though there are some peculiarities that characterize each country and that depend on the structure of its health system.

In Brazil, the practitioner (worker) cooperative model is very widespread. Similarly, Argentina is an emblematic example of the widespread diffusion of complex worker cooperatives, which developed after the 2001 financial crisis, given the strong privatization of the healthcare sector. In other countries, like Australia, worker cooperatives are oriented towards the management of medical centres. Pharmaceutical cooperatives are another type of producer cooperative that is quite common in Belgium, Spain and Italy, whereas Canada provides a unusual example; it is one of the rare cases in which the ambulance sector is managed directly by worker-members rather than by traditional non-profits, such as charities like Caritas.

User cooperatives

The rationale explaining the upsurge of health user cooperatives is the need to fill gaps in health service delivery, including developing prevention services and improving wellbeing. User cooperatives often ensure access to treatment by pathological category or provide services tailored to at-risk user groups. In Canada, for instance, clinics following the consumer model type have developed special health services for seniors, aboriginal people, the poor and people with chronic illnesses. Consumer cooperatives also contribute to filling gaps in health service delivery in marginal and sparsely populated areas where access to public health services is problematic. Singapore is among those countries where user cooperatives play a key role. Another example is Japan, where consumer cooperatives are becoming a sort of community cooperative. User cooperatives are similar to Japanese agricultural cooperatives, which have been providing health services to their members since 1947; their services are more attentive to user needs and have helped innovate rural medical practices.

Inclusive-multi stakeholder cooperatives—Community-based cooperatives

Multi-stakeholder cooperatives differ from traditional cooperatives since they are characterized by the participation of a variety of stakeholders in the membership or governing bodies. In the health sector, stakeholders may include workers, such as medical doctors and nurses, but also users and other individuals or enterprises with a stake in the cooperative's success. While affected by the cooperative's activity in different ways, participating stakeholders share a general-interest goal. This common endeavour strengthens the links that cooperatives have with the local community and their ability to approximate its common good.

Singapore has developed this cooperative model; its health community cooperatives manage centres that guarantee health and elderly care services and provide an integrated suite of services. Also

noteworthy are Italian social cooperatives, which tend to involve a plurality of stakeholders, including volunteers, in their governing bodies and are, hence, distinguished by a strong local anchorage. Social cooperatives deliver various types of health services, including elderly care and rehabilitation services for disabled people.

In Canada, cooperatives have often developed by integrating the needs of the stakeholders involved. It appears that most of the cooperatives analysed act according to the needs of the community and under a strong drive from the population. Worth mentioning are cooperatives delivering home healthcare in Quebec.

Cooperative competitive advantages in the health domain

Health cooperatives are not an alternative to public health care systems. They share the same general-interest objectives as public health care systems and are mostly willing to cooperate with public actors and make their competitive advantages available to improve the provision of health services. Rather, health cooperatives are an alternative to private for-profit providers, despite sharing similar management modalities with them.

The reasons for cooperative success in the health domain are diverse. They are primarily connected to the particular ownership asset of cooperatives. Furthermore, a cooperative competitive advantage results from the primacy of goals other than economic ones; like any type of cooperative, health care cooperatives are formed and operated not to maximize profit for investors, but rather to address the needs of specific stakeholder groups or the community at large. This peculiar aspect has several consequences briefly described below.

Increase accessibility of health services

Cooperatives are, in many instances, set up specifically to increase the accessibility of health services to poor stakeholders and marginal or peripheral communities, thus significantly contributing to reducing health inequalities. In these cases, health cooperatives provide poorer stakeholders or the entire community with the opportunity of transacting on favourable terms with the organization. The “open door” cooperative principle is, in this respect, crucial to ensuring greater participation among interested stakeholders. These types of health cooperatives are often supported, if not set up, by volunteers. In many instances, they succeed in attracting public financial support or rely on private resources gained through price discrimination to the advantage of poor users. These features make them significantly different from other private providers on which many public national policies rely.

Capture and meet new needs arising in society

By promoting a decentralization of power, cooperatives enable increased flexibility in the supply of health care services, which allows them to pay individualized attention to users with multiple health care access barriers. In fact, given their strong roots at the local level, cooperatives can be considered more knowledgeable about the specific needs arising in each community than public health care providers.

Often cooperatives meet new demands for social and health services arising in society and the unmet

demand for services that both public and for-profit providers are either unable or unwilling to meet. They fulfil this task within a shorter timeframe than public agencies and at lower costs than conventional enterprises. This ability stems from their double nature as social movements and enterprises; it enables them to enhance their local community links because the health cooperatives have either been created by the community itself or community groups are their direct beneficiaries. The adoption of participatory governance models, which enhance the involvement of a plurality of stakeholders, and participative management systems strengthen their exploitation of this ability. The participatory dimension of cooperatives has several beneficial impacts: it encourages the adoption of prevention strategies to fight against health risk factors at the local level, like pollution, and it enhances the relational dimension of health services, thus contributing to improving their quality.

Attract resources that would not be addressed to welfare aims and discriminate prices

The privatisation processes of most health care systems explicitly presuppose that shareholder-led health providers, rather than cooperatives, are assigned a dominant role. Cooperatives are indeed considered to be in a disadvantaged condition when it comes to attracting capital. This is due to cooperatives' widespread practice (and, in some countries, legal constraint) of not distributing profits; instead these are reinvested to strengthen the ability of cooperatives to achieve their institutional goals. However, the alleged disadvantaged condition of cooperatives stems exclusively from a few instances of evidence drawn from the manufacturing domain, which are not necessarily true in activities like health care provision, where the human asset is key. Our research shows that health cooperatives succeed in funding their activities like or even better than for-profit providers using alternative modalities, including the subscription of shares by large groups of users and the accumulation of profits in special reserves. The financial strategy pursued by Italian social cooperatives in this respect is a case in point.

Furthermore, health cooperatives often supply goods and services with low and uncertain, if not negative, profitability, which investor-owned enterprises are not interested in providing and public authorities are increasingly unable to supply. In cases of negative profitability, cooperatives can achieve the break-even point thanks to the attraction of additional resources, e.g. voluntary work and donations, or the implementation of price discrimination policies in different areas, including the delivery of health services and the sale of medicines and health insurance. Evidence gathered from the experiences of cooperatives shows that voluntary work and donations are especially important in the start-up phase of all types of cooperatives, regardless of their context of operation. The contribution of volunteers is especially relevant in Italian social cooperatives and Canadian health care clinics, providing primary health care services to their members and other individual citizens who choose them as their provider. It is equally important to note the voluntary nature of membership in Japanese agricultural cooperatives as a means whereby prevention is ensured. Similar considerations also apply to mutuals, which can compensate for the declining coverage of health and long-term care by public insurance schemes.

Support organizational innovation

Health cooperatives are distinguished by a tendency to innovate, less in terms of technological innovation than in the design of and experimentation with new organizational structures and services. Their capacity for innovation is primarily generated by their peculiar ownership and governance structures, which tend to engage stakeholders affected by cooperative activity. Based on the case studies conducted, health cooperatives are largely moving towards a more inclusive multi-stakeholder model. As already highlighted, this implies the active engagement of a plurality of stakeholders sharing a common goal in the membership as well as the cooperative's governing bodies. An example of this type of ownership-governance structure is provided by physician cooperatives, which often include patients as members; the contextual engagement of workers and users enables a strengthening of the trust relationship between the care provider and patient, contributing to a significant improvement in service quality. Nonetheless, the engagement of physicians who are well aware of what resources are needed to manage effectively health services also has a role in improving efficiency.

Moreover, the innovative reach of health cooperatives is strengthened by the services delivered, especially by the new cooperatives set up to respond to diversified needs, calling for personalized solutions, which public providers offering mainly standardized services fail to meet. Furthermore, many health cooperatives are increasingly able to combine the use of digital technologies with the relational dimension, which typically distinguishes many cooperatives. This combination allows for improvements in the quality of services delivered and a substantial reduction in the costs to be supported.

Country case studies based on selected types of health cooperatives

Belgium: Mutual aid societies

The Belgian health care system is mainly organized on two levels, i.e. federal and regional. Since 1980, part of the responsibility for health care policy has devolved from the federal government to the regional governments. Health care is primarily funded through social security contributions and taxation; compulsory health insurance is combined with a private system of health care delivery. The health insurance system strongly relies on mutual aid societies, which have a longstanding history in Belgium. All individuals entitled to health insurance must join or register with a sickness fund, either one of the six mutual aid societies or a regional service. Cooperative pharmacies are, nonetheless, significantly widespread and the '*Maisons médicales*' (community health centres) are another interesting form of participatory medicine; although they do not have the status of cooperatives, they share many similarities with them.

Brazil: Unimed, the largest health cooperative in the world

In Brazil, health has been universal since the Federal Constitution of 1988. However, the inability of this public health care system to reach all population groups, together with the low quality of some services, paved the way for the emergence of a network of private health plans, which grew

simultaneously with the public system. Cooperatives occupy most of the market, with Unimed being Brazil's largest health care network and the largest medical cooperative system in the world. Nevertheless, Unimed contributes to improving the health of the population who can afford to pay. Strengthening the cooperative culture among the public and building a solidarity partnership with the State to improve the health of the Brazilian population as a right remains a key challenge to be tackled by Unimed.

Canada: Examples of health cooperatives from Canada

The concept of a publicly-funded health service led to adoption of the Canada Health Act in 1984, which was broadly based on the UK pattern. However, this universal health care system shows several limitations: it focuses on rehabilitation rather than prevention, it excludes vision and dental care from publicly funded plans and it has long wait times, especially for diagnosis and treatment of mental illness as well as for diagnosis and surgeries typical of an aging population. The formation of health cooperatives has been a response to a community-based challenge. Existing cooperatives reflect the diverse priorities of their communities and are focused on the delivery of health care services.

Japan: Health and elderly care cooperatives

After accomplishing universal health care in 1961 and universal long-term care in 2000, Japan has achieved higher life expectancy levels and lower infant mortality rates. Its health and elderly care system is now struggling to sustain itself in terms of service delivery and finance due to the rapid ageing of the population. In Japan, the public sector and the non-profit sector used to dominate health and elderly care delivery, but now the for-profit sector largely operates the elderly care business. Cooperatives have created a viable model of health promotion and integrated community care; *Koseiren* were set up by agricultural cooperatives and operate in rural areas, while health cooperatives were organized as consumer cooperatives to provide health care at an affordable price in urban areas and promote health education/check-up activities for members, in collaboration with health care professionals.

Italy: New cooperative trends and innovations in the Italian health sector

The Italian national health system was established in 1978 to provide the population with universal coverage. The original structure of the system was entirely public, but due to sustainability problems, public agencies struggled to keep the system universal. Thus, interdependencies between the public and private sectors have progressively grown in importance. In this changing context, cooperatives of professionals and practitioners, social cooperatives offering health assistance, pharmaceutical cooperatives and mutuels have progressively started to offer solutions close to users' needs.

Spain: *Fundación Espriu* (Espriu Foundation), a best practice in solidarity and shared management

In Spain, the national health system was established during the late 1980s and reformed in 2011. The system is highly decentralised with the seventeen autonomous communities enjoying a high degree of autonomy. Recent reforms reduced universal coverage, excluding large sections of the population

from protection. These policies have strengthened the role played by health cooperatives, such as the Espriu Foundation, which is comprised of four entities, two insurance companies, two cooperatives of medical doctors and a consumer cooperative.

Closing remarks and perspectives

The diffusion and recent re-emergence of health cooperatives is very closely connected to several key factors, which have become apparent over the past few decades. These include the decentralization of health-care, the diversification and growth of the demand for health services and tensions related to resource availability.

The widespread and global development of health cooperatives confirms the key role played by the various cooperative forms. This role is key, not only in serving millions of people, but also in empowering users, especially the most disadvantaged ones. There is also a growing tendency to design new cooperative models and move towards more inclusive, multi-stakeholder governance, where various typologies of stakeholders are involved in the governing bodies of the cooperative. At the same time, there has been an important emergence of a type of non-profit organization, which performs like a cooperative, though it does not have that legal designation. This is the case, for instance, of associations in many countries or participative foundations (with members), which could easily shift towards a stronger entrepreneurial stance and assume the cooperative form.

Depending on the country, health cooperatives cover diverse roles within the health system; in some instances, they are fully integrated in the system, in other cases, they are largely or fully autonomous. Despite this evidence, the current and potential role of health cooperatives is heavily underestimated, especially by public policies, which tend to either favour shareholder for-profit entities in procurement procedures or use cooperatives in an opportunistic manner for cost-saving purposes. Our research confirms the importance of improving knowledge about the real dimension and roles of health cooperatives worldwide. Better knowledge in this important area is a necessary condition to assign cooperatives a proper place in health care systems. Moreover, it is essential to design enabling policies to further expand cooperatives in the health domain.

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PART 1. HEALTH COOPERATIVES: CONTEXT OF EMERGENCE, DEVELOPMENT SCENARIOS, SIZE AND TRENDS

Chapter 1. The transformation of health systems: Main trends and challenges

Good health is among local communities' primary values, so access to high quality health services is essential. The importance of ensuring healthy lives and promoting everyone's wellbeing is recognized by the third United Nations Sustainable Development Goal. Likewise, the OECD Better Life Index considers health a key concern for citizens in China, Russia, France, Canada and several African countries. Similarly, based on a Gallup Poll conducted in 2017, Americans identify healthcare concerns as the top financial problem in the country.

To address health needs, most nations have developed different types of health systems, combining various mixes of private for-profit, private non-profit, and public institutions as soon as they achieved a sufficient level of wealth. In industrialized countries, these systems have turned into highly complex institutional structures consisting of 'all the organizations, institutions, resources and people whose primary purpose is to improve health' (World Health Organisation, 2008).

Health systems are organized and function in significantly diverse ways across the globe. The number of actors engaged and their roles in managing health services also vary from one country to another. These variations largely depend upon the level of public regulation of related activities; the financing mechanism, e.g. taxation, compulsory insurance and a public or private insurance system; the degree of coverage for sickness; the nature and governance—public, private non-profit, mutual, cooperative or private for-profit—of the organizations managing the delivery of health services; and the modes of service delivery.

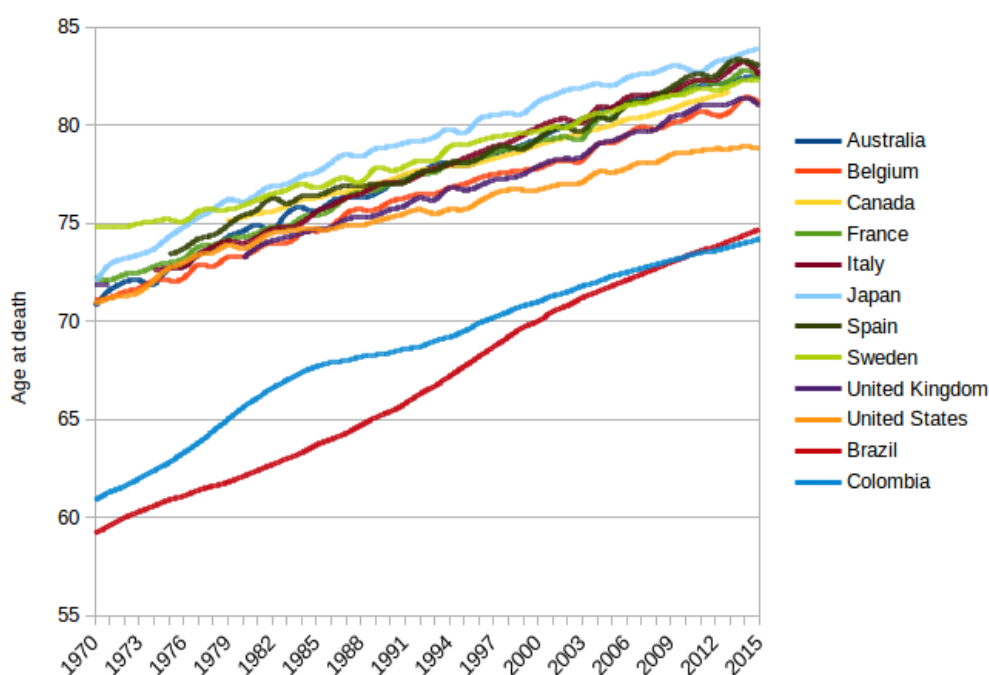
The economic literature corroborates that the health domain typically faces several potential market failures, such as the inability to pay for services and the information asymmetry between the insurers and the insured and between patients and physicians. This explains the dominance of non-profit organizations, mutual aid societies ('mutuals') and cooperatives in most developed countries until the first half of the 1990s when public health systems ensuring broad or universal coverage were established. Building public welfare systems has not implied the disappearance of non-profit organizations managed according to democratic principles. As corroborated by the present research, these organizational types have continued to play a key role, though their importance differs to a significant extent, depending on how each country health system has been organized.

Based on the varying mixes of public-private providers in the health domain, we can spot four main health system typologies. The first type includes health systems that are almost exclusively public with private actors (profit entities, non-profit entities and cooperative enterprises) covering a minor function. The second refers to public universal health systems where public actors have been integrated into the pre-existing private mutual and non-profit organizations. The third type includes health systems conceived to ensure universal public coverage, which have, however, failed to ensure

access to all population groups. Finally, the fourth type—the mixed health system—consists mainly of private health systems with only basic health services being ensured by public policies targeting low-income groups. As highlighted by this report, mutual societies and cooperatives cover diverse roles and have different relevance in each health system.

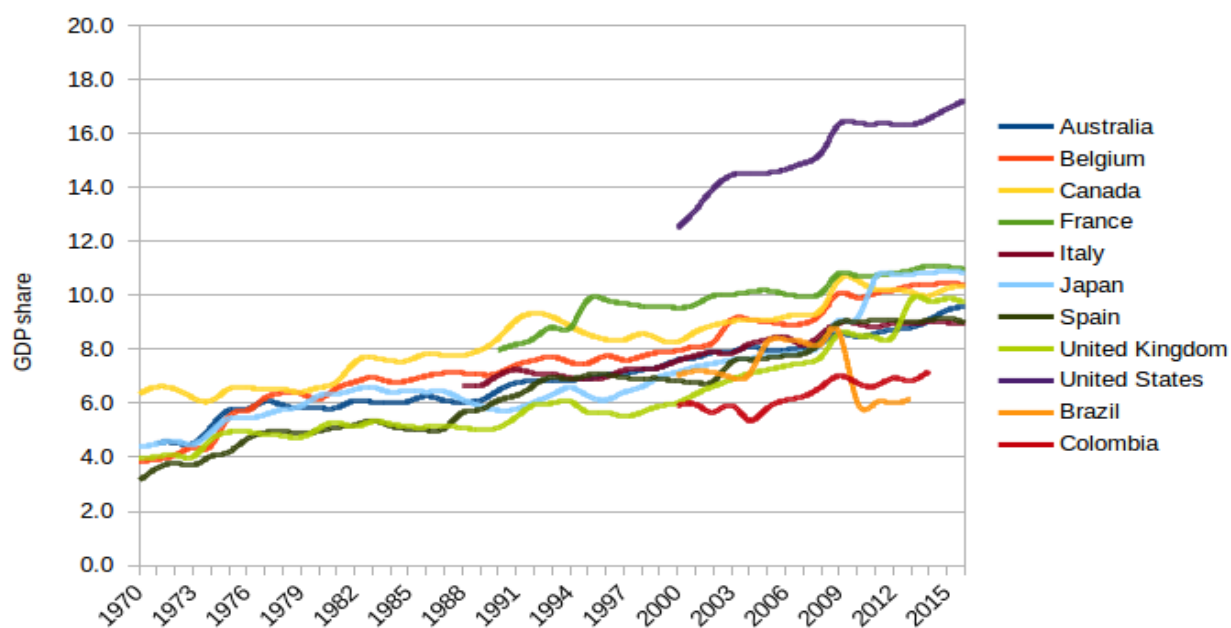
Over the past few decades, tension has been growing in health systems worldwide, mainly due to the dramatic growth of the imbalance between the demand for and the supply of health services. The demand for health services has been boosted mainly by extended life expectancy and people's increasing attentiveness to their personal health and wellbeing. OECD data confirm that life expectancy at birth is increasing in general and in the countries covered by this study (Figure 1). This trend is also reflected in the increase in health expenditure as a percentage of gross domestic product (GDP) (Figure 2). Lifestyle changes have taken place since the beginning of the last century and have played an important role in shaping health systems alongside the recent demographic trends. While the increase in healthcare expenditures in all countries studied is in line with a larger and longer-lived population, the increasing per capita expenditure (Figure 3) suggests that there is an ongoing process aimed at developing new responses to the challenges posed by these new lifestyles, which have emerged as a result of the worldwide demographic transition.

Figure 1. Life expectancy at birth



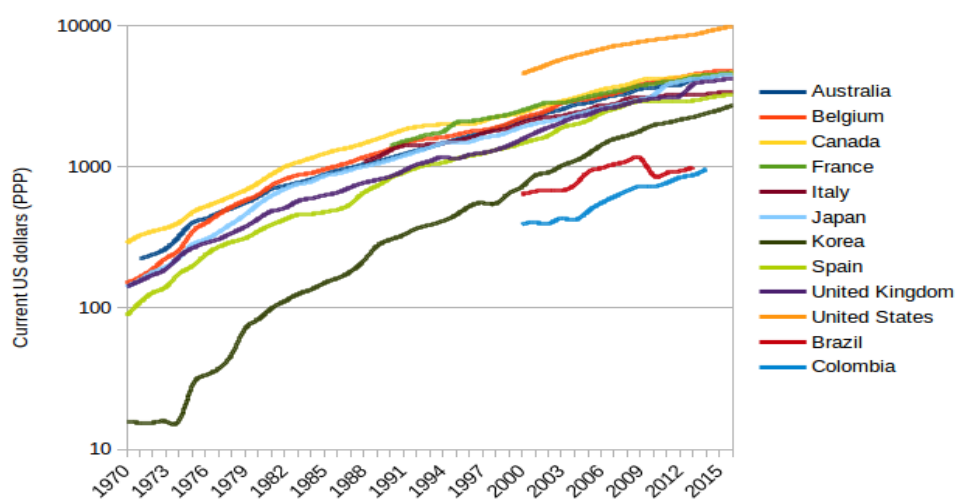
Source: OECD, 2017

Figure 2. Health expenditure (% of GDP)



Source: OECD, 2017

Figure 3. Health expenditure (per capita)



Recent studies show that per capita health expenditure increases significantly with age and that approximately one third of individual expenditure is relative to average age and almost half to old age (Figure 3).

Table 1. Age-specific annual and lifetime per capita expenditure (2000).

Age	Annual per capita expenditure (USD)	Lifetime per capita expenditure (USD)	Relative lifetime expenditure
0	3,432	316,579	100,0%
20	1,448	291,745	92,2%
40	2,601	252,082	79,6%
65	410,245	153,944	48,6%
85	17,071	38,400	12,1%

Source: Alemayehu, B. and Warner, K. E. (2004), The Lifetime Distribution of Health Care Costs. Health Services Research, 39: 627–642.

Longer life expectancy has led to increased rates of morbidity, as more people live long enough to experience the chronic illnesses and disabilities typically associated with aging. This trend has been strengthened by the development of health technologies, which enable successful treatment of several diseases and contribute to increased health expenditures.

Needless to say, there are numerous low-income countries—not covered by this first-year research—that lack a healthcare system altogether. Profoundly different considerations—out of the reach of this report—would be necessary for low-income countries.

Key problems and challenges faced by the health sector

All health systems analysed share a number of mounting problems, which are independent of the specific type of health system. The most common problems facing health systems over the past several decades include the following:

- **Dramatic increases in health expenditure to meet pressing health demands.** This problem is evident in health systems with a large public coverage, which normally face significant challenges in raising financial resources to fund new services and invest in either maintaining or purchasing new technical equipment and facilities. The same problem also characterizes health systems based on a mix of public and private coverage, which tend to react to this mounting problem by increasing the costs of insurance policies, thereby lowering the percentage of the population well covered by health insurance.
- **Neglected preventive care.** To reduce unnecessary healthcare utilization, most health systems have been designed specifically to treat diseases rather than prevent them. Accordingly, most health systems have traditionally paid attention to the role of medical doctors, while the responsibility and active participation of patients in improving their own health conditions have been disregarded in most cases. Although policy makers are increasingly aware of opportunities to reduce health costs and improve the wellbeing of the population (especially the elderly) through investments in prevention, the implementation of prevention measures is jeopardized by several concrete organizational difficulties.

- **Long wait times for healthcare.** Many health systems, especially public ones, are increasingly unable to guarantee reasonable waiting lists for patients seeking specialist visits and treatments, sometimes generating prolonged and unnecessary patient suffering.
- **Difficulty containing rising health costs.** Most health systems are unable to control rising health costs while preserving quality. This is especially evident in private health systems where the widespread recourse to defensive medicine has led to a dramatic increase in health expenditure.
- **Need to respond to the demand for long-term care services.** Most health systems are struggling to cope with long term care due to chronic and degenerative diseases.

Gaps in health service delivery have various implications:

- A progressive and relatively selective reduction in healthcare coverage ensured by both private and public health insurance systems and an increasing inequality among individuals and groups—exacerbated by more and more lower income people giving up on seeking or continuing healthcare treatment—and between urban and rural areas, where access to health services has always been difficult, but is now becoming a greater challenge;
- Increased user resource withdrawal through ticket imposition in public health systems and through the increased cost of private coverage and out-of-pocket expenditures in both public and private systems;
- More intense pressure on healthcare workers (especially medical doctors) to increase their productivity, causing a reduction in the amount of time allocated to patient care and negatively impacting medical ethics and professional satisfaction; and
- A growing gap between the demand for personalized services and standard healthcare provision, which calls for innovative organizational developments.
- Profound changes have been triggered by the development of digital medicine, which is potentially more widely distributed and more inclined to reduce health inequalities and favour cooperative relations than current medical practices.

At the same time there is widespread awareness that the healthcare sector will progressively expand and gain more economic and employment relevance, with the risk that inequalities will also increase exponentially. In this regard, studies on the impact of computerisation upon the labour market (Frey and Osborne, 2013) predict that around 47% of total worker employment is susceptible to automatization in the future. On the other hand, it has also been argued that healthcare work is in a low risk category of further computerization. In fact, while diagnostic tasks are already computerized in the healthcare sector, the global effect of computerisation could still lead to an increase in caregiver jobs.

Policy makers have so far been unable to propose clear and long-term solutions to address these problems. The most widespread policy responses have been the decentralization of healthcare from national to regional authorities and the increasing role of private providers as a consequence of the privatization of healthcare service delivery. The latter has been implemented by favouring the role of

for-profit providers although healthcare is traditionally the sector with the largest number of non-profit organizations, including cooperatives. These political choices support the argument that the potential of health cooperatives is largely overlooked, if not ignored. This asymmetry is mainly due to the (never demonstrated) assumption that the for-profit sector performs better than the public, non-profit and cooperative sectors—often assimilated by the public one—owing to its higher efficiency. Another explanation is the complexity of the non-profit and cooperative supply of healthcare—particularly the different forms, activities, sizes and features exhibited by this varied organizational landscape across the globe. This complexity makes it difficult to extrapolate and quantify the weight of non-profit healthcare-oriented organizations separately from generic ‘private’ organizations. Moreover, reliable and complete data on the true relevance of these actors, especially on the capacity of health cooperatives to perform health services and address health needs, are lacking altogether.

It is worth noting the tendency of policy makers, opinion makers and researchers to overlook one of the key findings of economic theory in the health domain: health is, by far, the sector most subject to market failures due to information asymmetry problems that cannot be adequately solved by regulation. This explains why the provision of health services by for-profit enterprises has proven to be unattainable or inefficient in many circumstances, in addition to being far from any aspiration of social justice. While it is self-evident that the healthcare sector offers good business opportunities, there is also widespread awareness among policy makers of the inability of conventional enterprises to take the interests of less wealthy patients into account. In this respect, the United States (US) is a case in point; healthcare expenditures as a percentage of the GDP in the US are almost twice the average for European countries. Moreover, despite passage of the Affordable Care Act (‘Obamacare’) in 2009, the degree of health coverage continues to be lower when compared to countries in the European Union (EU).

The progressive revival of health cooperatives

If one considers the pressing need to counteract mounting difficulties faced by healthcare systems worldwide, the continued importance—and revitalization—of healthcare cooperatives is not surprising. Indeed, despite having been downsized during the construction of public health systems, mutual societies and cooperatives never disappeared altogether, even in countries with universal public health systems. Meanwhile, in countries with mixed universal health-care systems (consisting of public and private providers) healthcare cooperatives have continued to serve their members over the past two centuries without interruption. Moreover, research conducted so far confirms that these cooperatives exist globally, independent of the type of healthcare system. However, their potential is still far from fully harnessed. For a health cooperative revival to happen fully, healthcare authorities and related workers need to better understand the role, relevance and potential of health cooperatives.

This was precisely the main goal pursued by the research project ‘Healthcare cooperatives and mutual aid societies worldwide: Analysis of their contribution to citizens’ health’, commissioned by the IHCO.

Chapter 2. IHCO research aims and outcomes

Research aims

IHCO and the European Research Institute on Cooperative and Social Enterprises (Euricse) agreed to jointly develop a pluri-annual research initiative on the contribution of healthcare cooperatives to improving people's health and wellbeing across the world. They also aimed to publish an annual report containing—for a progressively growing number of countries—both quantitative and qualitative analyses of healthcare cooperatives and mutual organizations as well as the systems in which they operate.

The nations covered by the first step of our research exclude low-income countries, i.e. most African and some Asian countries, which lack structured healthcare systems altogether. Instead, 15 countries were selected: Argentina, Australia, Belgium, Brazil, Canada, Colombia, France, Italy, Japan, Malaysia, Singapore, Spain, Sweden, the United Kingdom (UK) and the US. For each of these countries, Euricse developed a profile, which focuses on the main features of healthcare cooperatives vis-à-vis the healthcare system. In-depth case studies of the main features of these cooperatives were delivered in Belgium, Brazil, Canada, Italy, Spain and Japan.

Drawing on the case study analyses and country profiles investigated, Euricse aimed to accomplish the following objectives:

- Quantify the number of cooperatives, turnover rates, number of workers and number of users, while promoting a better understanding and knowledge of healthcare cooperatives;
- Via representative case studies, identify the role of cooperatives within the health systems studied;
- Unearth the specific problems these cooperatives can help address in the countries studied;
- Identify those activities, ownership models, organizational forms and governance forms that are effective and can better exploit the competitive advantage of these cooperatives over alternative health providers (public and for-profit).

Against this backdrop, the research initiative investigated various types of cooperatives: cooperatives of health practitioners, mainly doctors; user/patient cooperatives; and multi-stakeholder cooperatives, along with agricultural cooperatives, which, depending on the country, have emerged to provide different types of health services.

Research Methods

The present research project was based on quantitative and qualitative methodologies. The quantitative research aimed to analyse the size of the health cooperative sectors in the selected countries, examining the number of cooperatives in the health sectors and the number of their employees, members and users, as well as their turnover rates.

The statistical units covered by the analysis are the cooperatives, which operate in a wide spectrum of areas such as:

- Physician and general practitioner cooperatives, providing services related to treatment, cure and/or rehabilitation
- Cooperatives running healthcare facilities, hospitals, clinics, etc.
- Other cooperatives providing healthcare and health-related social services
- Cooperatives working on illness prevention, health promotion and/or health literacy
- Cooperatives in the field of pharmaceutical distribution and retailing
- Cooperatives or mutuals offering health plans or insurances, covering some or all of these services.

These sectors can be grouped into three macro categories of activity: strictly health and social care, pharmaceutical activity and health insurance. The economic units traceable back to these categories were identified using the International Standard Industrial Classification of All Economic Activities (ISIC)² codes listed in Table 2.

Table 2. ISIC rev. 4 in the health sector

Category	ISIC rev. 4 codes	ISIC rev. 4 name
Pharmaceutical activity	4772	Retail sale of pharmaceutical and medical goods, cosmetic and toilet articles in specialized stores
Health insurance	65	Health insurance
Strictly health and social care	8610	Hospital activities
	8620	Medical and dental practice activities
	8690	Other human health activities
	8710	Residential nursing care facilities
	8720	Residential care activities for mental retardation, mental health and substance abuse
	8730	Residential care activities for the elderly and disabled
	8810	Social work activities without accommodation for the elderly and disabled
	8890	Other social work activities without accommodation

Data analysis was based on the collection, aggregation and synthesis of already existing data, statistical and research reports, scientific papers, online databases and data provided directly by the

² <https://unstats.un.org/unsd/cr/registry/isic-4.asp>

organizations studied. Several possible data sources, both statistical and administrative, were taken into consideration. These included:

- Official statistics, which are realised and funded by state budgets under their official statistical programmes and can be based on different methods of collecting and analysing data, including statistical registers, censuses, surveys and satellite accounts;
- Other statistical data derived from research reports, surveys and databases carried out by other organisations at national or international levels (umbrella organizations and national and second-level organizations);
- Administrative registers and other administrative sources managed by governmental agencies or umbrella organizations; and
- Annual reports on cooperatives and cooperative groups.

The processes of data collection, aggregation and review were conducted with the support of key informants in each country.

Table 3. Data sources

Country	Data source
Australia	Business Council of Co-operatives and Mutuals ³
Belgium	NAMI-RIZIV ⁴ , Alliance nationale des Mutualités chrétiennes ⁵ , Office de contrôle de mutualités et des unions nationales de mutualités ⁶ , Ophaco Belgium ⁷
Brazil	RAIS.MTB ⁸
Canada	Policy Coordination and Regulatory Affairs -Innovation, Science and Economic Development Canada ⁹
Colombia	Confecoop ¹⁰
France	French Observatory for Social and Solidarity Economy, CNCRESS ¹¹
Italy	Italian National Institute of Statistics (Istat) ¹² and Aida - Bureau Van Dijk ¹³
Japan	Zenkyoren (National Mutual Insurance Federation of Agricultural Cooperatives), National Koseiren (National Agricultural Co-op Federation for Health and Welfare), HeW Co-op Japan (Japanese Consumer Co-op Federation for Health and Welfare).
Singapore	Singapore National Co-operative Federation ¹⁴
Spain	SABI - Bureau Van Dijk ¹⁵
Sweden	Business Register at Statistics Sweden ¹⁶
The United Kingdom	Co-operatives UK ¹⁷

The data collection process faced several challenges and brought about numerous limitations. First, very few countries have reliable statistics on cooperatives operating in the health sector. No data were found for Argentina, Malaysia and the US.

Second, statistics do not cover all variables of interest to our research. Available data proved to be particularly lacking regarding users, which made it necessary to compute preliminary and, in some cases, partial estimates based on a three-step procedure. First, we computed the average number of

³ www.bccm.coop

⁴ www.inami.fgov.be/fr/Pages/default.aspx

⁵ www.mc.be

⁶ www.ocm-cdz.be

⁷ www.ophaco.org

⁸ www.rais.gov.br/sitio/index.jsf

⁹ www.ic.gc.ca/eic/site/693.nsf/eng/h_00037.html

¹⁰ www.confecoop.coop

¹¹ www.cncres.org

¹² www.istat.it

¹³ www.bvdinfo.com/en-gb/our-products/data/national/aida

¹⁴ www.sncf.coop

¹⁵ www.bvdinfo.com/it-it/our-products/company-information/national-products/sabi

¹⁶ www.scb.se/en_/Services/Statistics-Swedens-Business-Register/

¹⁷ www.uk.coop

users per worker in the health, pharmaceutical and insurance sectors. To this end, we relied on the data available from countries that provided this information. Second, to fill gaps in data for countries lacking this information, we estimated the number of users (in the health, pharmaceutical and insurance sectors) by multiplying the number of employees in the sector by the ratio defined at the previous point. Finally, for each country, the total number of users was obtained by adding the estimations computed at sectorial levels. Please note that final data may include double counting in some instances.

This procedure made it possible to estimate the number of users for all countries except for the UK. Appendix 1 presents the data collected and the estimates produced for the fifteen countries examined.

The quantitative research was integrated by a case study analysis focusing on six country studies, which allowed for a more in-depth analysis of the universe of health cooperatives in each country studied. Researchers in charge of conducting country case studies shared a set of guidelines on how to carry out participant observations and interviews. Between one and four cooperatives were studied in each country. The rationale for selecting the case studies was the predominance of specific cooperative types in each country.

The case studies included a detailed description of the socio-economic context of each country and the role played by health cooperatives and mutual societies in the healthcare system. For each analysed organization, we focused on:

- The history and background analysis of the key factors explaining the formation of cooperatives and mutuals in each country;
- The different life cycle phases (implementation and start-up, growth and expansion, etc.) of the studied organization, focusing on the various resources (finance, voluntary, etc.) mobilized at each stage;
- The institutional/governance structure of each organizational type;
- The relationship with public authorities and other private, public and/or cooperative health organizations at the local, national and international levels, along with the relevance of formal reference networks, umbrella organizations or federative bodies to the organization studied;
- Information on asset turnover and employment; and
- The policy environment (types of public finance measures the organization has benefited from since its founding).

Worldwide analysis of healthcare systems

An interesting way to synthesize our findings is to connect the sizes, features and roles of cooperatives to the four health systems previously identified.

Public health systems where private organizations play a minor role: When they were set up, public health systems in Italy, Sweden and the UK have traditionally marginalized other than public providers. However, recent economic crises and social transformations have paved the way for the progressive re-emergence of private organizations in diverse health domains. In particular, private health providers have developed in areas where public providers were absent for various reasons.

These may include policy decisions to not provide specific services, e.g. dental services, altogether or the inability of public providers to respond to new health needs arising in society due to economic or organizational difficulties.

Public health systems incorporating private organizations: Countries with these systems include Belgium, Australia, Canada and Germany (not covered by this study). In these countries, private health providers, including cooperatives and mutuals, enjoy a longstanding history and are strongly integrated into the public health system. In this respect, Belgium is a case in point; mutuals implementing compulsory sickness-disability insurance are often regarded as almost semi-public institutions. Nevertheless, recent reforms are pushing towards greater autonomy of cooperative health providers.

Universal health systems, which leave large population groups uncovered: Brazil and Colombia can be included in this category. These countries were inspired by typical European health systems. They designed their health systems to ensure universal access to health services, but, notably, failed. In Brazil, access to healthcare has been universal since 1988. However, the inability of public health providers to reach all population groups has resulted in a complex network of public and private health providers with cooperatives occupying most of the market.

Mixed health systems: Finally, the US, Malaysia and Argentina are typical examples of the mixed health system. In these countries, people that resort to public health systems are individuals without social security who cannot afford to pay or people living in rural areas.

Independent of the type, health systems are distinguished by diverse degrees of centralization and decentralization: in centralized systems, all major legislation and funding decisions are managed by the central government; in federal systems, central governments set general guidelines, but implementation and funding are delegated mostly to regions; in municipal systems, decisions are the responsibility of smaller communities, e.g. cities and provinces. Fully centralized systems are the rule of the past. They are relatively rare today, likely because, in most countries, the presence of local specificities and the need to effectively control an increasingly complex social structure have exerted a push toward decentralized policymaking and legislation, especially in recent years, as can be seen in Italy.

Table 4 represents a snapshot of the current situation of health systems in the countries studied. Of course, the situation is fluid in many countries and there are transformations pointing in different directions. For instance, in some European countries, e.g. Spain, the weight of private providers has been increasing in recent years in response to a new philosophy guiding public policy. On the other hand, US healthcare, in which the private sector has always played a preponderant role, has taken a turn towards a more universalistic model with the recent reforms implemented by the Obama administration. Also, from the point of view of geographical administration, the situation is not static; for example, even relatively small countries, like Italy and Sweden, have reorganized territorial competences for some health services in recent years.

A general overview of the national health systems provides a coarse-grained map, which can be useful to convey the broad similarities and differences between these countries.

Table 4. Classification of national health systems

		Degree of centralization		
		Centralized health system	Federal or regionalized health system	Municipal health system
Type of health system	Public (with minor role of private providers)		Italy, UK	Sweden
	Public (private providers fully integrated)	Singapore	Australia, Belgium, France, Spain	Canada, Japan
	Universalistic systems that leave large population groups uncovered	Colombia		Brazil
	Mixed	Malaysia	US, Argentina	

Health cooperatives are widespread in all countries studied

The main result of the research is that, despite large variations per country, health cooperatives are found in all health systems surveyed. In particular, they play a significant role in public universal health systems where private healthcare providers are progressively gaining ground. They are also gaining momentum in healthcare systems with partial public coverage, where a large portion of responsibilities had traditionally been assigned to different types of private providers. Finally, health cooperatives are key in systems where different health providers—public and private, for-profit and non-profit—are allowed to freely operate and compete against one another.

In all countries, the range of services delivered by health cooperatives is very wide. It ranges from risk protection to compensate for declining health and long-term care coverage by public insurance institutions to the delivery of prevention and soft healthcare services by general practitioners or specialists. Furthermore, in some countries, cooperatives also distribute pharmaceutical products and manage healthcare clinics.

Country variations depend on several factors: the degree of coverage provided by the public healthcare system; the degree of freedom granted to private providers; cooperative traditions and cultures (social orientation); the ability of cooperative movements to self-organize to address new challenges; and the way cooperatives are recognized, regulated and supported by national laws. Such differences have contributed to shaping the role of cooperatives within the healthcare domain in different ways across countries.

Table 5 summarizes the number of health cooperatives, turnover, employees and users in 12 of the studied countries. In many cases, user data was estimated through the methods illustrated in the

Research Methods section. However, it should be considered that data might have been underestimated in some countries due to a lack of data on specific typologies of health cooperatives/mutuals or employees. Furthermore, it should be considered that, in some countries, organizations similar to cooperatives, i.e. associations in France, which cover the lion's share in the health domain, are not counted. We can therefore conclude that the size of health cooperatives is underestimated in most of the countries reported in the table.

This limitation notwithstanding, the data confirm the general relevance of health cooperatives in terms of turnover, employment and users in all countries studied. Health cooperatives are present in all countries studied; in several countries, they have several millions of users and provide work to tens and sometimes hundreds of thousands of workers. The data also confirm significant country variations. While in some countries, the entire population is involved in a cooperative or a mutual, and some people even interact with more than one, while in other countries, the diffusion of health cooperatives is limited. Countries where health cooperatives are most important—in terms of population share covered—are those where mutuals or other cooperative providers are fully or largely integrated in the system. In these countries, i.e. Belgium and Sweden, the whole population has membership in one or more mutuals.

However, it should be noted that in countries where the share of the population using health services delivered by cooperatives is still rather low, e.g. Canada, these organizations often cover a crucial social role. They often address the needs of the most disadvantaged people who hardly have access to services in general. Moreover, in countries like Italy and Japan, these types of cooperatives developed from the bottom-up, thanks to the mobilization of civil society. Despite having limited resources at their disposal, these health cooperatives have been acknowledged by public health systems and reached significant sizes—in terms of users served—in a short time.

Table 5. Number of cooperatives, turnover, employees and user in the studied countries

Country	Year	Organizations	Turnover (million)	Currency	Employees	Users* (million)	Users* (% of the population**)
Australia	2016	175	9,244	AUD	15,653	3.6	14.9%
Belgium	2014-2015-2016	785	1,002	EUR	19,702	13.2	116.3%
Brazil	2015	1,933	-	-	96,023	24.0	11.6%
Canada	2013	130	63	CAD	1,132	0.4***	1.1%
Colombia	2013-2015	152	9,872,594	COP	17,383	8.6	17.7%
France	2014	1,832	-	-	36,344	12.3	18.4%
Italy	2014	6,756	9,235	EUR	233,397	5.5	9.1%
Japan	2014-2015	145	1,359,320	JPY	91,969	12.2	9.6%
Singapore	2015	4	114	SGD	2,271	1.7	30.3%
Spain	2016	507	14,449	EUR	52,006	6.4	13.8%
Sweden	2015	298	149,411	SEK	19,367	13.6	137.3%

* Estimates

** Source: World Bank

*** Data refer to the users of cooperatives strictly in the health and social services. Data on the insurance sector are not available.

Besides enabling estimations of the size and relevance of the cooperative phenomenon in most of the countries studied, the case study analysis has also allowed for the identification of two distinct criteria explaining country variations related to the role played by health cooperatives. These are the degree of integration of cooperatives and mutual aid societies into the public health systems and the degree of centralization versus decentralization of the health systems.

Based on these criteria, three groups of countries have been identified:

The first group includes countries where healthcare cooperatives and mutual aid societies are highly integrated into the public health system, i.e. a high degree of institutionalization. Examples include Belgium and France, where mutuals have a longstanding history and continue to play a significant role. Although they are highly regulated, they have recently benefited from health system reforms and are achieving growing autonomy. They were set up by workers and trade unions to provide common insurance and assistance and were later incorporated into the public health systems built after World War II. In Belgium, mutuals are involved in complementary health insurance and are combined with a private system of healthcare delivery based on independent medical practice and free choice of service provider, and predominantly operate on a fee-for-service basis. In France, associations and mutual aid societies dominate the healthcare landscape, whereas cooperatives are almost absent.

The second group includes countries where cooperatives and mutual aid societies were downsized by publicly funded universal healthcare systems established during the 20th century. As part of the process of constructing European welfare states, national governments removed most insurance for

social and healthcare services from cooperative and mutual control, thus relegating these entities to play a minor role within the newly established healthcare systems. This situation changed gradually when the traditional welfare regimes started to show the first symptoms of crisis and cooperatives re-emerged as welfare and healthcare providers, especially to meet those needs that public health systems were unable to meet, as well as to address new needs arising in society. Italy and Spain are included in this group of countries (moderate and progressive institutionalization). In both countries, solutions offered by cooperatives had a role in broadening the quantity and types of health services under public coverage, which public health authorities were unable to deliver. The development of mutuals and cooperatives was supported by the increased use of contracts between public agencies and health cooperatives. This included the development of new contracting procedures for the delivery of health services with or without tender. Countries where a trend towards institutionalization is noticeable are also included in this group. Sweden provides a remarkable example as all types of providers including cooperatives and for-profit organizations compete equally, and local municipalities are involved in developing different kinds of agreements on topics connected to service delivery. These agreements are intended to test alternative business models in the welfare and healthcare systems with an aim to exploit the competitive advantage of non-profits and cooperatives.

The third group refers to countries where health cooperatives have always operated autonomously or with limited connections with public health suppliers. This happens in health systems that have been designed to ensure a universal reach but failed to do so because of their inability to deliver services in peripheral areas and/or a lack of financial resources. In many of these countries, health cooperatives and mutual aid societies perform alongside other providers, often to meet the needs of the most fragile population groups, which are the least likely to have access to health services. In Brazil, cooperatives occupy most of the market, including Unimed—Brazil's largest healthcare network and the largest medical cooperative system in the world. In this group are also mixed health systems where public health services are ensured only to individuals without social security benefits who cannot afford to pay. This is the case in Argentina, Malaysia and the US. With respect to the availability of data, this latter group of countries was the most problematic; accordingly, the next steps of the present research will endeavour to focus specifically on this fourth typology.

As illustrated by Table 6, when highlighting the degree of cooperative and mutual aid society institutionalization vis-à-vis the degree of decentralization in the health systems, all health systems studied except Malaysia have become more decentralized.

Table 6. Role of health cooperatives in the studied countries

		Degree of health system centralization vs. decentralization		
		Centralized health system	Federal regionalized health system	Municipal health system
Degree of integration of cooperatives/mutual aid societies in the public health system	Highly institutionalized cooperatives/mutual aid societies fully integrated in the public health system		Belgium, France	Canada
	Moderately institutionalized use of contractual agreements between public agencies and co-ops for the delivery of health services		Italy, UK, Spain	Japan, Sweden
	Not institutionalized Cooperatives perform autonomously	Malaysia	Brazil, US, Argentina, Australia	

Health cooperatives are extraordinarily able to adjust to national and local conditions

Research by Euricse confirms that health cooperatives are highly adaptable to the typical features of any healthcare system. They have traded an ability to reinvent themselves over time and tend to evolve their membership, governing bodies and service delivery to better fulfil unmet needs. Likewise, health cooperatives help overcome coordination failures that arise from asymmetric information typical in different types of healthcare services. Moreover, rather than competing with public providers, health cooperatives tend to fill gaps left by other actors.

Table 7. Health cooperative models in the studied countries

Health cooperative forms						
Country	Worker cooperatives	User cooperatives	Agricultural cooperatives	Mutuals	Inclusive/Multi-stakeholder cooperatives /community-based cooperatives	Organizations owned & controlled by cooperatives
Argentina	ERT—worker-recuperated enterprises					
Australia	General medical practice				Aboriginal co-ops	
Belgium	Pharmacy cooperatives			Mutual societies	Community health centres	
Brazil	Unimed cooperatives—medical, dental & psychological					
Canada	Ambulance cooperatives				Clinics, home care & health services	
Colombia	Medical & dental practices Pharmaceutical cooperatives					
France				Insurance; Mutual aid societies		
Italy	Medical & dental practices; Pharmaceutical cooperatives			Mutuals	Social cooperatives, i.e. residential elderly care, medical & dental practice	
Japan		Health promotion activities—HeW Cooperatives	Koseiren federations & hospitals; Health insurance (Zenkyoren)			
Singapore		Services for elderly people			NTUC Health	
Spain	Pharmaceutical cooperatives			Mutual provident societies; Insurance societies	Medical & dental practice activities	Organizations managed by cooperatives
Sweden	Medical & dental practice activities			Health insurance cooperatives		
United Kingdom	General practice activities			Private insurance		

Essentially, health cooperatives can adjust to changing economic, social and political conditions and can assume various forms consistent with their surrounding cultural and socioeconomic environment more readily than conventional corporations. Unlike other economic sectors, which are typically populated by one predominant type of cooperative, e.g. farmer co-ops in the agricultural sector and worker co-ops in the manufacturing sector, the healthcare sector is distinguished by a rich variety of cooperative forms. Depending on the type of problem addressed, members may include patient-users, medical doctors, nurses, customers of medicines, volunteers (not present in traditional co-ops) or a combination of these stakeholders. The choice in favour of one cooperative type over another depends upon the problem addressed. This may include the inability of users to pay for services, which is typically not a problem addressed by conventional, for-profit enterprises. Other objectives of healthcare cooperatives include: improving the working conditions and valorising the ethical commitment of medical doctors, nursing staff and paramedics; encountering the diversified needs of users; and striking a balance between the advantages provided by advanced technologies and the need to provide personalized services.

Table 5 identifies the most widespread healthcare cooperative types operating in the countries studied; the most popular types, by far, are the healthcare worker cooperatives and mutuals. Also, worth noting is the progressive evolution of the cooperative form towards inclusive membership and governance models. This trend is noticeable, especially for the delivery of healthcare services.

The country case studies and country profiles, which will be described in parts 2 and 3 of this report, provide insight into how different cooperative forms—worker cooperatives, user cooperatives, agricultural cooperatives, mutuals, multi-stakeholder cooperatives and community-based cooperatives—have developed in different health systems.

Worker and producer cooperatives

The aims of health worker cooperatives are to improve the organization of the medical profession; improve the conditions of workers, like medical doctors, who are often put under pressure to increase their productivity; and increase efficiency and effectiveness of the services delivered.

Examples of worker cooperatives include cooperatives that bring together professionals operating in different areas of the health sector: doctors, dentists, nurses, pharmacists and paramedics. Worker cooperatives are widespread in most of the countries studied (except Singapore and Japan), though there are some peculiarities that characterize each country and that depend on the structure of its health system.

Argentina is an emblematic example of the widespread diffusion of complex worker cooperatives. In fact, from the year 2001 onwards, worker-recuperated enterprises have spread throughout the country (Vieta, 2012). This trend developed after the 2001 financial crisis, which was the culmination of a period of strong privatization of the healthcare sector. The situation was so difficult that even private clinics found it impossible to cover all costs, which often led them to fail and cease operations. Workers from many of these organizations have started to reactivate their services, in some cases,

thanks to the help of the communities of reference. For instance, we have identified 15 such worker-recuperated enterprises.

In other countries, like Australia, the development of worker cooperatives is oriented towards the management of medical centres, since Australian doctors are mainly self-employed and must organize their work in independently managed medical centres. This is also the main trend in Italy, particularly in some Italian regions whose recent regulations are pushing doctors to organize themselves.

Pharmaceutical cooperatives are another type of producer cooperative; these are quite common in Belgium. They emerged historically to improve the coordination of pharmacists and distributors and thereby improve the distribution of drugs within the national territory. The first cooperative pharmacies appeared in Belgium at the end of the 19th century, during a period of great expansion of the cooperative movement. Over time, the sector has not only continued expanding but has also become more structured and concentrated, as shown by institutions, such as the Office of Co-operative Pharmacies in Belgium (OPHACO), which groups together about 600 cooperative pharmacies, eight wholesalers and represents approximately 20% of the market (see the Belgian case study for more detail). It is interesting to note that, alongside the development of cooperative pharmacies, private pharmacist associations have also multiplied in Belgium over time.

Other countries in which pharmaceutical cooperatives have spread include Spain and Italy. In Spain, one large pharmaceutical cooperative is Cofares (Martinez, 1996), an important distributor operating nationally, working with more than 9,500 pharmacies and partners and serving more than 3,000 pharmacies as customers. Its history dates back to 1944 and it has played an important role in the formation of the Spanish health system, which started to take shape in 1942. In 2015, pharmaceutical co-operatives in Spain covered more than 71% of the drug distribution sector. Pharmacists, who enjoy more services, certainly benefit from this type of cooperative, while users also receive positive impacts, benefitting from a less uneven territorial distribution (by lowering costs, it is possible to keep pharmacies open in depopulated or sparsely populated areas) and a higher quality of services. Also noteworthy are the two Spanish cooperatives of medical doctors belonging to Espriu Foundation—Lavinia, operating across all the country, and Autogestió Sanitaria, based in Barcelona. Lavinia is a medical services cooperative established in 1977 to manage the property of the insurance company, Asistencia Sanitaria Interprovincial de Seguros, S.A. (ASISA) and to facilitate the participation of doctor members in its healthcare activities. Today, Lavinia-ASISA Hospital Group owns the second most extensive network of non-public hospitals in Spain.

Similar to Spain, the diffusion of pharmaceutical cooperatives can also be seen in Italy, where the private sector is still very strong but where pharmaceutical cooperatives are growing, acquiring a national market share of almost 10.5% in 2016. One example is Cooperative Esercenti Farmacie, which is described in the Italian case study.

In Brazil, the practitioner (worker) cooperative model is very widespread. One of Brazil's largest health cooperatives is Unimed, which offers prospects for health sector improvement. Unimed is an organization with great market power, which is a particularly important feature if we consider that

the Brazilian healthcare system relies on private insurance companies and that, as of 2013 about 27% of the population had no health coverage.

Canada provides a peculiar example in the ambulance sector; it is one of the rare cases in which workers directly control this domain. In most cases, ambulances are managed by non-profits.

User cooperatives

The rationale explaining the upsurge of health user cooperatives is the need to fill gaps in health service delivery, including developing prevention services and improving wellbeing. User cooperatives in the health domain often ensure access to pathological treatment or provide services tailored to at-risk user groups. In Canada, for instance, clinics following the consumer model have developed special health services for seniors, aboriginal people, the poor and people with chronic illnesses. Consumer cooperatives also contribute to filling gaps in health service delivery in marginal and sparsely populated areas where access to public health services is problematic.

Singapore is among those countries where user health cooperatives play a key role. There are two large cooperatives ensuring access to a broad set of health services at the national level. They provide psychosocial and emotional support to family caregivers and endeavour to improve member life quality and life expectancy.

Another example is Japan, where consumer cooperatives are becoming a sort of community cooperative; they are responsible for enhancing and promoting solidarity activities among the members of the organization.

Agricultural cooperatives

Based on our research, Japan is the only country in which health services have been developed by agricultural cooperatives. Since 1947, when the Agricultural Cooperative Act was passed, agricultural cooperatives have provided care services for the elderly. The *Koseiren* are federations of agricultural cooperatives, founded in 1948, which offer care services for the elderly and are also open to non-members; for this reason, they were often converted into municipal public healthcare facilities. This type of structure can therefore guarantee services that are more attentive to user needs, provide inclusive management of patients and workers in Hospital Steering Committees and mobilize support for health promotion initiatives through their non-competitive attitude. These organizations also contribute to innovating rural medical practices.

Mutuals

Mutuals are widely developed across the countries studied. Their rationale is to pool different kinds of risks, including illness, job loss and old age, across their member associations. Mutuals are voluntary groups of natural or legal persons whose main purpose is to meet the needs of their members rather than achieve an investment return target (Grijpstra et al., 2011). They are based on the principles of solidarity and reciprocity and are characterized by free membership and no discrimination between members. Furthermore, they are non-profit organizations; all income is reinvested to improve the services provided to members.

The country where mutual societies plays the most central role in the national health system is Belgium, where 99% of the population is covered by mutual protections, the sole provider of compulsory health insurance. It should be noted that mutual societies have developed independently of the Belgian national health system since the 19th century, when workers began to meet voluntarily to improve risk protection from illness, loss of work and other social needs at the time. In the 20th century, mutual societies were integrated into public agencies and state benefits and subsidies facilitated access to health services.

The Belgian health model has evolved on two levels, regional and federal. The regional level is responsible for hospital management, health promotion, activities related to the elderly and services for pregnant women and children. Regional governments manage and control funds for compulsory health insurance. In Belgium, mutual societies are unusual because they are able to carry out independent prevention activities and services, which involve the general population, not only affiliates. They also offer services in marginal areas and for specific population groups, such as young and elderly women.

Mutual societies are also present in Spain, though they have not been integrated into the public system. Since 2012, universal health insurance coverage has been partially restructured in the aftermath of the long economic recession. There are, in fact, many people who are not covered by public insurance; some of them are professionals without direct health coverage and those not linked to the social security system because their income has exceeded a certain limit. A further reduction in universal healthcare was the exclusion of foreigners without residence permits from public health coverage. Mutual societies, in this context of the changing health protection system, have become an important point of reference for those who see their rights challenged.

Inclusive-multi stakeholder cooperatives—Community based cooperatives

Multi-stakeholder cooperatives differ from traditional cooperatives since they are characterized by the participation of a variety of stakeholders in the membership or governing bodies. In the health sector, stakeholders may include workers, such as medical doctors and nurses, but also users and other individuals or enterprises with a stake in the cooperative's success. While affected by the cooperative activity in different ways, participating stakeholders share a general-interest goal. This common endeavour strengthens the links that cooperatives have with the local community and their ability to approximate its common good.

According to the results of this research, in the health sector, many traditional cooperative forms have evolved or are evolving towards a multi-stakeholder model. One example is Singapore, where health community cooperatives (NTUC Health) manage centres that guarantee health and elderly care services and also provide an integrated suite of services, e.g. pharmacy retail outlets, dental clinics, family clinics, senior day care centres, home care services, care houses, senior activities and wellness centres, home care and case management for vulnerable elders.

Also noteworthy are Italian social cooperatives, which tend to involve a plurality of stakeholders, including volunteers, in their governing bodies and are, hence, distinguished by a strong local

anchorage. Social cooperatives deliver various types of health services, including elderly care and rehabilitation services for disabled people.

In Canada, cooperatives have often developed by integrating the needs of the stakeholders involved. It appears that most of the cooperatives analysed act according to the needs of the community and under a strong drive from the population. It is also worth mentioning cooperatives that deliver home healthcare in Quebec. Similarly, in Belgium, community health centres developed mainly during the 1970s under the push of a movement that favoured the integration of medical centres.

Health cooperatives are on the rise

The case study analysis confirms that health cooperatives have grown in importance over the past 20-30 years in all countries studied. Their increase has been dramatic, especially in countries where they were previously weakly developed or did not exist at all. Their growth has been a clear reaction to the increased demand for health services and the rising difficulties faced by public authorities to support expanding healthcare expenditures. Interesting examples are provided by health cooperatives targeting the needs of elderly populations, namely Italian social cooperatives, Canadian health cooperatives, and Japanese agricultural cooperatives (*Koseiren*). It is also worth noting that there are community-based cooperatives working with indigenous peoples in Canada. In France, health mutuels are becoming increasingly relevant in collective care, like healthcare centres targeting low-income patients, nursing homes and residential facilities for disadvantaged people.

Chapter 3. Cooperative competitive advantages in the health domain

Health cooperatives are not an alternative to public healthcare systems. They share the same general-interest objectives as public healthcare systems and are mostly willing to cooperate with public actors and make their competitive advantages available to improve the provision of health services. Rather, health cooperatives are an alternative to private for-profit providers, despite sharing similar management modalities with them.

The reasons for cooperative success in the health domain are diverse. They are primarily connected to the flexibility of the cooperative form, which stems from its peculiar ownership asset. Furthermore, a cooperative competitive advantage results from the primacy of goals other than economic ones; like any type of cooperative, healthcare cooperatives are formed and operated not to maximize profit for investors, but rather to address the needs of specific stakeholder groups or the community at large. This peculiar aspect has several consequences briefly described below.

Increase accessibility of health services

Cooperatives are, in many instances, set up specifically to increase the accessibility of health services to poor stakeholders and marginal or peripheral communities, thus significantly contributing to reducing health inequalities. In these cases, health cooperatives provide poorer stakeholders or the entire community with the opportunity of transacting on favourable terms with the organization. The cooperative ‘open door’ principle is, in this respect, crucial to ensuring greater participation among interested stakeholders. These types of health cooperatives are more often supported, if not set up, by

volunteers.

Capture and meet new needs arising in society

By promoting a decentralization of power, cooperatives enable increased flexibility in the supply of healthcare services, which allows them to pay individualized attention to users with multiple healthcare access barriers. In fact, given their strong roots at the local level, cooperatives can be considered more knowledgeable about the specific needs arising in each community than traditional public healthcare providers.

When compared to public health providers, cooperatives are more capable of meeting the new demand for social and health services arising in society and the unmet demand for services that both public and for-profit providers are either unable or unwilling to meet. They fulfil this task within a shorter timeframe than public agencies and at lower costs than conventional enterprises. This ability stems from their double nature as social movements and enterprises; it enables them to enhance their local community links because the health cooperatives have either been created by the community itself or community groups are their direct beneficiaries. The adoption of participatory governance models, which enhance the involvement of a plurality of stakeholders, and participative management systems strengthen their exploitation of this ability. The participatory dimension of cooperatives has several beneficial impacts: it encourages the adoption of prevention strategies in the fight against health risk factors at the local level, like pollution, and it enhances the relational dimension of health services, thus helping to improve their quality.

The ability to respond to additional needs is connected to the inter-sectorial nature of many healthcare cooperatives. The Japanese and Italian cases demonstrate that the beneficial impacts of these cooperatives on wellbeing and health improvement is higher when cooperatives take advantage of this feature.

Attract resources that would not be addressed to welfare aims and discriminate prices

The privatisation processes of most healthcare systems explicitly presuppose that shareholder-led health providers, rather than cooperatives, are assigned a dominant role. Cooperatives are indeed considered to be in a disadvantaged condition when it comes to attracting capital. This assumption stems exclusively from a theoretical model, which is not necessarily true in activities like healthcare provision, where the human asset is key. Contrary to what is normally thought, health cooperatives' widespread practice of not distributing profits, ensures that the profits generated are reinvested to strengthen the ability of the cooperatives to achieve their institutional goals.

Furthermore, health cooperatives often supply goods and services with low and uncertain, if not negative, profitability, which investor-owned enterprises are not interested in providing and public authorities are increasingly unable to supply. In cases of negative profitability, cooperatives can achieve the break-even point thanks to the attraction of additional resources, e.g. voluntary work and donations, or the implementation of price discrimination policies in different areas, including the delivery of health services and the sale of medicines and health insurance. Evidence gathered from the experiences of cooperatives shows that voluntary work and donations are especially important in

the start-up phase of all types of cooperatives, regardless of their context of operation. Volunteer contributions are especially relevant in Italian social cooperatives and Canadian healthcare clinics, providing primary healthcare services to their members and other individual citizens who choose them as their provider. It is equally important to note the voluntary nature of membership in Japanese agricultural cooperatives as a means whereby prevention is ensured. Similar considerations also apply to mutuals, which can compensate for the declining coverage of health and long-term care by public insurance institutions.

Support organizational innovation

Health cooperatives are distinguished by a tendency to innovate, less in terms of technological innovation than in the design of and experimentation with new organizational structures and services. Their capacity for innovation is primarily generated by their peculiar ownership and governance structures, which tend to engage stakeholders affected by cooperative activities. Based on the case studies conducted, health cooperatives are largely moving towards a more inclusive multi-stakeholder model. As already highlighted, this implies the active engagement of a plurality of stakeholders sharing a common goal in the membership as well as the cooperative's governing bodies. An example of this type of ownership-governance structure is provided by physician cooperatives, which often include patients as members; the contextual engagement of workers and users enables a strengthening of the trust relationship between the care provider and patient, contributing to a significant improvement in service quality. Nonetheless, the engagement of physicians who are well aware of what resources are needed to effectively manage health services also has a role in improving efficiency.

Moreover, the innovative reach of health cooperatives is strengthened by the services delivered, especially by the new cooperatives set up to respond to diversified needs calling for personalized solutions, which public providers offering mainly standardized services fail to meet. Furthermore, many health cooperatives are increasingly able to combine the use of digital technologies with the relational dimension, which typically distinguishes many cooperatives. This combination allows for improvements in the quality of services delivered and a substantial reduction in the costs to be supported.

Closing remarks and perspectives

Based on this research, the re-emergence of health cooperatives is very closely connected to the decentralization of health-care as well as the diversification and growth of the demand for health services, which has occurred over the past few decades.

The widespread and global development of health cooperatives confirms the key role played by the various cooperative forms in empowering users, especially the most disadvantaged ones. There is also a growing tendency to move towards a multi-stakeholder model, where various typologies of stakeholders are involved in the governing bodies of the cooperatives. At the same time, there has been an important emergence of organizations that perform like cooperatives, though they are not legally designated as cooperatives. This is the case, for instance, of associations in many countries,

which could easily shift towards a stronger entrepreneurial stance and assume the cooperative form. This evolution has happened in Italy, thanks to a particularly enabling environment.

Depending on the country, health cooperatives cover diverse roles within the health system; in some instances, they are fully integrated in the system, in others, they are autonomous.

Despite the growing appeal of health cooperatives, this research confirms that the current and potential role of health cooperatives is heavily underestimated. There is also a general tendency among policy makers, researchers and opinion makers to ignore the specificities and competitive advantages of healthcare cooperatives in favour of public and conventional for-profit providers. The scarce knowledge about and insufficient understanding of the cooperative phenomenon are the main explanations for the predominant under-estimation of health cooperatives, whose relevance is likely to increase further within the next decade, considering the pressing tensions healthcare systems will face. Cooperative development spaces are likely to increase in importance, especially for the supply of soft health services, like natural medical care, long-term care, prevention services and fast diagnostic treatments.

However, the lack of data demonstrates that additional research is needed with a view towards better understanding of healthcare cooperatives and their added value in healthcare. Also crucial is a broad dissemination of research findings beyond the cooperative movement itself.

PART 2. COUNTRY PROFILES: EMERGENCE AND ROLE OF COOPERATIVES AND MUTUALS IN THE HEALTHCARE SYSTEMS OF 15 SELECTED COUNTRIES

Chapter 1. Argentina

Context

Argentina is a federal republic located in South America. The country is divided into the autonomous city of Buenos Aires, which is also the capital of the country, and twenty-three provinces. According to the World Bank's estimates, the Argentinean population amounts to 43 million inhabitants¹⁸.

The national health system and its evolution

The Argentinean health system has gone through different historical phases, each featuring a distinctive healthcare model. The first phase ended in 1945 and was characterized by the decentralized-anarchic model; the second phase spanned the period 1945-1955 and featured a centralized model of healthcare; the subsequent phase (1955-1978) was the result of a strong shift to a more decentralized system with the so-called “Descentralización del Sistema”; finally, the current model established in 1978 relies on fiscal decentralization aimed at the achievement of short-term objectives.

Until 1945, health problems in Argentina were considered private matters for which the public sector was not responsible. Hence, the only actions undertaken by the State were to control public hygiene, curb epidemics and offer assistance in the case of catastrophes. The system at that time consisted mainly of organizations that operated in response to needs without coordination or long-term planning, also because they were structured as charitable organizations that relied solely on individual generosity for their funding. The second phase started with Perón, who changed the philosophy of the system by bringing healthcare under the direct responsibility of the State. In this period, there was an expansion of health coverage. Moreover, all public structures managed by charitable organizations were nationalized; new hospitals and health centres were opened, greatly increasing the number of available beds; and long-term planning started to gain importance. The above initiatives, which were financed entirely through public funding, put health at the centre of the priorities of Perón's government. This was also reflected by the opening of the Department of Hygiene and Health Assistance (the *Departamento Nacional de Higiene* became the *Dirección Nacional de Salud Pública y Asistencia Social*) and the Ministry of Public Health (*Secretaría de Salud Pública y el Ministerio de Salud Pública*). In this phase, workers started to organize themselves and to form organizations that would later become the *obras sociales*, currently the most prominent form of cooperation in the country (Rovella and Arella, 2006).

After the revolution of 1955, the provinces, and no longer the central government, became responsible

18 <https://data.worldbank.org/indicator/SP.POP.TOTL>

for the administration of health services. In this phase, workers' organizations became larger and more prominent and started offering healthcare services and protection to their members. In 1970, the government recognized the *Obras Sociales* – essentially umbrella organizations for worker's unions – with the *Ley de Obras Sociales*, which mandates that each worker be affiliated to an *obra* and that the resources of each organization come from employers and employees, each of which must contribute a fixed share of the employee's wage to the worker's *Obra Social*. In this setting, the State would not contribute to funding the *obras*, but would still act in the direction of universal healthcare through an extensive network of public hospitals and physicians (Rovella and Arella, 2006).

The last model differs from the previous one in that it is characterized by a more liberal structure, according to which the State should be less involved in managing social and health services and leave that sector open to private enterprise. These principles have been implemented through the decentralization of hospitals, which are no longer covered by the national budget, but have to be administered at the provincial level. This on one hand has freed up space in the national budget by eliminating a large cost item, but on the other, it has removed responsibility from the State with respect to the population's health and arguably has led to inequalities in the access to healthcare between the richer and poorer sections of the population (Acuña and Chudnovsky, 2002).

The Argentinean health system relies on three pillars: the public sector, compulsory health insurance, and the private sector. They are not integrated but instead target different parts of the population and receive funding from different sources. The administration of the public sector includes the provincial, national and ministerial levels. The network of hospitals and health centres, which furnish assistance free of charge to anyone in need, is the fundamental activity of the public sector. The people that most often resort to the public health structures are individuals without social security who cannot afford to pay. As of 2008, the latter part of the population consisted of more than 14 million people (Belló and Becerril-Montekio, 2011); overall, the public sector covers the needs of about 50% of the population¹⁹. The compulsory health insurance sector is funded and managed by the social insurance plans called *Obras Sociales*, umbrella organizations for worker's unions, which cover wage-earning employees and their families according to their field of activity or, in the case of public workers, their province of residence. Finally, the private sector includes private medical practitioners and centres that are associated with specific insurance plans, private medical insurance called “pre-paid medical firms” (*Empresas de Medicina Prepaga*) that make up a subset of the network of national clinics. Non-profit health mutuals and health cooperatives are also part of this sector and offer health plans, even though they do not operate on behalf of any social insurance plan²⁰.

As shown in Table 8, the most recent figures reported by the World Health Organization, which are relative to 2014, show that the per capita expenditure on health has been the equivalent of 605 USD, corresponding to a total expenditure of 5% of the total GDP. Between 2010 and 2014 per capita health expenditure decreased substantially, while the weight of private expenditure with respect to the total

19 Source: <https://www.justlanded.com/english/Argentina/Argentina-Guide/Health/Healthcare>

20 Sistema de salud de argentina Mariana Belló, Lic en Psic, M en C,(1) Victor M Becerril-Montekio, Lic en Ec, M en Soc.2

increased from 36% to 45%. The above figures are striking, given that it is estimated that at least half of the population resorts to public healthcare.

Table 8. Health expenditure in Argentina

Indicators	2010	2011	2012	2013	2014
Total Health Expenditure (THE) % Gross Domestic Product (GDP)	7	6	5	5	5
Private Health Expenditure (PvtHE) as % of Total Health Expenditure (THE)	36	36	41	45	45
Total Health Expenditure (THE) per Capita in USD	738	796	727	731	605
General Government Health Expenditure (GGHE) per Capita in USD	469	506	428	401	335
Out of Pocket Expenditure (OOPS) per Capita in USD	162	183	195	221	186
General Government Health Expenditure (GGHE) as % of Gross Domestic Product (GDP)	4	4	3	3	3

Source: World Health Organization 2017, Global Health Expenditure Database

Health cooperatives and mutuals in the national health system

The system of *Obra Sociales* in Argentina gained strength particularly from 1970 onwards under the government of General Onganía. Although they already existed, the *Obras* formed a heterogeneous sector during the 1950s and 1960s, offering very diverse services. The *Obras Sociales* sector consists of organizations that provide the necessary social services to workers and retired individuals (and their families) through compulsory insurance programmes. The sector consists of over 300 organizations, but it is also relatively concentrated, with the first 20 accounting for around two thirds of the total number of beneficiaries²¹.

Health co-operatives and mutuals operate mainly in primary care, nursing, and pharmaceutical services, with some providing pre-paid health coverage. Health cooperatives aggregate in the Argentinean Federation of Health Solidarity Enterprises (FAESS), while mutuals are members of the Argentinean Federation of Health Mutuals. FAESS was formed in 1999, when around 50% of the population did not have access to healthcare. Following a number of worker takeovers during the 2001 economic crisis, various hospitals started functioning as worker cooperatives. FAESS was set up by the Argentinean cooperative movement – the Cooperative Fund Mobilisation Institute and the Confederation of Cooperatives of the Argentine Republic, or Cooperar – and was inspired by health cooperatives in Spain and Brazil, which have highly developed health cooperative models.

In 2015 FAESS started working to amend the law stipulating that non-profit cooperatives must comply with the same regulatory requirements as private for-profit companies that provide health

21 <https://www.revista-portalesmedicos.com/revista-medica/historia-sistema-de-salud-argentino/>

services. While cooperatives exist to benefit their members, and not to make profits, that law failed to recognise their specific nature, thus hindering their development and fulfilment of their mission²².

A distinctive feature of the Argentinean cooperative healthcare sector is that in recent decades a series of organizations – formerly investor- or privately-owned businesses – in financial distress or already bankrupt were taken over and re-opened by their employees, most commonly as worker cooperatives (Ruggeri and Vieta, 2015). These organizations are called “worker-recuperated enterprises” (ERTs, *empresas recuperadas por sus trabajadores*). The legal form used in the vast majority of ERTs is the worker cooperative, which has proved to be the business form most appropriate for workers’ collective self-management in the country, given its legally recognized model and the simplicity of starting a cooperative (Ruggeri and Vieta, 2015). There are fifteen known cases of ERTs operating in the health sector, their names are: Clínica Mosconi, Ex Polimed, Las Flores Salud, Libra, Los Tilos, Fénix Salud, Hospital Israelita, Clínica Junín, Nuevo Perpetuo Socorro, Unión y Trabajo, Ados and Clínica La Merced (Vieta 2018).

22 <https://www.thenews.coop/97207/sector/health/argentinas-co-ops-work-state-provide-health-services/>

Chapter 2. Australia

Context

Australia is a federal parliamentary constitutional monarchy consisting of six states and two major mainland territories. In most cases the two territories operate as states, although the Commonwealth Parliament has the faculty to modify or repeal any legislation passed by the territory parliaments. According to the World Bank statistics, the Australian population is 24 million inhabitants²³.

The national health system and its evolution

In the Australian health system, service provision is assigned to the federal government, the state, and local authorities. The three levels share responsibility to assure citizens access to universal healthcare. The federal government is not directly involved in the delivery of most services, but provides funding to the states and their operators through two plans: the Medicare Benefits Scheme (MBS) and the Pharmaceutical Benefits Scheme (PBS). These have the purpose of funding health services and subsidizing the purchase of pharmaceuticals as well as residential care for the elderly (Glover, 2016). The plans are compulsory insurance schemes that are funded via a levy on the wages of (non low-income) workers, which are integrated by government funds whenever the proceeds of compulsory insurance alone are not enough to cover the costs of the health system. The states integrate federal funds and play a crucial role in the delivery of community health and preventive health programmes. Moreover, they have an important role to play in activities connected to public hospital ambulance services, public dental care, community health services, and mental healthcare. Local governments provide preventive health programs (Glover, 2016).

The health system is mainly financed by general taxation, with medical services supported by a universal national health insurance scheme (Healy, Sharman and Lokuge, 2006). The Australian Government, six States and two Territories share fiscal and operational responsibilities in providing services, but also private providers play a role in service provision, especially about insurance funds, hospitals and the diagnostic sector. Progressive taxation aims to maintain equity within the system. Nevertheless, there are some disparities, in particular with regard to out-of-pocket payments, access to dental care and private health insurance. In this respect there has been concern regarding indigenous Australians (about 2.4% of the population), who suffer poorer health conditions than those of the general population. Nevertheless, the stated key principle underlying much of Australia's health system remains universal access to healthcare regardless of one's ability to pay (Healy, Sharman and Lokuge, 2006).

The Australian Government introduced policies to restrict the use of voluntary health insurance in the late 1990s (Healy, Sharman and Lokuge, 2006). Policies such as the introduction of a surcharge levy for Medicare imposed on high-income earners without private complementary insurance²⁴ have been successful in easing part of the burden of healthcare for the public system and increasing private

23 <https://data.worldbank.org/indicator/SP.POP.TOTL>

24 <https://www.privatehealth.gov.au/healthinsurance/incentivessurcharges/mls.htm>

coverage (Healy, Sharman and Lokuge, 2006). Nevertheless, patients are obliged to make out-of-pocket payments for medicines not covered by government subsidies, dental care, the gap between medical services and fees charged by doctors, and payments to other healthcare professionals. Healthcare remains largely free for the user, though it is worth noting that the publicly funded healthcare system has experienced over time a strong drive towards privatization, as shown not only by the above-mentioned incentive to buy private health insurance but also from the path to privatization of Medibank, the country's largest health insurance provider (accounting for 29% of the market). Medibank was operated as a public non-for-profit entity until 2009, when it became a for-profit Government Business Enterprise paying dividends to the Federal Government, and was later sold in 2014 through an Initial Public Offering.

As shown in Table 9, the most recent figures reported by the World Health Organization, which are relative to 2014, show that the per capita expenditure on health has been the equivalent of 6,031USD, corresponding to a total expenditure of 9% of the total GDP. As of 2006, Australia spent 9.7% of GDP on health, slightly above the OECD average, which shows that public expenditure on health has remained roughly stable also in the medium term.

Table 9. Health expenditure in Australia

Indicators	2010	2011	2012	2013	2014
Total Health Expenditure (THE) % Gross Domestic Product (GDP)	9	9	9	9	9
Private Health Expenditure (PvtHE) as % of Total Health Expenditure (THE)	32	31	33	33	33
Total Health Expenditure (THE) per Capita in USD	5,325	6,368	6,544	6,258	6,031
General Government Health Expenditure (GGHE) per Capita in USD	3,619	4,372	4,395	4,194	4,043
Out of Pocket Expenditure (OOPS) per Capita in USD	990	1,142	1,226	1,178	1,135
General Government Health Expenditure (GGHE) as % of Gross Domestic Product (GDP)	6	6	6	6	6

Source: World Health Organization 2017, Global Health Expenditure Database

Health cooperatives and mutuals in the national health system

Health cooperatives are active especially in the field of general medical practice. Practitioners are mostly self-employed and run their practices as small businesses, whose fees are covered by both private and public money through the Medicare programme. Since the end of the 1990s there has been an increase in the number of companies that have taken over the management of more medical and specialist offices, giving rise to a phenomenon of corporatization of medical activities (Healy, Sharman and Lokuge, 2006). Cooperatives constitute the main alternative model to corporatization. The model of market-based cooperatives is emerging in contexts where General Practitioners have chosen to co-locate for efficiency purposes but want to retain ownership of their practice (Healy, Sharman and Lokuge, 2006).

Cooperatives have also found fertile ground since the late 1960s with the emergence of the Aboriginal political movement and its focus on Indigenous rights, such as land rights, Aboriginal sovereignty, and community control. The movement has received recognition of some of its claims, among which Aboriginal management of some Indigenous-specific social programmes and health services delivered by community-controlled cooperatives, inspired by models of comprehensive primary-healthcare (Anderson, et al., 2006).

Table 10. Types of cooperatives in Australia

Type of cooperative	Number of organizations	Full-time employees*	Part-time employees	Number of members*	Turnover (AUD)
Cooperative providing medical services to Aboriginal people	13	503	435	1,183	88,750,715
Cooperative providing medical services to patient members	1	45	26	-	8,314,396
Member controlled medical service for Aboriginal people	106	4,600	1,023	2,021	683,183,869
Member controlled organisation for Aboriginal health organisation members	35	2167	521	305	335,927,044
Member Owned Health Insurance	2	1,470	764	1,675,236	3,977,183,000
Member owned health insurance fund	16	896	465	1,068,925	2,729,142,112
Member owned well-being fund	1	1,301	1,435	300,000	1,420,728,000
Cooperative facilitating independent living for members who have a disability	1	2	-	-	300,000
Total	182	10,984	4,669	3,047,670	9,243,529,136

Source: Business Council of Co-operatives and Mutuals.

Year: 2016.

* Data for this variable was not available for all organizations. The numbers presented in the table a count of the available data. No estimate was possible to fill in the missing entries.

Chapter 3. Belgium

Context

Belgium is a federal constitutional monarchy governed by a parliamentary system. It is divided into three regions – the Flemish region, the Walloon region and the Brussels-capital region – and three communities, the Flemish community, the French community and the German-speaking community. According to the World Bank statistics, the Belgian population is 11 million inhabitants²⁵.

The national health system and its evolution

The Belgian health system is based on the principle of social insurance characterized by solidarity between the rich and the poor – healthy and sick – and with no selection of risk. The Belgian health system is organised at two levels corresponding to the federal government and regional governments of the three regions and communities (Grijpstra, et al., 2011). On the one hand, the Federal Government is responsible for regulating and financing compulsory insurance, determining accreditation criteria, financing hospitals and heavy medical care units, regulating the various professional qualifications and price control of medicines (Grijpstra, et al., 2011). On the other hand, regional governments are in charge of maternity and child health services, elderly care and hospital management. Insurance is compulsory and all persons entitled to insurance must register with one of the existing health insurance funds. The insurance is combined with a private healthcare system, i.e. independent medical practices, and is characterised by the free choice of service provider (Grijpstra, et al., 2011). The Belgian health system is based on the Bismarckian model, in which funding is largely provided by the social contributions of workers, the amount of which is proportional to the worker's wage. This is inspired by the so-called principle of solidarity between active people, according to which a person participates in funding the common good according to his or her means and receives depending on his/her need. The Belgian health system has also been influenced by the Beveridgean model, designed to provide the same basic protection to all citizens. This is reflected in the facts that identical flat-rate benefits are provided by the health system to all, that financing for healthcare also comes from taxation, and that the system is mainly run by the State.

The Belgian health system is financed by a combination of social security contributions and taxes. Public sector financing as a percentage of total healthcare expenditure fluctuates around 70% (Annemans et. al., 2009). Financing is based on progressive direct taxation, proportional social security contributions related to income, and alternative financing related to the consumption of goods and services (value added tax).

99% of the population is covered by insurance. The list and tariffs of benefits covered by compulsory healthcare insurance are determined at national level, and services not included in the list are non-refundable (Corens, et al., 2007). As shown in Table 11, the most recent figures reported by the World Health Organization, which are relative to 2014, show that the per capita expenditure on healthcare has been the equivalent of 4,884 USD, corresponding to a total expenditure of 11% of total GDP.

25 <https://data.worldbank.org/indicator/SP.POP.TOTL>

Table 11: Health expenditure in Belgium

Indicators	2010	2011	2012	2013	2014
Total Health Expenditure (THE) % Gross Domestic Product (GDP)	10	10	11	11	11
Private Health Expenditure (PvtHE) as % of Total Health Expenditure (THE)	22	23	22	22	22
Total Health Expenditure (THE) per Capita in USD	4,419	4,864	4,588	4,813	4,884
General Government Health Expenditure (GGHE) per Capita in USD	3,433	3,736	3,563	3,745	3,803
Out of Pocket Expenditure (OOPS) per Capita in USD	792	911	816	859	870
General Government Health Expenditure (GGHE) as % of Gross Domestic Product (GDP)	8	8	8	8	8

Source: World Health Organization 2017, Global Health Expenditure Database

Health cooperatives and mutuals in the national health system

The mutual movements first appeared in the 19th century as a form of protection for workers. Early mutuals were structured as voluntary associations of mutual assistance societies set up by local employers, workers, and philanthropists. Workers were then free to contribute and participate in the decisions of these first mutual societies. The idea of pooling risk (illness, job loss, old age) through an associative structure of free membership spread gradually. At the beginning of the 20th century, the mutual movement underwent strong expansion. Increasingly, local mutual societies grouped themselves into local federations and unions at the national level. Today, they represent an association aimed at promoting the physical, mental, and social well-being of their members. This is strengthened by the fact that mutuals are the only providers of compulsory healthcare insurance, covering 99% of the population (Corens, et al., 2007).

These organizations also tend to be quite large and their concentration relatively low, as shown by the fact that, as of 2009, there was a total of 57 mutual societies in Belgium grouped into five national associations based on ideological, political preferences – the National Alliance of Christian Mutualities, the National Union of Neutral Mutualities, the National Union of Socialist Mutualities, the National Union of Liberal Mutualities, and the Union of the Free and Professional Mutualities – of which 54 had more than 15,000 members and only 3 fewer than 15,000 (Corens, et al., 2007). In the absence of constraints, there might be a natural push towards higher concentration. However, an upper bound on their size is imposed by the requirement that each mutual assistance society only offers insurance to individuals registered with a member fund (Corens, et al., 2007). Moreover, the law mandates that individuals join or register with a mutual benefit society providing compulsory health insurance; the choice of the mutual society with which to register is generally free. The role of mutual benefit societies consists in regularly negotiating the fees for the services listed as part of compulsory health insurance. Traditionally, mutual benefit societies have also offered voluntary (complementary) insurance plans, but they have been forced by the European Union to create separate

legal entities to operate on the voluntary health insurance market: societies of mutual assistance (Grijpstra, et al., 2011).

Cooperatives are also important in the health sector, especially in the form of pharmacy cooperatives, which are large professional unions federating cooperative pharmacies and wholesale dispatchers representing approximately 20% of the market, subscribing to the principles and values of the social economy as well as the Charter and the commitments of the European Union of Social Pharmacies²⁶. The first cooperative pharmacies appeared in Belgium in the 1880s, a decade that saw the birth and rapid expansion of a strong cooperative movement. In parallel to the development of the cooperative pharmacies, it is interesting to note that over time there has been a proliferation of private pharmacist associations.

Belgian mutual health funds stand out from the rest of social economy enterprises due to their size, their long history and their special relationship with the public authorities. Yet the challenges they face are very similar to those of other structures: for example, resistance to competition and to the commodification of goods and services as well as difficulty in maintaining internal democracy. In Belgium, the status of mutuals is special. Indeed, their task of implementing compulsory sickness-disability insurance makes them appear almost as semi-public institutions. A further element that shows the high degree of integration of mutuals within the Belgian system is the fact that the accounting of the National Bank of Belgium includes part of their activities in the sector of public administration.

Table 12. Types of cooperatives in Belgium

ISIC rev. 4 codes	Description	Number of org.s	Number of members	Number of users	Number of volunteers	Number of employees	Turnover (EUR)
4772	Retail sale of pharmaceutical and medical goods, cosmetic and toilet articles in specialized stores	607 city pharmacies	13	1,8 Mil	0	3,500	1,000 Mil
65	Health insurance	71	11,114,281		29,346*	14,202**	n.a.
8620***	Medical and dental practice activities	107	1,200	220,000	20	2,000	1,700,000

Sources: NAMI-RIZIV (2014) Répertoire des unions nationales de mutualités, Juin 2014.

Alliance nationale des Mutualités chrétiennes (2016) Rapport Annuel 2015, p. 103 (source INAMI, service du contrôle administratif – direction contrôle et gestion des données d’accessibilité et archivage des données).

Office de contrôle de mutualités et des unions nationales de mutualités (2015) Rapport annuel 2014, p.69 Ophaco Belgium. Data at Dec 31st, 2016.

²⁶ https://ec.europa.eu/health/sites/health/files/files/falsified_medicines/2012-06_safety-features/eusp_en.pdf

* Data available only for NAMAC and NUSM.

** Full time. Data available for: The National Alliance of Christian Mutualities (NACM), The National Union of Neutral Mutualities (NUNM), The National Union of Socialist Mutualities (NUSM), The National Union of Liberal Mutualities (NULM), The National Union of the Free and Professional Mutualities (NUFPM).

*** Data Available for one federation Maisons Medicales as Community Health Centre (CHC).

Chapter 4. Brazil

Context

Brazil is the largest federal republic in South America. It is a federation composed of 26 states, which have autonomous administrations, a federal district and 5570 municipalities. The estimated population is 203,387,885 inhabitants²⁷.

The national health system and its evolution

In Brazil, access to healthcare has been universal since the Federal Constitution of 1988, which represented many advances in terms of access, coverage, structure and democratic management with respect to the past. According to the current legislation, the Health Ministry administers national health policy, while primary healthcare remains the responsibility of the federal government. Public healthcare is provided to all permanent Brazilian residents and foreigners on Brazilian territory through the National Healthcare System, known as the Unified Health System. To be noted is that a network of private health plans has grown simultaneously with the public system to cover a wider variety of needs.

The Reform was an important milestone in construction of the healthcare system. It originated in the struggle against the military regime that ruled the country during the period of dictatorship (1964-1984), which implemented governmental reforms that privileged the expansion of a largely private health system, particularly in large urban centres. The Federal Constitution of 1988 – the so-called "Citizen's Constitution" – finally enshrined health as a fundamental right and established that it was a duty of the State to develop public policies aimed at reducing disease and promoting health. The implementation of the principles of the Sanitary Reform and of the Constitution of 1988 began in 1990 through the Unified Health System or "Sistema Único de Saúde" (SUS). The current legal provisions governing the operation of the healthcare system were instituted in 1996 with the purpose of shifting responsibility for administration of the SUS to municipal governments, with technical and financial cooperation from the federal government and the states.

The Federal Constitution of 1988 declares that healthcare is free to private initiative, but that health actions and services are of public relevance and the State is responsible for regulation, supervision, and control. In the 1990s, a wave of privatizations and concessions took place following the recommendations of the Washington Consensus. As a result, in 1998, 24.5% of the Brazilian population had health insurance, a figure that increased to 27.9% by 2013. Regardless of the growth in average coverage, the distribution of private insurance remained rather heterogeneous. In fact, the South-East, South, and Centre-West regions had the highest proportions of insured individuals (36.9%, 32.8% and 30.4%, respectively), while the North and North-East regions had the lowest (13.3% and 15.5%, respectively). In urban areas, the percentage of people covered by health insurance plans was 31.7%, about five times higher than in rural areas (6.2%) (IBGE, 2015). With the strengthening of SUS, it was expected that the private provision of health services would decline considerably, but this did not happen. As mentioned above, the private sector established itself within

27 <https://data.worldbank.org/indicator/SP.POP.TOTL>

the health system in parallel with the public sector by offering outsourced services through the SUS, hospital and outpatient services paid by direct disbursement, and insurance plans. As a result of this co-evolution, the Brazilian health system consists of a complex network of providers and buyers of services that compete with each other, generating a public-private combination mostly financed by private resources.

As shown in Table 13, the most recent figures reported by the World Health Organization, which are relative to 2014, show that the per capita expenditure on health has been the equivalent of 947 USD, corresponding to a total expenditure of 8% of total GDP. The table also shows that in recent years the weight of private health expenditure has remained stable and prevalent, while government per capita expenditure in the health sector has neither grown nor decreased substantially.

Table 13. Health expenditure in Brazil

Indicators	2010	2011	2012	2013	2014
Total Health Expenditure (THE) % Gross Domestic Product (GDP)	8	8	8	8	8
Private Health Expenditure (PvtHE) as % of Total Health Expenditure (THE)	54	55	56	55	54
Total Health Expenditure (THE) per Capita in USD	920	1,055	985	993	947
General Government Health Expenditure (GGHE) per Capita in USD	421	477	437	448	436
Out of Pocket Expenditure (OOPS) per Capita in USD	251	283	265	256	241
General Government Health Expenditure (GGHE) as % of Gross Domestic Product (GDP)	4	4	4	4	4

Source: World Health Organization 2017, Global Health Expenditure Database

Health cooperatives and mutuals in the national health system

Cooperatives occupy most of the market, with Unimed being Brazil's largest healthcare network and the largest medical cooperative work system in the world with over 114,000 members and 348 cooperatives. Moreover, health cooperatives, whose explicit mission is the preservation and promotion of human health, operate today in distinct areas of the health sector: medical, dental, and psychological. The cooperative healthcare sector – which is present in 85% of the national territory and last year handled 36 billion US dollars – represents 32% of the private health market. In the scenario of supplementary healthcare, cooperatives occupy the second position, covering 29% of the total number of operators. The success of health cooperativism is due to its strong acceptance in society; higher remuneration and valuation of professionals; good relations with non-governmental organizations and public entities; and diffusion of values and cooperative principles. Health cooperatives are moving towards significant changes in governance, adopting professional criteria in their executive management.

Table 14. Types of cooperatives in Brazil

ISIC rev. 4 codes	Description	Number of organizations	Number of employees	Number of members
4772	Retail sale of pharmaceutical and medical goods, cosmetic and toilet articles in specialized stores	310	2,925	-
65	Health insurance	770	45,301	-
8610	Hospital activities	234	38,375	250,000
8620	Medical and dental practice activities	316	5,174	-
8690	Other human health activities	288	4,244	-
8720	Residential care activities for mental retardation, mental health and substance abuse	2	-	-
8730	Residential care activities for the elderly and disabled	5	-	-
8810	Social work activities without accommodation for the elderly and disabled	8	3	-

Source: RAIS.MTb – IHCO Case Study on Brazil.
Year: 2015.

Chapter 5. Canada

Context

Canada is a federal monarchy, which comprises ten provinces and three territories. Canada is located in the northern part of North America and is the second largest country in the world. According to the World Bank statistics, the Canadian population is 36 million inhabitants²⁸.

The national health system and its evolution

The Canadian healthcare system is highly decentralised. This is partly due to the conformation of the country's territory and its cultural diversity. In Canada, the health system is managed by the provinces, the territories and the federal government. The former has primary jurisdiction over the administration and governance of their health systems, the latter assume a role of support on territorial programmes organized by the provinces and territories. Provinces and territories manage and furnish health services and supervise providers. They have established regional health authorities that plan and provide public services at local level. These authorities are responsible for financing and providing hospital care, mental and public health services. The federal government co-finances provincial and territorial programmes. Publicly-funded health services must be publicly administered, fully covered, universal and accessible. The federal government also regulates the safety and effectiveness of medical devices, pharmaceuticals and natural health, finances health research, and manages a range of services for specific protected population groups (Allin and Rudoler, 2014).

Provinces and territories administer their own universal health insurance schemes covering all provincial and territorial residents according to their residence requirements. In fact, temporary legal visitors and undocumented immigrants are not covered by any federal or provincial programme (Allin and Rudoler, 2014).

General provincial and territorial spending contributes the largest share of resources to locally administered health services, although the federal government also contributes by transferring resources to the local administrative areas through Canada Health Transfer. The federal contribution has been estimated at 28.8 billion USD, accounting for roughly 24% of the total provincial and territorial health expenditure. The main funding sources for the public health services administered by local administrations are general provincial and territorial spending.

Around two thirds of Canadians also purchase some form of private health insurance offered by for-profit insurance companies, thus making the private sector a significant player accounting for 12% of total health expenditure as of 2014. Private plan premiums, which generally cover services that are excluded from public reimbursement (e.g. dental care, rehabilitation, home care), are mostly paid for by employers, unions or their organizations (Allin and Rudoler, 2014).

As shown in Table 15, the most recent figures reported by the World Health Organization, which are relative to 2014, show that the per capita expenditure on health has been the equivalent of 5,292 USD, corresponding to a total expenditure of 10% of total GDP. Estimates for 2016 predicted that total and

28 <https://data.worldbank.org/indicator/SP.POP.TOTL>

publicly funded health expenditures would account for around 11% and 8.0% of GDP respectively, and that 69.8% of total health spending would come from public sources.

Table 15. Health expenditure in Canada

Indicators	2010	2011	2012	2013	2014
Total Health Expenditure (THE) % Gross Domestic Product (GDP)	11	11	11	11	10
Private Health Expenditure (PvtHE) as % of Total Health Expenditure (THE)	30	29	29	29	29
Total Health Expenditure (THE) per Capita in USD	5,348	5,665	5,719	5,619	5,292
General Government Health Expenditure (GGHE) per Capita in USD	3,764	4,019	4,059	3,992	3,753
Out of Pocket Expenditure (OOPS) per Capita in USD	779	793	786	767	720
General Government Health Expenditure (GGHE) as % of Gross Domestic Product (GDP)	8	8	8	8	7

Source: World Health Organization 2017, Global Health Expenditure Database

Health cooperatives and mutuals in the national health system

The concept of cooperative delivery of services in the wellness, health, social services, medical and related services was active in Canada before the establishment of the Canada Health Act. The first cooperative operating health services were established in Québec in 1944. Then, in 1960 the Co-operative Commonwealth Federation led by Tommy Douglas, won the provincial election in Saskatchewan based on its promise to create North America's first publicly funded medical service. The ensuing turmoil led to a doctors' strike and then, in 1962 to the formation of the Community Health Services Association Ltd. Saskatchewan by a group of pro-medicare citizens, including doctors. Thereafter the movement towards cooperative healthcare became widespread, as community health associations quickly organized clinics and other facilities to help fill the gap created by the lost services of the striking doctors. Later, with Medicare up and running, several community health cooperatives ceased operations, while "others saw Medicare as merely a first step in the right direction and consequently pushed forward with their community health associations. They stood by their principles of consumer involvement and alternative planning, financing, and delivery mechanisms, in hopes of creating a more inclusive Medicare system" (Craddock and Vayid, 2004 :22). The initial distrust in the effectiveness of the newly deployed Medicare programme and the enduring popularity of the cooperative model can probably be partially explained by the fact that challenges related to the health of Canadians reflect the vast size of Canada, its climate, history, cultural diversity, and the complexity of its governance system. For example, geography and economic status influence access to wellness education, health services and medical facilities and services. Moreover, residents of remote areas and people without the financial means to travel to health and medical facilities are all at risk of being unable to access needed services. At the same time, diverse ethnicities and languages raise unresolved challenges in identification of health and medical needs and in delivery of services.

A recent surge in the home care segment driven by the ageing population has led to the dominance of organizations operating in that area within the cooperative health sector (Craddock and Vayid, 2004). Québec's dominance in cooperative-based home care delivery cannot be ignored, also because the region has extensively adopted an organizational model for its cooperative healthcare facilities – known as multi-stakeholder – which is one of the most widely adopted models in the Canadian cooperative landscape. Multi-stakeholder cooperatives are characterized by a combination of several types of members ranging from final users, service providers, workers, and any other individual or enterprise with a stake in the cooperative's success. A peculiarity of this organizational form is that different stakeholders share the common goal, contributing to the success of the cooperative and thereby favouring the emergence of solidarity (Craddock and Vayid, 2004).

Another notable cooperative sector that was established in Québec in the 1980s is the ambulance sector, which gained momentum when several organizations in the region started to transform into cooperatives following the desire of workers to undertake more responsibility and acquire greater control in the workplace. Ambulance coops generally follow the worker model of cooperatives, in which members are both owners and employees who control all of the cooperative's operations.

A further area of healthcare with a strong cooperative presence consists of healthcare clinics, which provide primary health services to their members and other citizens who choose them as their providers. The clinics tailor their services to fit the needs of their users. For example, some develop special services for at-risk client groups in their areas, such as seniors, aboriginal people, the poor, and persons with chronic illnesses. In general, cooperative clinics tend to follow the consumer model type, according to which the cooperative provides services for its members' personal use (Craddock and Vayid, 2004).

Table 16: Types of cooperatives in Canada

NAICS codes	NAICS sector	Number of org.s	Number of members	Number of users	Number of volunteers	Number of employees	Turnover (CAD)
62.1	Ambulatory healthcare services	81	141,795		765	869	51,029,963
62.2	Hospitals	-	-	-	-	-	-
62.31	Nursing care facilities	-	-	-	-	-	-
62.32	Residential developmental handicap, mental health and substance abuse facilities	1	**		**	**	**
62.33	Community care facilities for the elderly	1	**		**	**	**
62.41	Social assistance- Individual and family services	46	6,668		106	263	11,573,107
44.61	Health and personal care stores	-	-	-	-	-	-
52.4	Insurance carriers and related activities	1	**		**	**	**
4772	Pharmacy Co-op	-	-	-	-	-	-

Source: Policy Coordination and Regulatory Affairs -Innovation, Science and Economic Development Canada.
Year: 2013.

** Cannot release data since there is only 1 cooperative

Chapter 6. Colombia

Context

Colombia is located in the north-west of South America and has territories in Central America. Colombia is a constitutional republic consisting of 32 departments. According to the World Bank statistics, the Colombian population is 48.6 million inhabitants²⁹.

The national health system and its evolution

The national constitution was reformed in 1991. Around the same time, also the general system of social security was revised. A crucial step in the process was the implementation of Law 100 of 1993, which widely extended health coverage to the population. Law 100 of 1993 consisted of four books, each tackling a specific aspect of social security: pensions, healthcare, occupational safety, and complementary social services. According to the general principles of the law, healthcare is a public service that must be granted under conditions of proficiency, universality, social solidarity, and participation. In particular, article 153 mandates that health insurance be compulsory, that health providers have administrative autonomy, and that health users have free choice of health providers.

The 1993 reform passed on the burden of public financing of healthcare by transferring it from providers to users. As a result, employees are now forced to pay into health plans to which employers also contribute. This reform has thus contributed, on the one hand, to extending health coverage from 21% (before 1993) to 56% in 2004 and 66% in 2005, but on the other hand it has not acted on health inequalities in the country.

Significant differences in access to healthcare between urban and rural residents should be taken into account. In fact, coverage in the largest cities is higher than in rural areas, where the best services have been provided by departments in coffee-growing areas, while in non-Andean rural regions and marginal neighbourhoods in medium-sized and small towns, coverage and health quality are much lower.

The Colombian social security system is characterized by two regimes, contributive and subsidized, each operating under its own rules and covering a specific sub-population. The former applies to families and individuals who adhere to the system through the payment of predetermined fees or through employer/employee co-payments. The typical categories accessing contributive health are private sector employees with health benefits included in their contract, public servants, retired workers, and well-off self-employed individuals. The latter regime instead consists in the set of norms regulating social security contributions that are subsidized by the public sector or other solidarity funds (Unidad Administrativa de Organizaciones Solidarias³⁰). A person who cannot afford to pay the fees to the contributory regime but is still entitled to social security goes under the subsidized regime; some particularly significant groups within the subsidized regime are pregnant women - for

²⁹ <https://data.worldbank.org/indicator/SP.POP.TOTL>

³⁰ <http://www.orgsolidarias.gov.co>

whom assistance is guaranteed throughout their maternity period and during the weeks following childbirth - children, seniors, impaired individuals, and members of indigenous communities.

There is also a layer of public agencies and programmes regulating the Colombian healthcare sector. For example, the System for the Selection of Beneficiaries for Social Programs (*Sistema de Selección de Beneficiarios para Programas Sociales*), which serves the national system of identification of beneficiaries for social subsidies, classifies people according to their socio-economic level into 6 strata, stratum 1 being the poorest (e.g. homeless people and others in extreme poverty) and stratum 6 the highest level of affluence, in order to attribute subsidies and minimum benefit packages.

The National Health Superintendent (*Superintendencia de Salud*) decides which organizations qualify as *EPS: Entidades Promotoras de Salud* (health promoting entities) according to a number of criteria, including infrastructure, capital, number of users, functionality, and coverage. These entities are in charge of administering the contributive system essentially by selling health service packages to the public and contracting such services with the healthcare-providing institution. Some EPS providers offer a "*Plan Complementario*", which includes more coverage and priority service to the patient. Most EPS providers also offer "*Medicina Prepagada*", a type of health plan including the highest level of medical attention and priority service to the patient at much higher costs. However, it is important to note that EPS do not act as for-profit health insurance companies, which can freely decide whether or not to cover individuals; on the contrary, their duty is to promote affiliation to the contributive system of whoever has no coverage but has the requisites to apply for it. Contrary to the contributive regime, the subsidized regime of social security is administered directly by the public authorities through local and regional health departments, which receive the required funds directly from the Ministry of Health³¹.

The main cause of premature death in Colombia is heart disease, followed by stroke, respiratory diseases, road accidents and diabetes. According to the 2003 National Health Institute of Colombia, nearly 240,000 people - mostly women and young people - or 0.6% of the population have been infected with AIDS virus since it arrived in Colombia during the 1980s.

As shown in Table 17, the most recent figures reported by the World Health Organization, which are relative to 2014, show that the per capita expenditure on health has been the equivalent of 569 USD, corresponding to a total expenditure of 7% of total GDP. The longer-term trend in Colombia in healthcare expenditure can be better explained by looking back at data from the early 2000s. General government spending on health accounted for 20.5% of total government expenditures and for 84.1% of total health expenditures (private expenditures made up the balance) in 2003. Total expenditures on health constituted 5.6 percent of gross domestic product in 2005. The per capita expenditure on healthcare in 2005 at an average exchange rate was 150 USD (Library of Congress - FRD, 2007).

31 <http://www.orgsolidarias.gov.co/sites/default/files/pagina-basica/pdf/Cartilla%20Coop%20Salud%20WEB.pdf>
[Accessed: May 2017]

Table 17. Health expenditure in Colombia

Indicators	2010	2011	2012	2013	2014
Total Health Expenditure (THE) % Gross Domestic Product (GDP)	7	7	7	7	7
Private Health Expenditure (PvtHE) as % of Total Health Expenditure (THE)	26	24	24	24	25
Total Health Expenditure (THE) per Capita in USD	422	480	547	549	569
General Government Health Expenditure (GGHE) per Capita in USD	311	363	416	419	428
Out of Pocket Expenditure (OOPS) per Capita in USD	75	75	80	76	87
General Government Health Expenditure (GGHE) as % of Gross Domestic Product (GDP)	5	5	5	5	5

Source: World Health Organization 2017, Global Health Expenditure Database.

Health cooperatives and mutuals in the national health system

Cooperatives represent one of the main instruments for the economic and social development of communities in Colombia, and they play a fundamental role in the associative model of solidarity. The workers' cooperatives (*Cooperativas de trabajo asociado*) are defined by the legislator as associated labour cooperatives that link the personal work of their associates for the production of goods, the execution of works, or the provision of services (L. 79/88, article 70).

Table 18. Types of cooperatives in Colombia

ISIC rev. 3 codes	Description	Number of organizations	Number of members	Number of employees*	Turnover (million COP)
8511	Hospital activities	13	36,924	1,961	2,179,572.5
8512	Medical and dental practice activities	42	7,915	168	176,983.0
8519	Other human health activities	32	7,788	227	80,343.1
8532	Social work without accommodation	1	20	1	12,190.1
5231	Retail sale of pharmaceutical and medicinal products, cosmetics and toiletries	5	6,627	7,360	1,194,402.4
-**	Wholesale of pharmaceutical and medicinal products, cosmetics and toiletries	16	6,123	3,585	2,458,994.0
-	Mutuals in the sector of "Health and social services"	43	76,965	4,081	3,770,109.1

Source: Confecoop.

Year: 2013 – 2015.

* Data for this variable was not available for all organizations. The numbers presented in the table a count of the available data. No estimate was possible to fill in the missing entries.

** No associate ISIC code

Chapter 7. France

Context

The French Republic is in Western Europe and has several overseas regions and territories. Since 2016 France has been divided into 18 administrative regions: 13 regions in metropolitan areas of France (including the territorial of Corsica), and five located overseas. The regions are further subdivided into 101 departments. The French population is approximately 46,8 million³².

The national health system and its evolution

Although the French healthcare system consists of social insurance based on the Bismarckian model, it has historically had a more centralized character with a stronger role of the State than in other social insurance systems. In fact, though the French system displays the typical traits of Bismarckian systems, i.e. employment-based access to health protection, financing based on cost sharing between employee and employer, and administration entrusted to para-public sickness funds (Hassenteufel and Palier, 2007), it also has distinctive features such as the increasing importance of tax-based revenue for financing healthcare. These characteristics have made the French health system more oriented towards the Beveridgean model. Statutory health insurance (SHI; *assurance maladie*) covers the resident population through various employment schemes. The provision of care, on the other hand, is mixed and includes private doctors, private pay hospitals (FFS; *rémunération à l'acte*), public hospitals, private non-profit hospitals, and private (for-profit) hospitals. Successive policies and reforms since the 1990s have been aimed at regional devolution. As a consequence, a number of regional institutions have been established over time in order to represent stakeholders such as SHI programmes, the state, health professionals, and public health actors.

In 2009 the Hospital, Patients, Health and Territories (HPST) Act (*Loi No.2009–879 du 21 juillet 2009 portant réforme de l'hôpital et relative aux patients, à la santé et aux territoires*) was enacted to improve the system's efficiency. In particular, the new law concentrated the multiple institutions handling healthcare at the local level into a single regional health agency (*agence régionale de santé*; ARS), whose responsibility is to ensure the effectiveness of healthcare provision by promoting coordination between ambulatories and hospitals, as well as health and social care providers, while keeping expenditure within the national budget allocation. Among their duties, the ARSs plan health and social care for the elderly and the disabled through a regional strategic health plan (*Plan stratégique régional de santé*; PSRS), which involves the ambulatory care sector for service provision (Chevreul, et al., 2015). Apart from addressing the budget concerns due to an increased demand for healthcare services and a greater need for tax financing, the recent reform has also aimed to increase geographic equity in access to care (Chevreul, et al., 2015).

In 2016, the French government also reformed healthcare for foreigners, replacing the *Couverture Maladie Universelle* (CMU) system with *Protection Universelle Maladie* (PUMA), which guarantees that everyone who works or lives permanently in France longer than three months will have access

32 <https://data.worldbank.org/indicator/SP.POP.TOTL>

to French healthcare and reimbursements. Moreover, the reform eliminates up-front payments for most medical services, which are now paid for directly by the government or the health insurer instead of being reimbursed to claiming users.

The French healthcare system assures coverage to all residents regardless of age, income or status through a network of public and private hospitals, doctors and other medical specialists. Costs are covered mostly by the State via a public healthcare insurance scheme, which mandates that residents register with a French health insurer and a doctor through which to seek access to most treatments.³³ The determination of insurance premia is not left to the market; rather, it is centrally calibrated based on the income of the insuree.

In France, healthcare provision is a national responsibility, and the Ministry of Social Affairs, Health and Women's Rights defines the national strategy. Health administration is entrusted to the Regional Health Agencies, which are responsible for the health of the population, including prevention, care provision, public health and social assistance.

In 2013, total French expenditure on health (*dépenses totales de santé*) was estimated at 235 billion EUR (10.9% of GDP), above the average for EU countries. Total expenditure on health as share of GDP has also risen slightly faster than in European partners with the exception of the United Kingdom, from 10.4% in 1995 to 11.6% in 2013. As shown in Table 19, the most recent figures reported by the World Health Organization, which are relative to 2014, show that the per capita expenditure on health has been the equivalent of 4,959 USD, corresponding to a total expenditure of 12% of total GDP (Chevreul, et al., 2015).

Table 19. Health expenditure in France

Indicators	2010	2011	2012	2013	2014
Total Health Expenditure (THE) % Gross Domestic Product (GDP)	11	11	11	12	12
Private Health Expenditure (PvtHE) as % of Total Health Expenditure (THE)	22	22	22	22	22
Total Health Expenditure (THE) per Capita in USD	4.584	4.994	4.699	4.955	4.959
General Government Health Expenditure (GGHE) per Capita in USD	3.553	3.847	3.626	3.820	3.878
Out of Pocket Expenditure (OOPS) per Capita in USD	342	334	306	315	314
General Government Health Expenditure (GGHE) as % of Gross Domestic Product (GDP)	9	9	9	9	9

Source: World Health Organization 2017, Global Health Expenditure Database

³³ http://www.expatica.com/fr/healthcare/french-healthcare-france-health-care-system_101166.html

Health cooperatives and mutuals in the national health system

Social Security (i.e. public health insurance) covered 90.7% of health expenditures in 2012. The role of complementary organizations, including health mutuals and other private insurers, has been growing especially in collective care, like health centres (targeting especially low-income patients), nursing homes (63% of which are run by associations, foundations, and mutuals), hospitals (700 out of 2,700 hospitals are associations), and residential facilities for dependent or disabled persons (30% of which are under non-profit management).

In this landscape characterized by a very active non-profit sector, associations and mutual actors dominate, while cooperatives are almost absent, even though phenomena such as “medical deserts,” which could be overcome by promoting cooperation among stakeholders – patients, physicians, healthcare personnel – might encourage local governments to open the door for the development of cooperatives and other innovative responses to health needs in the future (Girard, 2014).

Mutual societies are mainly involved in supplementary health insurance. In France, there are two types of mutual societies: mutual assurance companies, which can carry out risk selection, and mutual societies. Mutual insurance undertakings are owned by the policyholders, operate on a non-profit basis, and do not have share capital (Girard, 2014).

Table 20. Types of cooperatives in France

ISIC rev. 4 codes	NAF code	NAF description	Number of organizations*	Number of employees
4772	47.73Z	Retail sale of pharmaceutical products in specialized stores	44	n.a.
	47.74Z	Retail sale of medical and orthopedic articles in specialized stores	212	
65		Insurance	n.a.	n.a.
8610	86.1	Hospital activities	91	
8620	86.2	Activity of doctors and dentists	519	18072
8690	86.9	Other activities for human health	162	
8710	87.1	Hospitalized accommodation	251	
8720	87.2	Accommodation for mentally ill and drug addicts	27	
8730	87.3	Accommodation for the elderly or physically disabled	83	35457
8810	88.1	Social care without accommodation for the elderly and for the disabled	126	
8890	88.9	Other social care activities without accommodation	317	317

Source: Observatoire national de l'ESS – CNCRESS, d'après INSEE SIRENE 2017
Year: 2014

Chapter 8. Italy

Context

Italy is a parliamentary republic located in the centre of the Mediterranean Sea, in southern Europe. It consists of 20 regions, including five special statute regions and two autonomous provinces. According to World Bank data, the Italian population amounts to approximately 60 and a half million people³⁴.

The health system and its evolution

The Italian national health system was instituted in 1978 and gradually implemented during the 1980s to provide universal coverage to the population. The system was initially entirely public; a feature that has granted universal coverage to the resident population but also created problems of sustainability due to increasing demand and organizational difficulties. Governments have therefore often been faced with challenges in maintaining the system universal, with the consequence of successive reforms that have changed the system's internal structure. Most prominently, market elements have been introduced in the system over time and a devolution process has been implemented aimed at delegating autonomy in healthcare provision to the Regions.

Implementation of the healthcare system followed diverse patterns. For example, in the northern regions, especially in those of the north-east, local administrations were able to exploit growing economic prosperity to consolidate the newly-established healthcare system. Conversely, in southern Italy fulfilment of the principle of universal coverage was jeopardized by widespread poverty and administrative inefficiency. Especially in poorer communities, the health system often proved unable to cope with new healthcare needs generated not only by profound demographic changes (decline of the family's role in providing social support, and ageing of the population) but also by the health consequences of new forms of social exclusion. Extensive reforms were adopted to remedy the limitations of the health system in dealing with these new healthcare needs. Major changes were made to the organization of the healthcare system in the 1990s with enactment of the 1992 bill *D.Lgs. 30 December 1992, n. 502* (and subsequent modifications by *D.Lgs. 7 December 1993, n. 517*), whereby region administrations became responsible for the planning and financing of healthcare services. Regions were granted further autonomy by becoming the institutions that controlled implementation activities on their territory and exercised a legislative as well as administrative function regarding healthcare provision on their territory. The regional administrations also became responsible for the organization and delivery of services related to nutrition, food safety, and medical research.

Finally, the constitutional reform law of 2001 made further changes to the roles of the central and regional administrations within the health system. Under the new regime, the government issues a National Health Plan (*Piano Sanitario Nazionale*) stating the national objectives in terms of prevention, care, and rehabilitation. The reform also stipulated a set of essential healthcare services (called *LEA, livelli essenziali di assistenza*), which must be supplied by all regions in order to

34 <https://data.worldbank.org/indicator/SP.POP.TOTL>

guarantee a universal standard of healthcare. The national commission responsible for defining and updating the LEA must consider the following criteria: effectiveness, adequacy, and consistency with the health system's functions and objectives (Ferrè, et al., 2014). Coverage by the National Health system is generally high-quality and accessible to all Italian citizens. It is completely free of charge, although regional differences persist especially in the length of waiting times. Complementary health insurance schemes offer the possibility to avoid waiting lists and to cover out-of-pocket costs for private and semi-private assistance. This type of insurance is however a relatively recent phenomenon, which still concerns a minority of the population, as less than 20% resorts to complementary health insurance (Grijpstra, et al., 2011).

As shown in Table 21, the most recent figures reported by the World Health Organization, which are relative to 2014, show that the per capita expenditure on health has been the equivalent of 3,258 USD, corresponding to a total expenditure of 9% of total GDP. The 2017 World Health Organization data confirm that healthcare is furnished at a cost of 3,027 USD per capita. As of 2006, 76% of health expenditure was provided through taxes, 19% was covered by out-of-pocket payments, and only 2% was accounted for by voluntary health insurance.

Table 21. Health expenditure in Italy

Indicators	2010	2011	2012	2013	2014
Total Health Expenditure (THE) % Gross Domestic Product (GDP)	9	9	9	9	9
Private Health Expenditure (PvtHE) as % of Total Health Expenditure (THE)	23	25	25	24	24
Total Health Expenditure (THE) per Capita in USD	3,384	3,559	3,242	3,295	3,258
General Government Health Expenditure (GGHE) per Capita in USD	2,607	2,675	2,443	2,491	2,463
Out of Pocket Expenditure (OOPS) per Capita in USD	661	746	678	680	690
General Government Health Expenditure (GGHE) as % of Gross Domestic Product (GDP)	7	7	7	7	7

Source: World Health Organization 2017, Global Health Expenditure Database

Health cooperatives and mutuals in the national health system

Mutual societies and cooperatives are well integrated into the Italian healthcare system. Historically, mutual societies were perhaps the most common form of protection during the late 19th and early 20th centuries. In fact, before the formation of the health system, the national protection system was very fragmented and social risks were mainly contained by the Catholic Church and employers. In 1878, there were approximately 2,000 Italian mutual societies, whose members were estimated to be 330,000 (Grijpstra, et al., 2011). During the 20th century, mutual societies became an important institution; even during the Fascist years they became an instrument in which various categories of workers were associated with dedicated funds and which was well integrated into the health system (Grijpstra, et al., 2011). With implementation of the universal health system, the role of mutual

societies decreased considerably. However, in recent years it has increased again. The reasons for the new role of mutual societies partly lie in the fact that they address social, health and care needs that the healthcare system and families can no longer meet.

Recently, in Italy, the role of healthcare cooperatives has grown considerably, to the point that there are now branches of national cooperative associations (e.g. such as Legacoop Sociali, Federsolidarietà and Federsanità) devoted to operating in the health sector.

Social cooperatives play a particularly important role within the healthcare system. They carry out several activities related to social services and social health. The Italian law distinguishes between type-A and type-B social cooperatives and mandates that the former deal with the management of social-health services, training and lifelong education, while the latter must foster the employment of disadvantaged people in industry, commerce, services, and agriculture. Type-A cooperatives can work with the public sector to complement some of the services furnished by the health system. Many of the actions of these organizations are intended to improve the functioning of the public system, which is highly bureaucratised and therefore unable to meet the emerging and diversified needs arising in society.

Institutional accreditation recognizes the status of providers of healthcare assistance to private structures, which take various forms: cooperatives specialized in healthcare; cooperatives operating on behalf of the health system (e.g. residences for elderly people); physician cooperatives, i.e. associations of physicians that share spaces or instruments; pharmaceutical cooperatives, which mediate between the needs of customers and retailers; and mutuals.

At the national level, the two cooperative federations have launched a project to put together social cooperatives, medical cooperatives, and mutuals in order to promote a common vision and organize an integrated response system whose objectives are stated in terms of health instead of services.

Table 22. Types of cooperatives in Italy

ISIC rev. 4 codes	Description	Number of organizations	Number of employees
4772	Retail sale of pharmaceutical and medical goods, cosmetic and toilet articles in specialized stores	21	229
65	Health insurance	4	2,404
8610	Hospital activities		
8620	Medical and dental practice activities	164	1,324
8690	Other human health activities	539	8,829
8710	Residential nursing care facilities	186	11,573
8720	Residential care activities for mental retardation, mental health and substance abuse	321	11,837
8730	Residential care activities for the elderly and disabled	952	62,160
8810	Social work activities without accommodation for the elderly and disabled	1,765	76,660
8890	Other social work activities without accommodation	2,804	58,381

Source: Istat - ASIA (Archivio Statistico delle Imprese Attive)

Year: 2014

Chapter 9. Japan

Context

Japan is an archipelago located in the Pacific Ocean off the eastern coast of the Asian mainland. The Japanese archipelago is made up of 6,852 islands stretching from the Sea of Okhotsk in the north to the East China Sea and Taiwan in the south-west. The country is divided into 47 prefectures in eight regions; according to the World Bank's figures, the population is about 127 million³⁵.

The national health system and its evolution

Japan's health system, which achieved universal coverage in 1961, follows a social health insurance model characterized by an effective separation of curative medicine and preventive services. The former are funded by insurance and provided by private and public practitioners, while the latter are funded by general taxation and delivered mainly by local public health authorities. The Japanese public health system is closely connected with local governments (prefectures and municipalities), which administer almost all services with the exception of quarantine. Services are then delivered by public health centres operating at the prefecture or municipal level.

In the 1970s, a new welfare policy attempted to offer free healthcare for the elderly, but the cost proved excessive for the public budget in the wake of the oil shocks. In 1990, a revision of social welfare laws allowed municipalities to outsource in-home services to non-public providers. In 1995, the Social Security System Council recommended restructuring the entire social welfare system. The changes that took effect with the Long-term Care Insurance (LTCI) Act of 2000 gave rise to a healthcare system strongly inspired by Germany's³⁶. The LTCI allowed non-public providers to enter the social welfare sector but reserved in-facilities care to municipalities and social welfare corporations. It is largely financed by insurance and tax, while user co-payments account for 10% of expenditure.

While considerable progress in the population's health was achieved after 2000, further improvements arguably required the closer integration of preventive and curative care services. A further reform enacted in 2008 aimed at integrating prevention into the insurance systems by requiring all health insurers to perform regular health check-ups to detect lifestyle-related diseases (e.g. hypertension, hyperlipidemia, and diabetes mellitus) and to provide appropriate guidance for individuals at risk (Tatara and Okamoto, 2009).

In 2011, the government introduced a plan for Integrated Community Care (ICC) which seeks to build a system called "integrated community care" by 2025, when the baby boomer generation will reach 75 years of age, providing integrated services in housing, medical care, long-term care, prevention

35 <https://data.worldbank.org/indicator/SP.POP.TOTL>

36 The LTCI system was built on the underlying principles of generalization of welfare services, user-centred mechanisms based on choice and contract, municipality-based finance and regulation, normalization by improving in-home services, in-kind benefits rather than cash benefits and a multi-dimensional system for providing services.

services and livelihood support to communities, thus enabling people to continue living in their home towns/villages even once they are in severe need of long-term care.

Following increasing financial pressure and the development of region-based governance, plans are being restructured under the 2015 Healthcare Reform Act. This states that starting in 2018, regions will assume overall administrative responsibility for community-based plans and work together with municipalities, which will still be insurers of their residents, to set premium rates and to collect premiums.

The health system ensures universal coverage of the population by statutory health insurance, which, however, is organized around the treatment of diseases and does not generally reimburse preventive medical activities. The national government regulates all aspects of the universal Statutory Health Insurance System (SHIS). The national government sets the SHIS fee schedule and gives subsidies to local governments, insurers, and providers, also developing and enforcing detailed regulations (Thomson, et al., 2011). The national government allocates budgets for the 47 prefectures, which then implement the services; the SHIS, on the other hand, consists of over 3,400 insurers.

In 2013, estimated total health expenditure amounted to approximately 10% of GDP, 84.3% of which was publicly financed, mainly through the SHIS (Thomson, et al., 2011). Private insurance plays a complementary role, although most of the population holds some form of private health insurance. The provision of privately funded healthcare has been limited to services such as dental orthodontics and complementary coverage for the treatment of injuries. As shown in Table 23, the most recent figures reported by the World Health Organization, which are relative to 2014, show that the per capita expenditure on health has been the equivalent of 3,703 USD, corresponding to a total expenditure of 10% of total GDP, substantially in line with the values of the recent past.

Table 23: Health expenditure in Japan

Indicators	2010	2011	2012	2013	2014
Total Health Expenditure (THE) % Gross Domestic Product (GDP)	10	10	10	10	10
Private Health Expenditure (PvtHE) as % of Total Health Expenditure (THE)	18	17	17	17	16
Total Health Expenditure (THE) per Capita in USD	4,110	4,654	4,749	3,960	3,703
General Government Health Expenditure (GGHE) per Capita in USD	3,374	3,844	3,927	3,296	3,095
Out of Pocket Expenditure (OOPS) per Capita in USD	594	650	659	550	515
General Government Health Expenditure (GGHE) as % of Gross Domestic Product (GDP)	8	8	8	9	9

Source: World Health Organization 2017, Global Health Expenditure Database

Health cooperatives and mutuals in the national health system

Cooperatives and non-profit organizations in general have a long tradition in Japan's social and healthcare system, with specific legislation passed over the years regulating their activities. For example, the Agricultural Co-operative Act of 1947 contains dispositions concerning healthcare and welfare businesses for the elderly, similarly to the Consumer Co-operative Act 1948 addressing the needs of physically impaired persons. The above acts enabled the cooperative health sector to thrive through the constitution of new medical cooperatives, the transformation of existing corporations like medical service societies or medical corporations, and the separation of health cooperatives from existing multipurpose consumer ones. In 1957, the Health Co-operative Association (HCA) was set up by 12 medical cooperatives to coordinate their activities at the national level as a specialized branch of the broader Japanese Consumers' Co-operative Union (JCCU). Since then, health cooperatives have encouraged consumer members to take part in the health promotion activities through health learning, regular check-ups, and the distribution of monthly newsletters.³⁷ All activities are combined with comprehensive medical examination and professional healthcare at the cooperatives' healthcare facilities. In 2010, the Japanese Health and Welfare Co-op Federation (HeW CO-OP Japan) was established as a successor to the HCA, separating from the JCCU.

In general, health cooperatives (or medical cooperatives) and JA *Koseiren*³⁸ (Prefectural federations of agricultural cooperatives for health and welfare) are engaged in healthcare, while other types of cooperatives are allowed to operate a range of elderly care services under the LTCI Act (Kurimoto and Kumakura, 2016). *Koseiren* federations were founded by agricultural cooperatives after the Second World War to provide healthcare for farmers and were later designated as public medical institutions. They are particularly active in small municipalities; in fact, 47 out of 114 *Koseiren* hospitals operate in municipalities with fewer than 50,000 inhabitants, sometimes assuming the role of municipal hospitals. Although they treat also non-members, their mission is to provide support for farmers by training and dispatching doctors and travelling clinics, as well as by promoting health-related initiatives.

37 Han groups are neighbourhood groups consisting of 3-10 members who conduct self-checks on blood pressure or salt/sugar contents in urine using simple devices, initially assisted by health workers or voluntary health advisers. The branches are organized in school districts to coordinate health-related activities in communities.

38 JA stands for Japan Agricultural cooperatives.

Table 24. Types of cooperatives in Japan

ISIC rev. 4 codes	Description	Number of organizations	Number of members	Number of employees	Turnover (JPY Million)
65	Health insurance	Zenkyoren*	5,462,800	5,516	305,349
Others	Koseiren**	34	n.a.	49,016	748,622
	HeWCoop	110	2,928,000	37,437	329,637

Source: National Koseiren (National Agricultural Co-op Federation for Health and Welfare) and HeW Co-op Japan (Japanese Consumer Co-op Federation for Health and Welfare).

Year: 2014 (National Agricultural Co-op Federation for Health and Welfare) and 2015 (Japanese Consumer Co-op Federation for Health and Welfare).

* In Japan, insurance cooperatives sell both life and non-life insurance, while health insurance is mostly included in life insurance. *Zenkyoren* (Agricultural Insurance Co-op Federation) has separate data for health insurance, in which members are policy holders and turnover is the premium income.

** Koseiren is the prefectural federation affiliated with primary cooperatives.

Chapter 10. Malaysia

Context

Malaysia is a federal state made up of 13 states and three federal territories divided into two regions: 11 states and two federal territories are located in the peninsula, while two states and one federal territory are located in East Malaysia. World Bank data estimate that the population is about 31 million³⁹.

The national health system and its evolution

Healthcare in Malaysia is divided between private and public, giving rise to a system in which the public universal system and a private healthcare system coexist. Public provision is rather basic, especially in rural areas (Jafaar, et al., 2012). The Malaysian healthcare system was initially structured according to the English model whereby facilities were prevalently in urban areas. Healthcare services were later expanded, particularly for economically disadvantaged persons and the rural population. At the time of independence, there were 10 major hospitals, 56 district hospitals, and 7 institutions for leprosy and mental health patients. Between 1960 and 2009, the number of hospitals run by the Ministry of Health nearly doubled, reaching 130 units, while non-government organizations also started running hospitals, such as the Penang Adventist Hospital built in 1929. Private hospitals have increased from only a few in the 1950s to over 200 today, almost twice as many as public hospitals, but they still provide less than one-quarter of the country's hospital beds.

In 2009, the government issued a plan entitled *Care for Malaysia* aimed at reforming the system according to the principle of “use according to need, pay according to ability”. However, the plan has not yet been fully implemented. This is not to say that the expansion and development of healthcare are not considered an important issue by the population. On the contrary, 5% of the government's social development budget is allocated to public healthcare, an increase of more than 47% (more than 2 billion MYR) with respect to the recent past, an effort driven by the growing and ageing population, and the urgent need to refurbish existing hospitals, build and equip new facilities, and improve physician training.

The Malaysian health system consists of universal services and a rapidly growing private sector. Public sector health services are organized within a public service structure centrally administered by the Ministry of Health, financed by taxes and managed by the government. Other government departments also provide health services to specific sections of the population. For example, the Ministry of Higher Education runs the university teaching hospitals; the Ministry of Defense operates several military hospitals and medical centers; the Department of Aboriginal (Orang Asli) Affairs provides health services to the indigenous population in collaboration with the Ministry of Health; the Department of Social Welfare provides nursing homes for the elderly; finally, the Ministry of Home Affairs is in charge of drug rehabilitation centers (Jafaar, et al., 2012).

39 <https://data.worldbank.org/indicator/SP.POP.TOTL>

The Ministry of Health plans and regulates most public-sector health services, the pharmaceutical industry, and food safety. For example, healthcare professionals are required by law to register with statutory professional bodies. Overall, public healthcare provides about 82% of in-patient care and 35% of ambulatory care, while private services account for about 18% of in-patient care and 62% of ambulatory care (Jafaar, et al., 2012). The private health sector, which is much less regulated than its public counterpart, operates mainly in urban areas through physician clinics and private hospitals. Private companies run diagnostic laboratories and some ambulance services. Non-governmental organizations provide some health services for particular groups (Jaafar et al., 2012).

As shown in Table 25, the most recent figures reported by the World Health Organization, which are relative to 2014, show that the per capita expenditure on healthcare has been the equivalent of 456 USD, corresponding to a total expenditure of 4% of total GDP.

Table 25. Health expenditure in Malaysia

Indicators	2010	2011	2012	2013	2014
Total Health Expenditure (THE) % Gross Domestic Product (GDP)	4	4	4	4	4
Private Health Expenditure (PvtHE) as % of Total Health Expenditure (THE)	43	45	45	45	45
Total Health Expenditure (THE) per Capita in USD	351	394	422	427	456
General Government Health Expenditure (GGHE) per Capita in USD	201	216	233	234	252
Out of Pocket Expenditure (OOPS) per Capita in USD	115	138	147	154	161
General Government Health Expenditure (GGHE) as % of Gross Domestic Product (GDP)	2	2	2	2	2

Source: World Health Organization 2017, Global Health Expenditure Database

Chapter 11. Singapore

Context

Singapore is an island country located at the southern end of the Malay peninsula in Asia. It is a parliamentary republic. The population of Singapore consists of approximately 5 million and a half individuals⁴⁰.

The national health system and its evolution

Singapore's healthcare system offers universal healthcare coverage to citizens and is funded with a combination of public benefits and individual savings. The first level of protection is provided by state subsidies covering up to 80% of the costs incurred for primary or hospital care. Subsidies are financed by three insurance programmes targeted to helping individuals and families pay for their care: Medisave, MediShield, and Medifund. Medisave is a mandatory insurance scheme requiring workers and employers to contribute an equal percentage of the paid wages to a personal account in the employee's name, which can be used to pay for health services (e.g. hospitalization, day surgery, outpatient expenses), and health insurance for the account holder as well as family members. MediShield is a low-cost insurance scheme aimed to help holders meet the medical expenses due to major or prolonged illnesses in excess of their Medisave balance. Singaporeans and permanent residents are automatically covered by MediShield, but undocumented immigrants and visitors are not covered. Finally, Medifund is the government fund for citizens who have received treatment from a Medifund-approved institution and cannot afford their medical expenses despite the coverage provided by the other two programmes. Private health insurance is available in the country as well, the provision of which is regulated by the Monetary Authority of Singapore. Private insurance plans are available from for-profit insurers to supplement MediShield coverage, some of which are also offered by employers also to employees as a benefit (Thomson, et al., 2011). However, Medisave use has been expanded over time to cover chronic conditions, as well as health screenings and vaccinations for selected groups. Further changes have taken place since 2015 to address the growing need for chronic disease and long-term care. For example, coverage now includes individuals with preexisting conditions, and it is for life instead of ending at 90 years of age like in the past.

Singapore's health system is centralized, meaning that the government has planned, built, and continues to maintain the nation's public healthcare infrastructure. The administration of health services is delegated by the Ministry of Health, which is in charge also of assessing health needs, planning and delivering services through the available network of hospitals, day care centres, and nursing homes (Thomson, et al., 2011). Several agencies and bodies aid the Ministry in its efforts to manage the system. For example, professional bodies (e.g. Singapore Medical Council, Singapore Dental Council, Singapore Nursing Board, and Singapore Pharmacy Council) regulate specific aspects of the medical profession by issuing guidelines and codes of ethics and conduct. They have the role of explaining political motivations to society. The role of the Health Sciences Authority, on the other hand, is to regulate the production, import, and supply of health products (such as

⁴⁰ <https://data.worldbank.org/indicator/SP.POP.TOTL>

pharmaceuticals, traditional medicines and health supplements). Hospitals, clinics, laboratories, and nursing homes (both public and private) are required to consistently fulfill the standards imposed and verified by the Ministry in order to be authorized to operate. Doctors who wish to practice in Singapore must secure a position at a healthcare institution and register with the Singapore Medical Council, which maintains the official register of doctors. Furthermore, they must meet the requirements of continuing medical training defined by the Medical Council (Thomson, et al., 2011).

As shown in Table 26, the most recent figures reported by the World Health Organization, which are relative to 2014, show that the per capita expenditure on health has been the equivalent of 2.752 USD, corresponding to a total expenditure of 5% of total GDP.

Table 26. Health expenditure in Singapore

Indicators	2010	2011	2012	2013	2014
Total Health Expenditure (THE) % Gross Domestic Product (GDP)	4	4	4	5	5
Private Health Expenditure (PvtHE) as % of Total Health Expenditure (THE)	65	66	64	62	58
Total Health Expenditure (THE) per Capita in USD	1,842	2,086	2,310	2,532	2,752
General Government Health Expenditure (GGHE) per Capita in USD	638	714	821	971	1,149
Out of Pocket Expenditure (OOPS) per Capita in USD	1,126	1,279	1,389	1,466	-
General Government Health Expenditure (GGHE) as % of Gross Domestic Product (GDP)	1	1	2	2	2

Source: World Health Organization 2017, Global Health Expenditure Database

Health cooperatives and mutuals in the national health system

Given the small extension of the country and the comprehensiveness of public coverage, there does not seem to be much room for the expansion of the activities of health cooperatives or other non-profit organizations in general medical practice. Perhaps the most fertile ground for development in the present and near future is represented by services to elderly individuals, whose share of the total population has grown sharply in recent years as in all developed countries, generating new problems and opportunities (Annual report on the cooperative societies in Singapore, 2016). In fact, the ageing population has brought about direct needs such as a demand for nurses and healthcare professionals to help manage long-term chronic conditions and health as well as eldercare services to meet the growing needs of families and their dependents and infrastructure (dental clinics, senior day care centres, nursing homes, senior activity and wellness centres) available for accessible prices. The situation however also brings indirect needs, connected to the demand for healthcare that need to be addressed. For example, the quality of life of caregivers for the elderly is also a concern, as these individuals are found to sometimes develop a tendency to neglect their own health (e.g. by eating

poor-quality food), fall victim to fatigue and consequently lose their motivation⁴¹. Some cooperatives propose to help solve the issue by providing valuable information, support and coaching.

In general, cooperatives in Singapore fall into one of three categories: consumer and services, credit cooperatives, and school cooperatives. The first category consists of business-driven organizations providing goods and services to their members to meet their daily needs and fulfil the social mission to help residents moderate the cost of living. Members of the second category provide financial services to their members who are within a pre-existing common bond of association or community of interest. Finally, the third category operates in secondary schools and junior colleges with the aim of exposing students to cooperative principles and social entrepreneurship (Annual report on the cooperative societies in Singapore, 2016).

Table 27. Types of cooperatives in Singapore

Type of Cooperative	Number of organizations	Name of the organizations	Number of users	Number of Employees	Turnover (USD)
Social Service and Health co-operatives	2	SCCL	n.a.	1	175,699
		TGLC	n.a.	10	529,734
Mutuals and Health Insurance Co-operatives	1			1,371	3,104 billions
Health Community Co-operatives	1	NTUC Health	More than 300,000	889	113,447 millions

Source: Singapore National Co-operative Federation.

Year: 2015

41 <http://www.silvercaregivers.org.sg/services-37.html>

Chapter 12. Spain

Context

Spain is a parliamentary monarchy located on the Iberian Peninsula in Western Europe. The country consists of 17 autonomous communities, and the two autonomous cities of Ceuta and Melilla. Spain also comprises the archipelagos of the Balearic and Canary Islands. World Bank data estimate that the population is about 46,443 million⁴².

The national health system and its evolution

The history of the Spanish health system has gone through two phases: the first started in 1942 when the system was based on the Bismarckian model, a centralized, bureaucratized system with non-universal coverage, which was funded by wage-linked social insurance for illness. The second phase began when the system was reformed in 1974 and in 1986, giving rise to the current health system. The turning point was the General Health Law 14/1986, which enacted a change towards a Beveridgean model based on universal care and funded through general taxes, thus creating the bases of the National Health System, in which the autonomous communities were expected to create their own health services and provide medical care through regional units in health districts.

A landmark development in the process leading to the attainment of universal coverage took place in 2003 when the Law on the Cohesion and Quality of the National Health System (Law 16/2003) was approved. Its objective was to ensure equality, access for all citizens of Spain on the same conditions to all provisions by means of coordination and cooperation among the autonomous communities. A further crucial step was the General Law 33/2011 on Public Health, which constituted the final stage in linking universal entitlement to health protection to free public healthcare. A notable change introduced in 2011 concerned the financing of the national health system. In fact, until 2011 the funds of the National Health System came mainly from contributions made by workers and companies (social contributions), the state (national budgets), the autonomous communities (local taxes), and from the payment of fees for specific services. After 2011, the General Law on Public Health 16/2013 ruled that the National Health System must be funded by taxes and no longer linked to social security contributions.

The current Spanish health system is decentralized, with health services delegated to the regional governments and coordinated at the national level through the Ministry for Health and Social Services. The national government provides certain services by means of collaboration agreements with private institutions⁴³. Each regional government has its own administrative and management body responsible for all the health centres, services and facilities in its region, provincial administrations, town councils and any other intra-regional administration. The central government retains healthcare management in the cities with autonomy statutes – Ceuta and Melilla – through the National Health Management Institute - INGESA.

42 <https://data.worldbank.org/indicator/SP.POP.TOTL>

43 General Law 33/2011, dated 4 October, on Public Health.

Care levels are divided between two main groups: primary care and specialised care. The former is provided by medical centres, which are the gateways to the system and also have a role in disease prevention. Specialised care, instead, is provided by specialized centres and hospitals offering diagnosis services and more technically complex and costly treatments. In this case, access is restricted and depends upon referral from primary care doctors. The coverage of the National Health System has often changed since 1986. Universal health coverage was finally established in 2011. However, in 2012, in the context of the recession, a General Law⁴⁴ was enacted that again left professionals without direct health coverage, and also people with no link to social security whose income exceeded a certain unspecified limit. A further reduction of universal healthcare concerned the exclusion of foreigners without a residency permit from public health coverage⁴⁵.

As shown in Table 28, the most recent figures reported by the World Health Organization, which are relative to 2014, show that the per capita expenditure on health has been the equivalent of 2,658 USD, corresponding to a total expenditure of 9% of total GDP. The table also shows that in recent years the weight of private health expenditure has increased, while both total and government per capita expenditure in the health sector have substantially declined.

Table 28. Health expenditure in Spain

Indicators	2010	2011	2012	2013	2014
Total Health Expenditure (THE) % Gross Domestic Product (GDP)	10	9	9	9	9
Private Health Expenditure (PvtHE) as % of Total Health Expenditure (THE)	25	26	28	29	29
Total Health Expenditure (THE) per Capita in USD	2,847	2,954	2,651	2,644	2,658
General Government Health Expenditure (GGHE) per Capita in USD	2,137	2,182	1,902	1,890	1,884
Out of Pocket Expenditure (OOPS) per Capita in USD	576	612	598	621	638
General Government Health Expenditure (GGHE) as% of Gross Domestic Product (GDP)	7	7	7	7	6

Source: World Health Organization 2017, Global Health Expenditure Database

Health cooperatives and mutuals in the national health system

The origin of cooperatives and mutual insurance societies in Spain's health system is the model based on the *igualatorio* system (medical insurance groups), known in Spain as *iguales*. Throughout the nineteenth century and part of the twentieth, this system was the origin of mutual insurance societies, cooperatives, and what were known at the time as "sickness funds". Currently, health cooperatives are grouped in the *Cooperativa Sanitaria de Galicia* (COSAGA), the *CES Clínicas* in Madrid and the entities which form the *Fundación Espriu*. COSAGA was established in 1985 when a group of

44 Royal Decree-Law 16/2012, dated 20 April on urgent measures to ensure the sustainability of the National Health System.

45 Proposal for the Law on the Universalisation of the Right to Public Healthcare, September 2016

healthcare professionals became convinced that the best way to provide a quality service to their patients was to work as a team. Their objective was to furnish comprehensive accident and emergency, outpatient and hospitalisation care. COSAGA is currently formed by 12 members and 120 employees (Girard, 2014). The services that it offers are primary, specialised and hospital care and accident and emergency services. *CES Clínicas* (Girard, 2014) was founded in 1980 by a group of dentists as a worker cooperative. It offers a wide range of dental services, and more recently it has added women's health services (gynaecology). It now comprises 80 health professionals who care for over 80,000 patients in its five clinics (Martín García, 1996). The *Fundación Espriu* was established in 1989 with the aim of promoting social cooperatives in the country and the comprehensive health cooperativism concept, which is pivotal in its expansion plans. The Espriu Foundation involves two insurance companies (ASISA and *Assistència Sanitatia Col·legial* - ASC), two cooperatives of medical doctors (*Lavinia* and *Autogestió Sanitaria*), and a consumer cooperative (*Scias*)⁴⁶.

Pharmaceutical cooperatives in Spain have mostly developed as distribution companies with a huge impact on the sector. Their market share in 2015 was 71.2%. Pharmaceutical cooperatives are companies with pharmaceutical capital owned by the pharmacies themselves. The cooperative experience in pharmaceutical distribution dates to the beginning of the twentieth century. Its objective was to ensure that pharmacies throughout the country had access to the same references regardless of size or geographical location (rural or urban).

In Spain, mutual insurance societies are divided between mutual provident societies and mutual insurance societies collaborating with social security. The mutual provident societies are insurance entities providing a type of voluntary insurance that complements the mandatory social security system⁴⁷. The mutual insurance societies collaborating with social security are private non-profit associations of entrepreneurs established on authorisation from the Ministry for Employment and Social Security. Their main activities are connected to protection against occupational accidents and diseases⁴⁸.

Health cooperatives are seen as organizations that complements the public social security system, offering services not provided by the national health system. They work as private entities, obtaining their incomes from the sale of health services in the market in which they are specialized (*CES Clínicas* in dental services and the other cooperative groups, COSAGA and the Espriu Foundation in general health services). Health cooperatives contribute to shortening waiting lists, and reducing the costs of some services for a part of the population because they provide services to a specific group that contributes to financing the public system through taxes, but which demands fewer services from the public system, thus freeing up resources to the benefit of all.

In November 2016, the Minister for Employment in Spain confirmed that the social economy has played a major role in economic recovery and that the social economy is a source of opportunities and employment for everyone and, therefore, is more *social* today than it ever was. Its commitment

46 More details on the Espriu Foundation are provided in the Spanish case study

47 http://www.seg-social.es/Internet_1/Glosario/index.htm?ssUserText=M#12093

48 http://www.seg-social.es/Internet_1/Glosario/index.htm?ssUserText=M#12093

to stable, quality employment and its great potential to contribute to sustainable development also makes it essential for complying with the objectives established in the Europe 2020 strategy. Several political forces recognise the role of cooperatives, but the support for them is unequal across the autonomous communities. From a regulatory viewpoint, in 2011, Law 5/2011 on Social Economy was approved by the consensus of all the political parties. This milestone is hugely important, although the measures proposed by this law have not been implemented. Nationally, cooperatives have Law 27/1999 as a reference, but they are regulated directly by 15 regional cooperative laws. This situation adds enormous complexity to the development of cooperatives on a national level. Finally, mutual provident societies are regulated by the national law dating from 1995⁴⁹ and the 2002⁵⁰ regulation. About the support that they receive, cooperatives and mutual insurance societies are not known by the general public. Obviously, there is clear recognition in their area of influence, but in many cases, they are not recognised as entities that differ from other capitalist companies.

49 Law 30/1995, dated 8 November, on the Organisation and Supervision of Private Insurance.

50 Royal Decree 1430/2002, whereby the Regulation on Mutual Provident Societies was approved.

Table 29. Types of cooperatives in Spain

ISIC rev. 4 codes	Type of activity	Number of organizations	Number of Members	Number of Users	Number of Employees	Turnover (EUR)
65	Health insurance	371	-	2,550,000	1,376	3,326,000
4772	Retail sale of pharmaceutical and medical goods, cosmetic and toilet articles in specialized stores	19	-	-	137	74,183,000
_*	Wholesale of pharmaceutical and medical goods, cosmetic and toilet articles in specialized stores	29	321	-	2,938	8,414,000
8610	Hospital activities	2	5	-	1,264	67,247,000
8620	Medical and dental practice activities	10	-	-	35	1,714,000
8690	Other human health activities	3	-	-	212	7,708,000
8710	Residential nursing care facilities	1	3	-	41	763,998,000
8720	Residential care activities for mental retardation, mental health and substance abuse	8	-	-	187	5,908,000
8730	Residential care activities for the elderly and disabled	11	-	-	412	8,317,000
8810	Social work activities without accommodation for the elderly and disabled	10	30	-	262	31,44,000
8890	Other social work activities without accommodation	41	-	-	2	90,836,000
-	Organizations owned and controlled by cooperatives	2	182,845	2,264,966	45,140	1,684,784,000

Source: SABI - Sistema de Análisis de Balances Ibéricos. Bureau van Dijk.

Year: 2016

** Code 4646 of the Clasfication National de Actividades Economicas (CNAE)

Chapter 13. Sweden

Context

Sweden is a monarchy with a parliamentary form of government. It is the third largest country of the European Union. Sweden is divided into 20 county councils/regions (*landsting*) and 290 municipalities (*kommuner*). The Swedish population is almost 10 million inhabitants as of 2017⁵¹.

The national health system and its evolution

Three government levels participate in the Swedish health system: at the national level, the Ministry of Health and Social Affairs is responsible for health policy, regulation and surveillance; the regional level is responsible for ensuring the quality of health services and, in the case of 12 regions, financing health services for citizens; finally, county councils oversee the funding and provision of health services. Municipalities provide care for the elderly and the disabled, while primary care centres and hospitals are mainly operated by county councils. There are also eight government agencies directly involved in health and care and public health, each with specific tasks attributed to them by the government. Coverage is universal. Since 1982 (health and Medical Service Act States) the health system has covered all legal residents, and emergency coverage is provided to all patients from European Union and European Economic Area countries and from other countries that have bilateral agreements with Sweden (Thomson et al., 2011).

The Swedish health system is the result of the historical evolution of Swedish society, in which local and self-government have grown and increased their importance. Until the late 1960s the development of the health sector increased, and hospitals grew in number and size basically because of the expanding medical profession (Anell, Glenngard and Merkur, 2012). For these reasons, most of the reforms in healthcare have been introduced by county councils and municipalities. During the past two decades, a critical attitude has developed towards councils and municipalities as providers of healthcare services due to concerns related to distributive justice, cost control, efficiency, value and quality, which have become more prominent in the governance of healthcare services. New Public Management based, among other things, on the purchaser/provider split was gradually introduced and implemented from the early 1990s onwards. An effect of the decentralised structure of Swedish healthcare, which spread throughout the 1970s and 1980s, was the increased importance of county councils and regions in service management. On the contrary, the conservative and centre-right national governments that followed from the 1990s to 2006 favoured policies of privatization of services, causing competition between (public and private) primary care providers. Competition is limited to the number of registered patients because there is no competition on the prices of services, which are set by counties (Anell, Glenngard and Merkur, 2012).

The main county council reforms have been based on improved primary care and coordinated care for the elderly. Private companies also act as primary care providers, although public ownership of health centres is prevalent. For example, as of 2015 private companies provided about 20% of public hospital care and about 30% of public primary care. In line with policy decisions adopted in the 1990s,

51 <https://data.worldbank.org/indicator/SP.POP.TOTL>

the hospital sector has undergone reforms aimed at the specialization and concentration of services. On the other hand, reforms initiated at the national level have focused on defining the competences of county councils and municipalities, guaranteeing direct benefits for patient groups, and attaining regional equality of services. In addition, reforms have been carried out since the 1990s to reduce waiting times for services, which have been regulated since 2010, to improve primary care, psychiatric care and coordination of care for the elderly (Anell, Glenngard and Merkur, 2012).

Table 30. Health expenditure in Sweden

Indicators	2010	2011	2012	2013	2014
Total Health Expenditure (THE) % Gross Domestic Product (GDP)	9	12	12	12	12
Private Health Expenditure (PvtHE) as % of Total Health Expenditure (THE)	18	15	16	16	16
Total Health Expenditure (THE) per Capita in USD	4,694	6,662	6,522	7	6,808
General Government Health Expenditure (GGHE) per Capita in USD	3,827	5,644	5,501	5,88	5,721
Out of Pocket Expenditure (OOPS) per Capita in USD	752	890	898	986	957
General Government Health Expenditure (GGHE) as % of Gross Domestic Product (GDP)	8	10	10	10	10

Source: World Health Organization 2017, Global Health Expenditure Database

As shown in Table 30, the most recent figures reported by the World Health organization, which are relative to 2014, show that the per capita expenditure on healthcare has been the equivalent of 6,808 USD, corresponding to a total expenditure of 12% of total GDP. The table also shows that in recent years the weight of private health expenditure has declined, while both total and government per capita expenditure in the health sector increased substantially between 2010 and 2011 and remained stable thereafter. In 2013, about 16 percent of all health expenditure was private, of which 93 percent was paid out-of-pocket⁵². Most of the out-of-pocket expenditure was spent on medicines. One of the main benefits of private complementary healthcare insurance is that it reduces waiting times for specialist visits. Organization and management, however, vary across councils, and also supplier fees are set by county councils. National state authorities are responsible for regulation and supervision, but finance and supply are regional and municipal responsibilities (Anell, Glenngard and Merkur, 2012).

Health cooperatives and mutuals in the national health system

Before the reform, cooperatives played a very limited role in the health system. In the current system they have the same role as any other non-public provider, which means that they have great difficulties in competing with financially stronger for-profit companies.

⁵² <http://www.sverigeisiffror.scb.se/BE0101%20/12-06-2017> [Accessed: May 2017]

Table 31. Types of cooperatives in Sweden

ISIC rev 4 codes	Description	Number of organizations **	Number of employees	Turnover (SEK)*
862	Medical and dental practice activities	13	126 (9 org.s)	79,593,000 (8 org.s)
8720, 8730, 8790	Residential care activities	40	846 (34 org.s)	163,058,000 (15 org.s)
8690, 8810	Other residential care activities & social work activities without accommodation for the elderly and disabled	114	4,372 (84 org.s)	101,941,000 (56 org.s)
4772	Retail sale of pharmaceutical and medical goods, cosmetic and toilet articles in specialized stores	-	-	-
65	Health insurance	40	13,500	149,000,000,000
8890	Other social work activities without accommodation	91	523 (70 org.s)	66,752,000 (27 org.s)

Source: Business Register at Statistics Sweden

Year: 2015

* Technically, most health-related services are not included in these turnover figures, since they are not subject to VAT.

** Associations and companies that are run as cooperatives are still to be mapped and had to be identified individually for this study. Data should therefore be considered rough approximations.

Non-public service providers have been included in the public system in various ways, such as public procurement, citizen choice as well as management and employee buy-out. The political idea is that all types of providers including co-operative, public and for-profit should compete equally. There are price regulations, so that citizen-users are able to choose irrespective of their financial capacity. Public regulation is also strong regarding accreditation. In fact, a private healthcare provider must have an agreement with the county council in order to be publicly reimbursed. If the private provider does not have an agreement, the provider is not reimbursed, and the patient will have to pay the full charge to the provider. However, there are private providers (physicians and physiotherapists) who are reimbursed by the county councils but based on earlier state regulation (*nationella taxan*). This old principle for reimbursement of providers operates in parallel, and sometimes in conflict, with more recently adopted principles of payment to private providers (Anell, Glenngard and Merkur, 2012).

Following a similar path to other European countries (e.g. Germany), Swedish mutuals have become an integral part of the health system: they are now public law entities and regional bodies responsible for exclusively managing the compulsory health insurance system. The Swedish health system is supported by taxes collected locally and nationally, and it guarantees access to highly subsidized health services for the entire resident population. Social insurance, which includes sickness insurance, parental insurance (leave), a basic retirement pension, a supplementary pension, child allowance,

income support, and housing allowance, is administered by the Swedish Social Insurance Agency (*Försäkringskassan*). The Agency operates throughout the country and is also involved in the prevention and reduction of ill health through programmes aimed at restoring individuals to a productive life whenever possible. The system admits voluntary supplementary health insurance, which can be administered by true mutual enterprises. However, the extent of public coverage leaves little room for the private sector, which in the early 2000s was supplying some form of coverage to less than 3% of the total population. For this reason, insurance mutuals are much more active in the non-life insurance market, the analysis of which, however, falls outside the scope of this report (Grijpstra et al., 2011).

Since the turn of the century, the trend has been an increasing share of for-profit companies in private health production. At the same time, the largest companies are growing bigger and the sector is becoming more concentrated. There is an ongoing political debate on the issue of distributing profit to owners in health sector enterprise. Some Swedish municipalities and regions are engaged in developing different kinds of agreements with civil society organizations including cooperatives, both on a general level regarding co-operation principles and rules as well as on more specific topics connected to service supply. These agreements are intended to test alternative business models in the welfare system, with the aim of taking advantage of some qualities of third sector organizations. A recent government investigation has also proposed reforming public procurement legislation in favour of not-for-profit providers.

Chapter 14. The United Kingdom

Context

The United Kingdom of Great Britain and Northern Ireland is located in Western Europe. The United Kingdom is unusual in that it is a unitary state that consists of four countries, England, Scotland, Wales and Northern Ireland, the last three of which have devolved administrations, each with varying powers, based in their capital cities. World Bank data estimate that the population is about 64 million⁵³.

The National health system and its evolution

The vast majority of healthcare in the UK is provided by the public health service – the National Health Service – which provides healthcare to all permanent residents of the United Kingdom (and EU citizens), is free at the point of delivery and paid for from general taxation. The United Kingdom government collects funds, which are pooled at the central level and then allocated to each of the devolved administrations. Scotland, Wales and Northern Ireland set their own health policies, whereas that for England is directly decided by the United Kingdom government. These policy-makers distribute funds and oversee delivery of services, generally via regional organizations that vary by nation, though some services, such as very specialized health services, are organized at the national level in England, Scotland, Wales and Northern Ireland (Cylus et al., 2015).

Increasing financial pressure, the spread of the National Insurance scheme, unequal access to health services, fragmentation and a lack of coordination in service provision, and the conversion of popular attitudes towards the role of the government, combined as compelling reasons for the UK political parties to consider establishing a national and public welfare system (Bridgen, 2007). Social and economic problems alongside the spread of Keynesian economic ideas sparked the desire to develop a better and different society. Late in 1942, the publication of the Beveridge Report promulgated social reforms into the mass media arena, increasing the public consensus on the need to involve the government in dealing with “want, disease, squalor, ignorance and idleness” (Beveridge, 1942). The document promoted a far-reaching public-sector role in abolishing unemployment, creating a free national health service, protecting (with social insurance) all social groups, and increasing education levels (Harris, 1990). Political pressure and the election of the Labour Government at the end of the war in 1945 supported the development of major social policy reforms (Harris, 1990; Timmins, 1995). The principle example of these reforms was the National Health Service established in 1948 in England and Wales. A separate Act had formed the health system in Scotland in 1947, and both systems presented the same characteristics: healthcare was to be free at the point of delivery, universal, and comprehensive.

This constituted a sharp turn with respect to the previous role of the state, in relation to social security, which was mainly delineating the Poor Laws. Most assistance was carried out by working-class self-help organizations (Friendly Societies, Trades Union and Cooperatives), which had developed

53 <https://data.worldbank.org/indicator/SP.POP.TOTL>

throughout the 19th century (Grijpstra et al., 2011). The national health system initially served England, Scotland and Wales in a similar manner from the beginning, while Northern Ireland's health system operated semi-autonomously. Important changes took place in the 1970s, however, when the health authorities of Northern Ireland started answering to the UK Parliament and, later, with the creation of regional health authorities, area health authorities and Family Practitioner Committees. The aim of the new authorities was to create organizations with defined responsibilities for populations.

The growth of the public sector as direct service provider continued for more than 20 years until the 1970s. Public debt began to increase at the beginning of the 1970s when an economic crisis arose (Castles et al., 2010; Ferrera et al., 2012; Taylor-Gooby, 2002). The economic difficulties of the 1970s heralded a general disillusionment with the performance of state-owned services and in the UK they led to the election of the "New Right" Thatcher-led Conservative Government (Gidron, Kramer and Salomon, 1992). Policies of the New Right particularly affected the healthcare sector. The establishment of a competitive mechanism for the "contracting out" of services and the creation of internal "quasi-markets" through the purchaser/provider split (in particular in the UK healthcare systems) created a favourable environment for including third sector organizations (and consequently social enterprises) in service provision (Aiken, 2010; Allen, 2009; Baggott, 2004; Le Grand, 1991; Le Grand and Bartlett, 1993; Taylor, 2003). With the National Health Service and Community Care Act of 1990, the government introduced General Practitioner fundholding, which implied that practices serving over 11,000 patients could apply for their own health system budgets to cover their staff costs, prescriptions, outpatient care, and a defined range of hospital services. Fund holders thus became, together with district health authorities, "purchasers" of health services on behalf of their patients (Cylus et al., 2015).

In 1997, a reform took place targeting health financing and services, which gave the four countries of the Union the power to determine how services are organized. This has led to some divergences between the national implementations, but all have maintained a National Health Service which provides universal access to a comprehensive package of services that are mostly delivered free of charge. With the health system Plan of 2000, the UK government committed an unprecedented amount of funding to increase spending for the whole of the United Kingdom and match the EU average. As a consequence, Scotland, Wales and Northern Ireland were able to enjoy a significant increase in funding, but because of devolution, the policies for managing performance differed. Since devolution, England, Scotland, Wales and Northern Ireland have taken their own approaches to healthcare. The main approach in England has been towards decentralization, reinforcement of the internal market, and more localized decision-making. Scotland and Wales have moved in the other direction, particularly since the advent of political devolution in 1999. Although the National Health Services of Scotland and England were founded as more or less identical systems, Scottish health policy has since been much more "consistent, consensual and professionally dominated, with an ideology of partnership and mutuality to counter English competition thinking" (Greer, 2016: 18). Social policies embedded in the pursuit of greater social integration, inclusion, fairness and solidarity have been promoted (Egdell and Dutton, 2016; Law and Mooney, 2012). Hence, rather than the

constant change seen in the health system in England, there has been significant continuity in Scotland, which can be traced back to the first ever Scottish Health White Paper in 1998 up to the present day, despite changes in the party of government in Scotland during that time (Greer, Wilson and Donnelly, 2016).

Under the Health Act (2006), the Secretary of State has a legal duty to promote a comprehensive health service, providing services free of charge for those eligible for the National Health Service without discrimination and within certain time limits (Thomson et al., 2011).

Table 32. Health expenditure in the UK

Indicators	2010	2011	2012	2013	2014
Total Health Expenditure (THE) % Gross Domestic Product (GDP)	10	9	9	9	9
Private Health Expenditure (PvtHE) as % of Total Health Expenditure (THE)	16	17	17	17	17
Total Health Expenditure (THE) per Capita in USD	3,491	3,649	3,649	3,685	3,935
General Government Health Expenditure (GGHE) per Capita in USD	2,916	3,034	3,025	3,070	3,272
Out of Pocket Expenditure (OOPS) per Capita in USD	336	339	345	352	383
General Government Health Expenditure (GGHE) as % of Gross Domestic Product (GDP)	8	8	8	8	8

Source: World Health Organization 2017, Global Health Expenditure Database

As shown in Table 32, the most recent figures reported by the World Health Organization, which are relative to 2014, show that the per capita expenditure on health has been the equivalent of 3,935 USD, corresponding to a total expenditure of 9% of total GDP. The United Kingdom spends less on health when compared to other Western European countries. Nevertheless, the national health services have shown improvements in major health indicators such as amenable mortality over the past decades. However, there remains considerable room for further improvement especially concerning the widening gap in health outcomes between the most deprived and the most privileged parts of the population (Cylos et al., 2015).

Health cooperatives and mutuals in the national health system

Cooperatives operating in the social and health sector have been registered historically under multiple legal forms. The UK has been at the forefront of the cooperative movement since the world's first documented cooperatives emerged in Scotland towards the end of the 18th Century, and the Rochdale Pioneers in Northern England set down their principles in 1844. While the formation of the health system a hundred years later more or less usurped the role of civil society actors such as cooperatives and mutuals in the provision of health and social care services, it is fair to say that in more recent years a more plural system – a “mixed economy” of provision – particularly in England, has emerged.

The National Health Service and Community Care Act of 1993 constituted an important step for the potential expansion of health and social cooperatives in the UK in that the legislation contained therein allowed the provision of a wide range of social care services that were hitherto run exclusively by the public sector to be operated also by the third and the private sector. This led to some growth in care provision by cooperatives and the social economy in general, though the expansion has been largely curbed by the substantial growth in market share experienced by for-profit private providers (Conaty, 2014). The legal form of health cooperatives is mainly adopted by General Practitioners. In fact, since the early 2000s in England, responsibility for commissioning out-of-hours care has shifted to purchasing bodies, with services provided by GP cooperatives or private sector providers. As of 2014, around 10% of GP practices provide their own out-of-hours services; the other 90% delegate out-of-hours care to GP cooperatives or other specialized providers (Cylos et al., 2015).

Mutuals also still have a role in the health system of the UK as providers of voluntary insurance schemes, the purpose of which is mainly to provide additional medical services, cover out-of-pocket payments and to avoid waiting lists. The total number of people covered by private insurance is about 7.3 million, about 12.2 % of the population, part of which is provided by mutuals. As of 2007, 8 out of 18 private medical insurers in the UK were mutual societies (Grijpstra et al., 2011).

Social enterprises (including those that emerged from the cooperative tradition) have played an increasingly active part in the provision of health and social care in recent years. A Social Enterprise Unit was established in the UK Department of Health in 2009. Large-scale UK Government initiatives such as the Social Enterprise Investment Fund (2007) and the Social Enterprise Pathfinder Programme, designed to increase the supply of social enterprises in the healthcare sector, were created (Allen, 2009; Hall, Miller and Millar, 2012; Miller, Millar and Hall, 2012). The “Right to Request” policy within the health system in England was launched, in order to encourage staff in the publicly owned health system to “spin out” existing services into mutually owned organizations which were labelled “social enterprises” (Miller, Millar and Hall, 2012). Since 2005, national health system staff have been able to develop spin-off social enterprises, initially with a focus on “intrapreneurship” inside the organization, before they were allowed to create “spin-off” organizations (Department of Health, 2008). Moreover, contracts between the health system and these “spin-offs” lasting for between three and four years were guaranteed, a sign of the still significantly public characteristics of these organizations (Hall, Miller and Millar, 2016).

In the future, according to the Health System and Policy Monitor of the European Observatory on Health System and Policies, the impact of the UK citizens’ vote to leave the EU could have major implications for health and social care. While the impact on health and social care services of leaving the EU is impossible to forecast, the vote implies that a number of important issues will need to be solved, including on staffing, accessing treatment in the UK and abroad, regulation, cross-border cooperation, and funding and finance⁵⁴.

54 <http://www.hspm.org/countries/england11032013/countrypage.aspx>

Table 33. Types of cooperatives in the UK

ISIC rev. 4 codes	Type of activity	Number of organizations	Turnover (GBP)
8610	Hospital activities	1	11,869,000
8620	Medical and dental practice activities	5	9,027,770
8690	Other human health activities	3	22,771,318
8730	Residential care activities for the elderly and disabled	1	402,438
8810	Social work activities without accommodation for the elderly and disabled	6	1,924,804
8890	Other social work activities without accommodation	10	8,304,391
-	Not classified	2	632,112

Source: Co-operatives UK. Note that these data do not include mutuals

Year: 2012-2014

Chapter 15. The United States

Context

The United States of America are a constitutional federal republic composed of 50 states, a federal district, five large self-governing territories and various possessions. The population of the United States consists of about 323 million inhabitants⁵⁵.

The national health system and its evolution

Private health insurance in the United States began in the 1930s with the non-profit Blue Cross plans for hospital care, aimed at guaranteeing hospital coverage for workers and employers while providing a steady stream of revenues on the part of hospitals during the Great Depression. The competition by for-profit insurers against Blue Cross and Blue Shield plans took off after the Second World War, when commercial insurers employed “experience rating” (with premiums based on past health status) which allowed them to charge lower prices to groups with lower expected medical expenses. The number of Americans with private health insurance coverage grew dramatically in the 1940s and 1950s, rising to half of the United States population by 1950. In 1965, the two major federal health insurance programmes, Medicare and Medicaid, were established. Medicare covered Americans aged 65 and older, and Medicaid focused on low-income individuals. In March 2010, the United States enacted a major health-care reform, the Affordable Care Act (ACA), which expanded coverage to the majority of uninsured Americans, through subsidies for lower-income individuals and families; compulsory insurance for most people; mandatory coverage by employers running firms over 50 employees; expansion of Medicaid; and a regulation of health insurers requiring that they provide and maintain coverage to all applicants and not charge more for those with a history of illness or preexisting conditions. Although the ACA does not result in universal health-care coverage, it represents along with Medicare and Medicaid a major effort to move towards that goal (Rice et al., 2013).

In the United States healthcare system, power is divided between the federal and state governments. In particular, states fund and manage many public health functions, implement Medicaid on their territory while paying part of the cost, and set the rules for health insurance policies not covered by employer plans. The federal level instead regulates pharmaceuticals, and medical devices are regulated at federal level. There is relatively limited coordination among the federal, State, and local levels in terms of planning in the United States in comparison to other countries, with service provision in under-served areas regulated through incentives rather than public intervention. Private sector stakeholders play a strong role in the US health-care system now as they have done for most of the country’s history. The main public programmes, which started only in the 1960s, are Medicare, which provides coverage for seniors and some disabled persons, and Medicaid, which is aimed at providing health-care services for low-income citizens (Rice et al., 2013).

55 <https://data.worldbank.org/indicator/SP.POP.TOTL>

Medicaid is a state and federal programme that provides health coverage for people with very low incomes. The Centers for Medicare and Medicaid Services (CMS) administer Medicare, a federal programme for adults aged 65 and older and people with disabilities, and work in partnership with state governments to administer both Medicaid and the Children's Health Insurance Program, a conglomeration of federal–state programmes aimed at low-income citizens. There are also other public initiatives that are worth mentioning. For example, the State Children's Health Insurance Program (SCHIP) is a joint state/federal programme providing health insurance to children in families who earn too much money to qualify for Medicaid, but cannot afford to buy private insurance; instead, risk pools allow people with pre-existing conditions such as cancer, diabetes, heart disease or other chronic illnesses to be able to switch jobs or seek self-employment without fear of being without healthcare benefits.

Private health insurance spending accounted for about 33 percent of total healthcare spending in 2013 (Rice et. al. 2013). Private insurance plans are regulated by the states and by appointed state insurance commissioners. Private insurance can be purchased directly by individuals, but costs can also be shared between employers and employees. Cost sharing is incentivized via public subsidies in the form of employer tax cuts. Employer tax exemption, which is the government's third-largest healthcare expenditure after Medicare and Medicaid, is estimated at 260 billion USD per year in reduced tax revenues (NBER, 2014). Since 2014, health insurance administered by the federal level has been introduced to guarantee subsidies and income premiums for low and mid-income people. This has led to an increase in insurance coverage, with some people relying on a mix of both public and private insurance plans. For example, many Medicare beneficiaries purchase private supplemental Medigap policies to cover additional services and cost-sharing.

As shown in Table 34, the most recent figures reported by the World Health Organization, which are relative to 2014, reveal that the per capita expenditure on health has been the equivalent of 9,403 USD, corresponding to a total expenditure of 17 percent of total GDP. In addition, the 2000-2010 period has been characterized by increased public insurance coverage in response to the growing average age of the population and the economic downturn. Funding for Medicaid and SCHIP has increased significantly with the Health Reform Bill of 2010. Overall, legislation aimed at promoting publicly funded healthcare has led the proportion of the population covered by Medicaid to rise from 10.5 percent in 2000 to 14.5 percent in 2010 and to 20 percent in the following five years⁵⁶. The portion covered by Medicare increased from 13.5 percent in 2000 to 15.9 percent in 2010, then decreased to 14 percent in 2015 (DeNavas-Walt, Proctor and Smith, 2011; H. J. K. Family Foundation, 2017). The uninsured proportion was stable at 14-15 percent from 1990 to 2008, then rose to a peak of 18 percent in the third quarter of 2013 and rapidly fell to 11 percent in 2015 (R. W. J. Foundation, 2007). The proportion without insurance has stabilized at 9 percent⁵⁷.

56 <http://awesome-b6.site/article-life-insurance-trends-2014> [Accessed: May 2017]

57 <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html>

Table 34. Health expenditure in the US

Indicators	2010	2011	2012	2013	2014
Total Health Expenditure (THE) % Gross Domestic Product (GDP)	17	17	17	17	17
Private Health Expenditure (PvtHE) as % of Total Health Expenditure (THE)	53	53	53	52	52
Total Health Expenditure (THE) per Capita in USD	8,269	8,524	8,790	8,988	9,403
General Government Health Expenditure (GGHE) per Capita in USD	3,926	4,035	4,154	4,279	4,541
Out of Pocket Expenditure (OOPS) per Capita in USD	973	997	1,019	1,032	1,039
General Government Health Expenditure (GGHE) as % of Gross Domestic Product (GDP)	8	8	8	8	8

Source: World Health Organization 2017, Global Health Expenditure Database

Health cooperatives and mutuals in the health national system

Cooperatives do not have a recognized role in the Health System of the United States. They however gained prominence in the public debate during the debate on the ACA. In fact, it was difficult to reach an agreement on the implementation that would allow the reform to reach its goals better. Financing of the health system was a major issue in the debate. The proposal of a government-sponsored insurance plan in competition with private insurers was eliminated in the final bill due to political opposition. A compromise was sought with proposal of a law enabling the establishment of at least one cooperative health insurance company at the state level. However, funding for this was withdrawn in December 2012. The above debate came close to cutting out a pivotal role for healthcare cooperatives even though it fell short in the end. The insurers then decided not to hinder the reform of healthcare because they were convinced that under the new regime everyone would be obliged to purchase health insurance and that, by acquiescing, they would not suffer competition from public health insurance. This made it possible to plan the public funding of qualified non-profit health insurance issuers called Consumer Operated and Oriented Plans (CO-OPs), which were supposed to offer health plans in the individual and small group markets⁵⁸. Given the strong bargaining position accorded to insurers, government support for state-level consumer-controlled insurance cooperatives was not viewed as threatening at this point. Initially, substantial funds were awarded to the CO-OPS, but later during the implementation of the ACA most of the 6 billion USD for these organizations was cut, ultimately relegating the non-profit sector to a marginal role within the health system (Rice et al., 2013).

58 <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Insurance-Programs/Consumer-Operated-and-Oriented-Plan-Program.html>

PART 3. CASE STUDIES: INVESTIGATING REPRESENTATIVE HEALTH COOPERATIVE TYPES AND MUTUALS IN SELECTED COUNTRIES

Chapter 1. Belgium: The role of mutuals⁵⁹

The Belgian health system⁶⁰

The Belgian health system is based on the principle of social insurance characterized by solidarity between the rich and the poor, healthy and sick people and with no selection of risk. The organization of health services allows therapeutic freedom for physicians, freedom of choice for patients and remuneration based on fee-for-service payments.

Almost the entire population (more than 99 percent) is entitled to a very broad benefits package. The services that are covered by compulsory health insurance are described in the nationally established fee schedule (more than 8,000 services). Services not included in the fee schedule are not reimbursable. Financing is based on progressive direct taxation, proportional social security contributions related to income, and alternative financing related to the consumption of goods and services (value added tax).

Approximately 20 percent of the total healthcare expenditures are paid by the patients through official co-payments, supplements and non-reimbursed medical acts, drugs and devices. Co-payments are the same for everyone except for people with preferential reimbursement status.

Decision-making in the Belgian health system relies on negotiations between several stakeholders. General policy matters concerning health insurance and the public health budget are decided by representatives of the government and the mutual health funds, but also by representatives of employers, salaried employees and self-employed workers. An important part of the health system is also regulated by national conventions and agreements between representatives of healthcare providers and sickness funds.

In Belgium, responsibilities for health policy are co-shared by the federal level and the federated entities (regions and communities). The federal level is responsible for the regulation and financing of compulsory health insurance; the determination of accreditation criteria (that is, minimum standards for the running of hospital services); the financing of hospital budgets and heavy medical equipment; legislation covering different professional qualifications; and the registration of pharmaceuticals and their price control.

At the level of federated entities (regions and communities), governments are responsible for health promotion and prevention; maternity and child health services; different aspects of elderly care, home care, coordination and collaboration in primary healthcare and palliative care; the implementation of accreditation standards and the determination of additional accreditation criteria; and the financing of

⁵⁹ Enzo Pezzini

⁶⁰ Corens, D. (2007).

hospital investment. To facilitate cooperation between the federal level and governments of regions and communities, inter-ministerial conferences are regularly organized.

Compulsory health insurance is organized through six private, non-profit-making national associations of mutual health funds (“*mutualités/ziekenfondsen*”) and one public national association sickness fund. The major responsibilities of the sickness funds are to reimburse health service benefits and to represent their members in the National Institute for Health and Disability Insurance (INAMI-RIZIV).

The INAMI-RIZIV is responsible for coordinating the healthcare and disability insurance. Its regulatory authority is the Federal Public Service for Social Security (SPF Sécurité sociale – FOD sociale Zekerheid). All those involved in healthcare provision have seats on the INAMI-RIZIV’s management bodies: public authorities, mutual health funds, care providers (doctors, dentists, ancillary medical staff, etc.), and social partners (trade unions, employers, small firms and traders’ organizations).

The INAMI-RIZIV allocates funding between the national unions of mutual health funds and the auxiliary fund. In addition to managing healthcare and disability insurance, the INAMI-RIZIV has further responsibilities. These include defining the standard codes schedule of medical care provision and the refund rates; approving care providers and care facilities; defining agreements between doctors and sickness funds; recognizing disability; operational oversight of mutual health; managing mutual health funds’ financial accountability.

Since 1995, Belgian mutual health funds have been made more financially accountable for the expenditure of their insured members. Private profit-making health insurance companies account for only a small part of the non-compulsory health insurance market. Healthcare is provided by public health services, independent ambulatory care professionals, independent pharmacists, hospitals and specific facilities for the elderly. Hospital care is provided by either private non-profit-making or public hospitals. Most medical specialists work independently in hospitals or in private practices on an ambulatory basis. General practitioners (GPs) provide ambulatory or primary care. Dentists and pharmacists also generally work independently.

Several measures have been undertaken to increase the accountability of healthcare providers. Some of the new objectives of policy-makers include the integration of care and multidisciplinary cooperation; patients’ pathways, care programs and networks have been created⁶¹.

Patients in Belgium participate in healthcare financing via co-payments, for which the patient pays a certain fixed amount of the cost of a service, with the third-party payer covering the balance of the amount; and via co-insurance, for which the patient pays a certain 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-

⁶¹ European Observatory on Health Systems and Policies:

<http://www.hspm.org/countries/belgium25062012/livinghit.aspx?Section=1.4%20Health%20status&Type=Section>

party payer system, for which the sickness fund directly pays the provider while the patient only pays the coinsurance or co-payment, which covers in-patient care and pharmaceuticals.

History and background of mutual societies

The first instances of solidarity date back to the self-help funds of mediaeval times, and, more specifically, to the 15th century, when professional guilds arose from the first mutual assistance funds. Craft guilds and corporations supported mutual cooperation to protect their members against certain risks. However, this phenomenon was typically urban. In the countryside, the family remained the main basis of security, while the Church was the only institution expected to take care of socially excluded people. The 1830 Belgian Constitution allowed freedom of association, whereas coalitions of workers (in unions) and the right to strike were both banned.

The mutual movement appeared in the 19th century, and especially during its second half, when the first structured voluntary associations of mutual assistance societies set up by local employers, workers and philanthropists arose. Workers were free to contribute to and participate in the decisions of these first mutual societies, which then formed the basis of a new social movement. The idea of pooling risks (illness, job loss, old age) according to an associative structure of free membership gradually spread. These associations, only conceived for mutual aid against unemployment, illness and old age, were allowed but not legally recognized until 1851, when public authorities enabled fraternal benefit societies to acquire legal status and benefit from advantages (i.e., tax exemptions). However, this law contained so many restrictions and regulations that very few mutuals chose to acquire legal status.

Things changed in 1894 when a new law extended the tasks of mutual assistance societies and encouraged them to group together in federations to provide common services. The 1894 law governed the action of the insurance funds for more than a century. It formed the basis of the mutual movement in Belgium and allowed the integration of the insurance funds into the compulsory insurance system. During the last decade of the 19th century, insurance services (reimbursement of drugs and visits to the GP) were organized by a growing number of mutual societies. Specialized treatments, surgery and hospitalization resulting from the immense progress of science and medical techniques had to be supported by the federations.

Mutual societies get organized

At the beginning of the 20th century, the mutual movement expanded greatly. Increasingly, local mutual societies grouped themselves into local federations and unions at the national level.

The “Alliance nationale des Mutualités chrétiennes” (National Alliance of Christian Mutualities) was the first union to receive official recognition and legal status in 1906. The others followed rapidly: in 1908, the “*Union nationale des Mutualités neutres*” (National Union of Neutral Mutualities); in 1913, the “*Union nationale des Mutualités socialistes*” (National Union of Socialist Mutualities); in 1914, the “*Union nationale des Mutualités libérales*” (National Union of Liberal Mutualities); and in 1920, the “*Union nationale des Mutualités libres*” (National Union of Free Mutualities).

By 1920, the healthcare sector was also benefiting from state subsidies. Mutual societies continued to diversify their activities: they developed more preventive components (particularly in the fight against tuberculosis) and built facilities to allow access to care to the greatest number of people possible.

The principal characteristics of the Belgian health system result from decisions made after the Second World War to create a compulsory health insurance system based on independent medical practice, free choice of healthcare provider by the patient, fee-for-service payment of providers and reimbursement.

During the Second World War, important steps towards a compulsory social insurance system were made. On August 7 1943, representatives of employers and trade unions signed a draft Agreement on Social Solidarity that laid the foundations for the Social Security Act of 28 December 1944, which established a social security system compulsory for all salaried workers. This law created the National Social Security Office (ONSS-RSZ), which was established to collect the contributions for all social security sectors and the National Fund for Sickness and Disability to manage health insurance in particular.

A system based on solidarity

Similarly to France and the Netherlands, Belgium built its system of social protection on the basis of a Bismarckian model, of German influence, which differs from the Beveridgian model inspired by the British tradition.

Two major principles distinguish the two systems. In Bismarckian systems, funding is largely provided by social contributions (employers and workers). Similarly, granted benefits (unemployment benefit, disability, etc.) are proportional to the remuneration lost. The logic adopted is the following: since employers and workers are those who finance the system of social protection, they are those who are expected to manage it. In Belgium, social security is therefore “co-managed” by the employees themselves (represented by the labour unions) and employers (represented by the employers’ associations) in a joint management system. Similarly, the various branches of social security are “co-managed” by the actors involved. By contrast, Beveridgean systems are universal and are designed to provide the same basic protection to all citizens. They provide identical flat-rate benefits for all. Financing is derived from taxation and the system is mainly run by the state. Belgium is built around a common Bismarckian management model and, accordingly, in 1944 the management of disability insurance was entrusted to insurers, trade unions and representatives of service providers rather than the State. Many actors have in fact considered it appropriate to entrust the organization and management of this new insurance to mutual societies that have a network well distributed throughout the country and significant experience in the sector.

The Leburton Law

One of the main turning points in the history of the Belgian health system was the Health Insurance Act of 9 August 1963 (Leburton Law). This law extended coverage under compulsory health

insurance within a private system of medical care based on the principles of independent medical practice, free choice of physician and hospital for the patient, and fee-for-service payment.

This law introduced the following developments: the so-called “nomenclature”, which lists the reimbursed medical services and gives them a relative value; the current National Institute for Health and Disability Insurance (INAMI-RIZIV) replacing the National Fund for Sickness and Disability; the definition of a new category of beneficiaries – including widows, orphans, pensioners and disabled people – having a preferential reimbursement rate for healthcare costs; and the current system of conventions and agreements between representatives of mutual health funds and of healthcare providers.

In all countries that adopted the Bismarckian model, protection gradually spread by extension to categories of the population initially unprotected. Indeed, the Belgian health insurance system has gradually evolved towards universal coverage. In 1964, the self-employed were obliged to insure themselves against major risks⁶² in medical care. Health insurance coverage was extended to public sector workers for both major and minor risks⁶³ in 1965; to those physically incapable of working in 1967; to the mentally ill in 1968; domestic workers in 1969, members of the clergy and of religious communities in 1969, and to everyone not yet protected in 1969. From 1998, all beneficiaries of compulsory health insurance were covered under either the general scheme (for minor and major risks) or the scheme for self-employed workers (for major risks), and since 2008 all beneficiaries have been covered for both minor and major risks. Currently, every person resident in Belgium can therefore benefit from the health insurance system, which translates into a rate of over 99 percent population coverage.

The national unions/alliances of mutual health funds

In 1990, a new law defining the characteristics and mission of mutual societies was adopted⁶⁴. Mutual health organizations were described as “associations which, in a spirit of providence, mutual assistance and solidarity, aim to promote the physical, mental and social well-being of their members. They operate as not-for-profit associations”. This Act created the Office of Control of Mutuels (OCM)⁶⁵, which required the old federations of mutual societies to join a national union. Their role was strengthened since only they were recognized as an insurer and payer in respect of compulsory insurance. Today they must supervise healthcare expenditure and ensure that it conforms with the legal regulations. Some services are only reimbursed if there has been a prior approval by the so-called “advisory physicians” of the sickness funds. These advisory physicians can question the prescription of expensive pharmaceuticals and the length of hospital stays. All individuals entitled to

62 Major risks include hospital care, delivery of babies, major surgery, dialysis functional rehabilitation care, implantable medical devices and specialist care, among others.

63 Minor risks include physicians’ visits, dental care, minor surgery, home care and pharmaceuticals for outpatient care, among others.

64 Loi du 6 août 1990 relative aux mutualités et aux unions nationales de mutualités.

65 The OCM - Control Office of health insurance funds and the national unions of mutual societies is a public body competent for both compulsory insurance and complementary insurance. It is managed by a Council consisting of two representatives of INAMI-RIZIV and four members chosen for their competence: <http://www.ocm-cdz.be/>

health insurance must join or register with a mutual health fund. The choice is free, except for railway workers (1% of the insured in the general system in 2015), who are automatically covered by the health insurance fund of the Belgian railway company.

Mutual health funds are mainly organized according to religious or political affiliations into national unions and specific funds:

- The National Alliance of Christian Mutualities (NACM): Alliance nationale des mutualités chrétiennes/Landsbond der christelijke mutualiteiten
- The National Union of Neutral Mutualities (NUNM): Union nationale des mutualités neutres/Landsbond van de neutrale ziekenfondsen
- The National Union of Socialist Mutualities (NUSM): Union nationale des mutualités socialistes/Nationaal verbond van socialistische mutualiteiten
- The National Union of Liberal Mutualities (NULM): Union nationale des mutualités libérales/Landsbond van liberale mutualiteiten
- The National Union of the Free and Professional Mutualities (NUFPM): Union nationale des mutualités libres /Landsbond van de onafhankelijke ziekenfondsen
- The Auxiliary Fund (AF): Caisse auxiliaire d'assurance maladie-invalidité/Hulpkas voor ziekte- en invaliditeitsverzekering
- Health insurance fund of the Belgian railway company (HR Rail): Caisse des soins de santé de HR Rail/Kas der geneeskundige verzorging van HR Rail

Table 35. Mutual health funds: key data

Sickness fund	Number of regional mutuals ⁶⁶	Number of affiliates (31 -12-2015)⁶⁷	Number of affiliates (%)	Number of employees (equivalent full time)⁶⁸	Number of volunteers
NACM	19	4,574,738	41.16	5,644, 64	18,000 ⁶⁹
NUNM	7	518,110	4.66	656,25	
NUSM	11	3,133,997	28.20	4,506,50	11346
NULM	10	563,300	5.07	970,00	
NUFPM	7	2,127,620	19.14	2,424,30	
				14,201,69	
AF	12	90,261	0.81		
HR Rail	5	106,255	0.96		
		11,114,281			

In 2015, the NACM and the NUSM together had the largest share of the general system, jointly covering almost 70 percent of the population. The Auxiliary Fund is an additional neutral public body intended for those patients who do not want to affiliate themselves with any of these groups. It accounts for 0.81 percent of the insured.

The regional health insurance funds have their independence and their own decision-making power. They are committed to following common guidelines. They are in direct contact with members (advisers, social services, doctors, etc.). The national unions have been granted official recognition and legal status. They define the strategic axes in consultation with the regional health insurance funds. They represent the regional health insurance funds in the political and decision-making bodies.

The three missions of a mutual health fund are:

- To manage compulsory health insurance on behalf of the state and defend its affiliates in tariff negotiations with healthcare providers. Compulsory insurance (automatically deducted by the employer on wages) pays, according to specific schedules defined by the partners at the federal level, benefits of physicians, compensation in the event of incapacity for work or maternity leave, etc.
- To offer various benefits to its affiliates through the complementary insurance system. Complementary insurance offers refunds and benefits in a manner defined by each mutual health insurance company. For example, a mutual insurance company will offer a refund of 50 percent when glasses are purchased, a bonus of 300 euros for a birth, etc. If some of these

66 INAMI-RIZIV (2014) Répertoire des unions nationales de mutualités, Juin 2014

67 Alliance nationale des Mutualités chrétiennes (2016) Rapport Annuel 2015, p. 103 (source INAMI, service du contrôle administratif – direction contrôle et gestion des données d’accessibilité et archivage des données)

68 Office de contrôle de mutualités et des unions nationales de mutualités (2015) Rapport annuel 2014, p.69

69 ANMC: “The Christian Mutuality in Belgium: history, social and political role”. PowerPoint presentation (unpublished).

advantages are common to mutual societies belonging to the same national union, most are decided within each mutuality. They will depend on the priorities defined by the general assemblies of these insurance funds but also the network of partners available to each.

- To provide its affiliates with information and services relating to health and social rights. Information and guidance services which are not limited to their affiliates: for example, permanent education, disease prevention services, cooperation in the development of activities organized for specific audiences (women, young people, seniors, etc.).

For their role in the compulsory health insurance system, as well as in the administration of the incapacity and disability insurance, mutual health funds receive subsidies from the INAMI-RIZIV to cover their administrative costs. This subsidy is based on the number and social characteristics of their members, with some corrections for efficiency in the management of the system. The Law also allows mutual health funds to develop services and activities outside mandatory social security provided that they are related to the health and well-being of their members.

On 28 November 2016, the Minister of Social Affairs and Public Health signed a pact with the sickness funds concerning their future role. The objective is for them to evolve towards “sickness funds for health” by reinforcing their role as “health coaches”. They will, for example, further strengthen efforts to inform members about health and the healthcare system; promote healthy lifestyles; and develop patient empowerment. The pact also contains commitments to supporting health policy through the provision of data, and provides guidelines on good governance and financial management⁷⁰.

Competition with the private sector

The privatization of healthcare is not a new dynamic, but it has intensified in recent years. And mutual societies are directly affected by this phenomenon, which puts them increasingly in direct competition with private businesses. In the field of voluntary health insurance, they compete with commercial insurance companies, but unlike the latter, mutual health funds are not allowed to operate risk selection.

In this context, it is not easy to preserve solidarity in face of competition and privatization. A striking example is the several-year dispute (from 2000 to 2010) between Belgian mutual health funds and private insurance companies. At issue was the fact that the five mutuals offered services resembling the products offered by the insurance companies, including “hospitalization” insurance. After a first complaint, the intervention of the DG Competition of the European Commission and lengthy negotiations, Assuralia – which represents the sector of commercial private insurance – and mutuals reached an agreement that was converted into law in April 2010. It requires mutuals to create a separate legal structure (a mutual insurance company “SMA – Société Mutualiste d’Assurances”) to manage their hospitalization insurance. This SMA is subject to the same constraints as insurers for

⁷⁰ <https://www.mc.be/actualite/opinions/2016/pacte-mutualite.jsp>

profit. For example, employees who work there must have training in insurance brokerage. In addition, the solvency constraint is required.

Competition among mutual health funds

Legally, mutual health fund members have the opportunity to change their mutual health fund each quarter if they have been enrolled for a period of at least one year. With only about 1 percent of all members switching each year, insurance mobility is low. Competition among mutual health funds concentrates mainly on their service to members and the complementary activities and services that they offer. For instance, the main services and benefits offered by the Christian Mutual Health Fund are: *Hospi solidaire* (hospitalization coverage for all adults and children in a family); CM-Hospitaalplan (significant reimbursement of the costs of hospitalization); CM-Thuiszorgplan (19 homecare services); home-based childcare service for sick children; holidays for children and young people; information and advice through the *En Marche* or *Straal/Visie* magazine and socio-educational services.

Also, the socialist mutual health fund offers specific services such as domestic help and homecare services (family support, nurses, physiotherapists), social work, family planning guidance for suicidal persons, medical help in pediatrics, housing for elderly persons.

Missions and action areas of mutual societies

Mutual societies evolve in a constantly changing environment. The social, economic and political context acts on the institutions and individuals: the legislative framework becomes more complex, new medical technologies are required, new needs emerge in the field of health and healthcare (ageing population, increase in chronic diseases) while the budgetary framework hardens. In this context, the force and originality of mutual societies (particularly the two main ones: Christian and Socialist) lies in their identities as both mutual health funds and social movements.

Christian Mutuality (MC)

The social movement

MC embodies this mission of social movement through services of aid and assistance as well as through the commitment of its members in various domains, including social assistance, health promotion, continuous education, etc.

MC's socio-educational sector develops action in three ways: health promotion through information, prevention and health education; community life and collective action to allow persons and associations of (old, young, disabled, etc.) persons to take responsibility for themselves, stand up for their own interests, and raise awareness in society; voluntary work through the maintenance and strengthening of a solidarity network (more or less 18,000 voluntary workers).

This sector comprises the following services: Infor Santé, which promotes the wellbeing of members by developing prevention activities with the active participation of healthcare consumers; the social service, which provides information and social aid to persons so that they can gain optimal access to rights, legislations and social services which concern them, with especial attention

to “vulnerable” people; Solival, which favours the autonomy and home care of sick and disabled people by offering adapted solutions.

In addition, there are six autonomous movements, three on the French-speaking side and three on the Dutch-speaking side:

- Alteo (French) and Samana (Dutch) are the social movements for ill and disabled people; they involve more than 10,000 voluntary workers.
- Enéo (French) and OKRA (Dutch) are the movements for seniors; they have more than 260,000 members, active in sport, culture, trips, advice, rights protection, etc.
- Jeunesse et Santé (French) and Kazou (Dutch) are the youth movements; their activities are (among others): holiday stays, playgrounds, training for animators, awareness raising campaigns (food, social security, protection of the environment, etc.)

These movements are constituted in the form of non-profit associations with their own bodies, and programmes of activities. They are all recognized by the French and Flemish communities, receive public subsidies and conclude agreements with the MC. The movement constitutes a privileged space in which the individual social and cultural commitment can turn into collective action for the protection of social rights.

The dimension of the social entrepreneur

The mobilization of the mutual members has led to the creation of hospitals, nurses at home, residencies for people with disabilities, or, more recently, care services for sick children. For instance, since 2016 the MC has been involved in or managed organizations in the following areas: specialized care (hospitals, polyclinics, dental surgeries); home care (nursing care, help in daily life, guards, home management, televigilance); sale and loan of equipment; pharmacies; disability (work integration social enterprises, residential services, support etc.); care of the elderly (residential services, day care, short stays); mental health; transport of sick; and disabled persons.

International cooperation “Solidarity beyond borders”

The objectives of international cooperation are to support sustainable local initiatives that help to improve people’s health, especially through improved access to quality healthcare by creating independent mutual benefit movements, and to make the MC movement aware of the need for international solidarity. The MC furnishes technical and financial support in seven countries in Africa and two in Central Europe, and financial support in two countries in Asia and one in Latin America. There is a close collaboration with Solidarité Mondiale/Wereldsolidariteit, the NGO of the Christian labour movement.

The Socialist Mutual Health Fund – Solidaris – is also involved in international cooperation initiatives to promote access to healthcare by third-world populations through two non-governmental organizations: Solidarité Socialiste (SOLSOC) and Fonds pour la Coopération et le Développement (FOS). It invests in projects to assist mutual health funds in several countries in Africa and South America and collaborates with the Bureau International du Travail (BIT).

Institutional/governance structure

Once again, we use the MC to describe the governance structure of Belgian mutual health funds. The National Alliance of Christian Mutual Insurance Funds consists of nineteen regional insurance funds (federations), a national secretariat and various management bodies.

(a) The statutory bodies:

The General Assembly is the main decision-making body. It is made up of elected representatives belonging to the member health insurance funds. Its main responsibilities are the election and dismissal of the members of the Board of Directors, the approval of financial reports, the appointment of one or more corporate auditors. It shall meet at least once a year to approve accounts and balance sheets.

The Board of Directors is responsible for day-to-day management and exercises all powers not attributed to the general assembly by law or by the articles of association. The Board of Directors is composed of members elected by the General Assembly for a period of six years. The workers are represented in the composition of the board. The term is renewable. The Board of Directors meets at least four times a year.

The National Committee of MC is composed of the president, vice-presidents, secretary-general, treasurer, three national secretaries, staff representatives. Its tasks are the dispatch of day-to-day matters and preparation of cases to be submitted to the Board of Directors. The Committee meets twice a month.

The Regional Director's college meets once a month with the national directorate by language group. This body gives advice to the National Directorate in regard to the management of compulsory and complementary insurance, as well as the development of new services, coordination, and sharing of experiences by the regional health insurance funds.

(b) Everyday management:

The Management Committee is responsible for the everyday management of the MC and the national secretariat. It is composed of the president, general secretary, treasurer, three national secretaries, and four directors. The Management Committee meets once a week.

External relations

All the five Belgian "private" mutual health funds are members of the AIM, the International Association of Mutual Benefit Societies⁷¹. AIM is a founding member of Social Economy Europe⁷² the EU-level representative organization for the Social Economy set up in November 2000. Mutuals can appear as "aliens" within the social economy because they stand out from the majority of social economy enterprises due to their size, their long history and their special relationship with the public

⁷¹ AIM is the umbrella organisation of non-profit healthcare payers, health mutuals and health insurance funds in Europe and in the world. Through its 63 members from 28 countries, AIM provides health coverage to 240 million people in the world and around 200 million in Europe through compulsory and/or complementary health insurance and management of health and social facilities: <http://aim-mutual.org/>

⁷² <http://www.socialeconomy.eu.org/>

authorities. Yet the challenges that they face are very similar to those of other structures: resistance to competition and to the commodification of goods and services, difficulties of internal democracy, European and international issues, “political” unawareness among members and workers, etc.

The definition of social economy explicitly mentions mutual societies. In Belgium, however, the status of mutuals is special. Indeed, in their function as implementation of compulsory sickness-disability insurance, mutuals are sometimes regarded as semi-public institutions. The almost complete integration of the insurance funds into the social security system has prompted the creation of a body, the Office of Control of health insurance funds and national mutual unions (OCM).

Consequently, the accountants of the National Bank of Belgium include mutuals in the public administration sector, at least for that part of their activities related to compulsory sickness-disability insurance.

Three arguments nonetheless advocate inclusion of mutuals in the “third sector” of the social economy. The first argument concerns their activities: apart from compulsory sickness-disability insurance, we have seen that they also develop supplementary insurance schemes and social services undoubtedly falling within the field of the social economy. The second argument is historical: mutual societies emerged as social economy organizations. Finally, from a legal point of view, they are now separate entities of the State. Mutual insurance companies are consequently considered as pertaining to the social economy⁷³.

The « Maisons Medicales » as Community Health Centres (CHC)

History and background

The historical context in which the “maisons medicales” (CHC) arose, i.e. the early 1970s, obviously had an impact on their objectives and modes of organization. They emerged during the 1970s, when youth social, political and cultural movements questioned the functioning of the institutions that are at the basis of the organization of society. These movements complained about: the poor distribution of wealth; the alliance of political and economic powers; a more formal than real democracy that produced an unequal and inequitable society in the areas of health, education, culture, housing, justice; a society in which the rich became richer and the poor poorer. In Belgium and Europe, this movement promoted the creation of alternative and integrated medical centers, mental health centers, alternative schools, and consumer associations⁷⁴. Indeed, the CHC is a model of contestation and self-management that arose after the events of May 1968. Their emergence was also supported by the joint collective reaction of healthcare professionals, dissatisfied with working conditions, and patients.

In 1970, the first multidisciplinary health team (three general practitioners and a nurse) was established. In November 1971, they published the innovative statutes “Maison medical”. The Maison Medical of Seraing was founded in the same period.

73 Adam S.: Mutualités – Dictionnaire économie sociale, Centre d’économie sociale, Université de Liège

74 <http://www.maisonmedicale.org/Histoire-des-maisons-medicales.html>

At the end of the 1970s, the “economic crisis” worsened the situation leading to rising unemployment, greater insecurity, and increasing immigration. At the end of 1979, a doctors’ strike organized by the Professional Union was countered by the workers’ unions and mutual health funds, with the active participation of doctors termed “progressive” and working in CHC, who enabled the continuity of healthcare provision. This enabled CHCs to get to know each other and be known by political parties, trade unions and mutual health funds.

A year later, in 1980, the “Fédération des maisons médicales et collectifs de santé francophones” (FMMCSF) was born. It was also the time of the declaration of Alma-Ata⁷⁵ and the Ottawa Charter⁷⁶. In the countries of the third world, revolutionary movements emerged. All these projects wanted to change the situation in their area and prove that another mode of organization was possible. Thereafter, the CHC movement was consolidated and the desire to improve public health strengthened.

A comprehensive structure

Each CHC is composed of a multidisciplinary team providing primary care. It serves an entire neighbourhood, taking a comprehensive approach to health that covers its physical, psychological and social dimensions. It engages in health promotion work, integrating care and prevention. The CHC is based on community participation, harnessing the resources of local residents and the neighbourhood, and working in partnership with the local network. The professionals who work in the CHC do so in partnership with patients to maintain, improve or restore health and social well-being. Exchange and coordination meetings among team members are held regularly, and the flow of information is promoted under conditions of strict confidentiality. All staff members also participate in health promotion activities.

Payment method

Two payment models are used:

- “Fee for service”. The patient pays the consultation fee according to the charge scales established in the agreement between the care provider and the sickness funds. Part of the fee paid by the patient is then reimbursed by his/her sickness fund (co-payment). In certain cases, the care provider applies the direct settlement system.

75 The Declaration of Alma-Ata was adopted at the International Conference on Primary Health Care (PHC), Almaty (formerly Alma-Ata), Kazakhstan (formerly Kazakh Soviet Socialist Republic), 6–12 September 1978. It expressed the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all people. It was the first international declaration underlining the importance of primary healthcare. The primary healthcare approach has since then been accepted by member countries of the World Health Organization (WHO) as the key to achieving the goal of "Health For All" but at first only in developing countries. This applied to all other countries five years later.

76 The Ottawa Charter for Health Promotion was adopted by the First International Conference on Health Promotion, Ottawa, on November 21 1986. The Ottawa Charter is a global health milestone, and remains a vital reference for health promotion. The Charter identifies five components of health promotion action and prerequisites for health, including peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity: <http://www.who.int/healthpromotion/conferences/previous/ottawa/en/>

- “Capitation fee”. This financing method is practiced in most health centres. Under the terms of a contract signed between the patient, his/her sickness fund and the CHC to which the patient is affiliated, the National Institute for Health and Disability Insurance (INAMI-RIZIV) pays the health centre a fixed contribution per patient registered with a sickness fund every month. This lump sum is allocated whether or not the health centre’s services are used. The affiliated patient no longer pays a fee during consultations or visits. The system is free at point of use. The fixed contributions cover the services of GPs, nurses and physiotherapists. Together, the fixed contribution income enables the health centre to organize care for all users. A bond of solidarity is therefore created between healthy patients and those with more serious problems.

Institutional/governance structure

From the beginning, CHC teams chose an autonomous operating mode. Since safeguarding and developing users’ autonomy is a specific priority, users are assigned a central role. Healthcare professionals and patients endeavour to establish cooperative relationships.

The Federation des Maisons Medicales and the francophone health collective brings together more than 100 medical centres located in the Wallonia-Brussels Community. It represents a movement for a more inclusive, equitable and socially just society.

The overall goal is to promote a health policy based on an organized system for primary healthcare, and, in particular, to support CHCs composed of multidisciplinary teams that seek to operate according to a model of the integrated health centre.

Two other federations also include CHCs and pursue similar missions as part of quality primary healthcare in Belgium: the VWGC (Vereniging van Wijkgezondheidscentra), which includes the Dutch medical homes in Flanders and Brussels⁷⁷, and the Fédération Médecine pour le Peuple⁷⁸, which includes Maisons Medicales associated with the Parti de Travailleurs de Belgique.

The self-managing model in CHC ideally presents the following features:

- a multidisciplinary team
- an egalitarian organization
- a division of responsibilities
- a more egalitarian income distribution
- the majority of workers present in the institution’s management and decision-making bodies
- no hierarchy
- every worker’s right to be a member of the general assembly
- the presence of patients, representatives of the political and social spheres in the institution’s management and decision-making bodies

⁷⁷ <http://vwgc.be/>

⁷⁸ <https://www.gvhv-mplp.be/index.php/fr/>

The CHCs that belong to the Federation share the principles that are defined in the “Charter of Maisons Médicales”, which wants to be “a common base, a mobilizer text, a project. Not a fair description of what we are, but a model to which we agree to move forward and remaining adaptable to the realities of the teams and their implantation site. The Charter is a founding moment: it expresses our directions in sustainable terms of the principles.”⁷⁹

Size and diffusion

The number of CHCs has increased by 40% in the past ten years. Applications by the Belgian population are constantly growing. In the Federation of French-speaking health centres, the served population is twice more disadvantaged, with 44% of beneficiaries of increased intervention⁸⁰ compared to 23% in the population of the Brussels and Walloon regions. The most represented professions were doctors (26%), receptionists⁸¹ (22%), physiotherapists (13%) and nurses (11%). Other professions that are present are: psychologists, dentists, social workers, officers of community health and promotion of health, coordinators of care. Young doctors are interested in the CHC sector. The proportion of general practitioners aged under 45 is 70% against only 28% at the national level (Fédération des maison médicales, 2016).

Table 36. Community Health Centres

	Number of organisations	Number of members	Number of users	Number of volunteers	Number of employees
Federation of French-speaking health Centres	107	1200	220.000	20	2000
VWCG (Flanders)	30	-	-	-	-
Fédération médecine pour le Peuple	11	-	-	-	-

There are no statistics that summarize all the accounting data of the CHC.

Analysis of the budgets of two CHCs shows that turnover amounts in one case to 600,000 EUR, and to 2,200,000 EUR in the other.

The turnover of the federation is 1,700,000 EUR.

⁷⁹ <http://www.maisonmedicale.org/La-charte-des-maisons-medicales-406.html>

⁸⁰ Some people have a more important healthcare reimbursement. They pay cheaper medications, doctor visits and consultations. And, in the case of hospitalization, the personal share is less important. These people receive what is called “increased intervention”.

⁸¹ Serves as the interface between all internal and external parties in health centre. The receptionist welcomes patients, listens to their needs and directs them to the right professional. He/she is the first person at the health centre to listen to what patients have to say.

Pharmacy Cooperatives

OPHACO (Office Des Pharmacies Cooperatives De Belgique) is the recognized professional Union federating 600 cooperative pharmacies in Belgium (distributed into 15 separate legal entities) and 8 wholesalers-dispatchers. The cooperative pharmacies affiliated with the OPHACO represent some 20 percent of the ambulatory (i.e., non hospital) pharmacy market in Belgium. As a recognized and representative professional organization, OPHACO is present, at the institutional level, on the boards and technical committees reporting to public health, the economy, employment and labour and Social Affairs.

At the international level, the OPHACO is a member of the International Cooperative Alliance (ICA) and the International Health Cooperative Organization (IHCO). In addition, the OPHACO is a member of the European Union of Social Pharmacies (UEPS), whose members – cooperatives, mutual societies and local public initiatives – subscribe to the principles and values of the social economy as well as to the Charter and the commitments of the European Social Pharmacies.

*History and background*⁸²

The first cooperative pharmacies appeared in Belgium in the 1880s. That decade saw the birth and rapid expansion of a strong cooperative movement. The Vooruit centre in Ghent is the pioneer institution of this movement. The first two cooperative pharmacies opened on January 1 1882 in Brussels: the “Pharmacies popular Brussel” (PPB).

In parallel to the development of the cooperative pharmacies, private pharmacist associations proliferated. By 1885, they registered a growth in number.

To gain an idea of this evolution, four figures are significant:

- in 1846, there were three unions of pharmacists
- in 1885, there were 15 unions of pharmacists
- in 1893, there were 25 unions of pharmacists
- in 1914, there were 42 unions of pharmacists

The creation of these associations of pharmacists is the sign of a policy of corporatist defence of pharmacists. A study conducted by the Vrije Universiteit Brussel (VUB), in 1988, did not hesitate to include the cooperative pharmacy among the “pet peeves” of private pharmacists, and this from the years 1880-1890.

Cooperative dividends, which each cooperator receives at the end of the year, based on its purchases and profits of the cooperative, was immediately considered as a form of unfair competition.

At the beginning of the 20th Century, there were pharmacies created by the Mutualities and those created by consumer cooperatives, as well as a few more autonomous cooperative pharmacies.

The main representative of the first group, “*Les Pharmacies populaires de Bruxelles*” Cooperative Society, continued its growth after the war, as demonstrated by the account of their sales:

82 <http://www.ophaco.org/images/documents/90.pdf>

- 1919: 1,400,000 F (16 offices)
- 1922: 2,000,000 F
- 1924: 3,400,000 F
- 1926: 5,200,000 F (20 offices)
- 1930: 10,300,000 F

In 1931, the cooperative recorded annual sales of 11 million at its 22 offices, its 4 drugstores and its central store.

Pharmacies in the second group (consumer cooperatives) were mostly linked to the Socialist Party. The third group, the “*Maison des Mutualistes*” was founded in Brussels in 1921. The “*Maison des Mutualistes*” is a cooperative which was originally devoted not to the constitution of cooperative pharmacies but to social works, in a broad sense, in the field of healthcare, such as rehabilitation. In 1925, some pharmacies opened across the country. The interwar period was especially marked by the rise of antagonism, with a fringe of the private pharmacy sector particularly hostile to the consumer cooperative.

The conflict was particularly fierce and created a situation of almost permanent hostility that persisted widely after WWII. The rebate of overpayment is and will remain the stumbling block between cooperatives and individuals. Cooperative Pharmacies had to face several trials to defend the rebate and continue to provide their customers with this benefit in a period affected by the crisis.

On 3 March 1946, in Brussels, on the premises of the “*Maison des Mutualistes*” the general assembly decided the constitution of the OPHACO. The Christian social pharmacy joined the OPHACO in 1953 and especially in 1962.

Size and diffusion

These pharmacies achieve an annual turnover in the order of 600 million EUR and meet the needs in regard to medicines, medical devices, special food and other health products of 2.2 million people. In terms of employment, the members of the OPHACO companies directly or indirectly employ nearly 3,500 people including nearly 1000 pharmacists.

Chapter 2. Brazil: Unimed, the largest health cooperative in the world⁸³

Introduction

Access to healthcare is considered a fundamental right of the human being. Different models of provision and access to services coexist in the world. In Brazil, although healthcare has been universal since 1988, a strong interface between the public and private spheres has always existed. The public sphere comprises the so-called “complementary healthcare”, in which cooperatives have fulfilled a significant function in the provision of services in medical, dental and psychological areas.

This chapter analyses the Brazilian case study, which deals with the Unimed Cooperative System – the largest healthcare network in Brazil and the largest medical cooperative system in the world.

Brazilian context

Healthcare cannot be understood outside its context, since social, economic, political, cultural, behavioural and environmental factors influence both the occurrence of health problems and their risk factors in the population, as well as the design and structure of the policy and services offered. In the Brazilian case, there are some peculiarities concerning the implementation and analysis of health policy: 1) severe inequality and poverty, which significantly impact on the occurrence of demands for health services; 2) the country’s population of about 208 million and its continental dimension – with regions that significantly differ one from another – which generate large internal inequalities (Paim et al., 2011) and make the management of health services more complex; 3) the political-institutional system, which bears the legacy of centuries of colonization and reproduces authoritarian and patrimonialist governments that have marked Latin American history and culture.

Brief history and analysis of health policy in Brazil

The Brazilian notion of citizenship and social protection was based on Eurocentric standards and expressed by elites (internal and external) that engendered meritocratic and welfarist State structures and practices. Social rights were instituted by the Federal Constitution of 1934, but the social protection system was fragmented, uneven and centralized in large bureaucracies (Paim et al., 2011). The development of healthcare in Brazil should be understood in this context.

In healthcare, the Sanitary Reform was an important milestone. It originated in the struggle against the military regime that ruled the country during the period of dictatorship (1964-1984), which implemented governmental reforms that gave rise to the expansion of a largely private health system, particularly in large urban centres. The Sanitary Reform was carried forward by a broad social movement and defended health as a social and political issue to be addressed in the public space and not exclusively in a biological dimension to be solved by medical services (Paim et al., 2011). The postulates of the health reform movement were: i) a unified, decentralized and hierarchical system based on community participation and integral care; ii) a private sector conceived as a complementary provider of public services and with freedom to expand the private medical market (Berlinguer, Teixeira and Campos, 1988).

⁸³ Adriane Vieira Ferrarini and Bruno Gomes de Assumpção.

The Brazilian project began to take shape in the mid-1970s and was structured over a decade during the struggle for (re)democratization. However, it was the Federal Constitution of 1988 – the so-called "Citizen's Constitution" – which enshrined health as a fundamental right, a "right of all and duty of the State", to develop public policies aimed at reducing disease and at promoting, protecting and restoring health. Implementation of the principles of the Sanitary Reform and of the Constitution of 1988 began in 1990 through the Unified Health System or "*Sistema Único de Saúde*" (SUS). The SUS is considered a "system" because it is formed by institutions of the three federal levels (municipal, state and federal) and it is denominated "unique" due to the adoption of the same philosophical and systematic principles throughout the country. These principles are the following: universality (regardless of social security contributions and payments for care, with no privilege or discrimination); equity (capacity of the service to meet differentiated needs); and integrality (care for the individual and community). SUS is responsible for health promotion, health surveillance, vector control and health education, as well as ensuring the continuity of care at the primary, outpatient and hospital levels (low, medium and high complexity).

As regards the methodological framework, SUS presupposes the democratization of health policy management through social participation – also called "social control" – and decentralization whereby services are organized according to the local population's needs through so-called "health municipalization" (Costa, 2007). With regard to health expenditure, among the group of countries with public models of universal access, in 2011 Brazil was the one with the lowest State participation in health financing (WHO, 2014).

However, in the past 20 years Brazil has been able to expand the coverage of the services (about 75 percent of the population makes exclusive use of the SUS), to increase by 70 percent the volume of the services provided (more significantly among the low-income population), and to triple the structure (especially in states with low *per capita income*, which contributed to the reduction of regional disparities). As for the quality of services, several studies point to significant concerns regarding staff training, adequacy of care, use of quality assurance systems or procedures, and compliance with licensing (Gragnolati, Lindelow and Couttolenc, 2013).

As regards users' perceptions, some surveys report particularly high levels of dissatisfaction with public healthcare in Brazil (Gouveia et al., 2009; Datafolha, 2014). The System of Indicators of Social Perception (SIPS) – a survey carried out in 2011 – showed that the biggest problem reported concerning the SUS was the lack of doctors (58.1 percent of respondents). Secondly, there was the "delay in being treated in public health centres or hospitals" (35.4 percent), followed by "delay in obtaining a specialist consultation" (33.8 percent). The survey revealed that the delivery of services in a quick time-frame was mentioned as the main reason explaining the search for health plans (IPEA, 2011). However, other research has shown that the level of user satisfaction was good, in general, being higher in relation to the care or treatment received than the service structure (Castro et al., 2008; Massuia, Mendes and Cecílio, 2010; Gouveia et al., 2009). "There seems to be an understanding by users that SUS fulfills its role, even with the known issues, and that the positive assessment involves an expectation of continuity of the public health service" (Castro et al., 2008, p.133).

Despite the difficulties and controversies, SUS was a true paradigm shift in health policy in Brazil and contributed significantly to improving the level and distribution of affordable and equitable health services, which in turn was reflected in the increase of life expectancy, reduction of maternal and infant mortality and reduction of geographical inequalities. Despite the important role of health, it should be noted that these gains are partly attributable to the evolution of other policies and services, such as access to safe drinking water and sanitation, better quality food, higher levels of schooling, and improvement of the economic situation of the families.

The public and private interface of the provision of health services

The public and private systems have always interacted in the provision of health services in Brazil. Historically, health policies have stimulated the private sector in healthcare, either by accrediting doctors' offices, or by setting up and remunerating specialized diagnostic and therapeutic clinics, hospitals, or by providing incentives to health plan and health insurance companies. Health plans in Brazil are embedded in this dense and complex organizational model, since the dimensions of financing, management and provision of services may be public and private (Leal, 2014).

The emergence of the supplementary health market dates back to the 1950s. In the mid-1960s, the so-called “agreements” between employers (with their own networks) and doctors – mediated by Social Security – strongly stimulated entrepreneurship of medicine over practice and the autonomy of each hospital. The creation of the National Social Security Institute (INPS) in 1966 expanded the state's medical assistance delivery, basically through the acquisition of private services, in front of a huge network of providers extending throughout Brazil. In the 1980s, the revelation of the existence of a large health insurance market occurred in parallel with the significant intensification of the sale of individual plans; entry of large-scale health insurers; adherence of new categories of workers (especially civil servants); and the linkage of private assistance to the financing of supplementary medical care (Bahia, 2001).

The Federal Constitution of 1988 declared that healthcare was free to private initiative, but that health actions and services were of public importance, and the state was responsible for regulation, supervision and control. In the 1990s, there ensued a sequence of privatizations and concessions implemented by recommendations of the Washington Consensus. As a result, in 1998, 24.5 percent of the Brazilian population had health insurance (Paim et al., 2011) and, in 2013, 27.9 percent. The South-East, South and Centre-West regions had the highest proportions (36.9 percent, 32.8 percent and 30.4percent, respectively) and the North and North-East regions, the lowest (13.3percent and 15.5percent, respectively). In urban areas, the percentage of people covered by health insurance plans was 31.7 percent, about five times higher than in rural areas (6.2 percent) (IBGE, 2015). Also in 1998, a law was enacted to regulate health plans, which made it illegal to deny coverage to patients with preexisting diseases and injuries and to limit the use of specific health services or procedures. In 2000, the National Health Surveillance Agency or “Agência Nacional de Saúde” (ANS) was created to guarantee the legal and administrative regulation of the private health insurance plans market.

With the strengthening of SUS, it was expected that the private provision of health services would decline considerably, but this did not happen. The private health subsystem established itself with the

public sector, offering outsourced services through the SUS, hospital and outpatient services paid by direct disbursement, private medicines, and health insurance plans. The Brazilian healthcare system consists of a complex network of providers and buyers of services that compete with each other, generating a public-private combination financed above all by private resources.

The health system has three subsectors: the public one, in which services are financed and provided by the State at all three levels of government, including military health services; the private (for-profit or non-profit) one financed by public or private resources; and the supplementary healthcare sector, with different types of private health plans and insurance policies, as well as fiscal subsidies. The public and private components of the system are distinct but interconnected, and people can use the services of all three subsectors, depending on their ease of access or the ability to pay (Paim et al., 2011).

The demand for private health plans and insurance comes especially from public and private enterprises that offer such benefits to their employees. Using data from the National Household Sample Survey (PNAD)/Brazilian Institute of Geography and Statistics (IBGE) (IBGE, 2010), researchers analyzed the evolution of the profile of people who used health services between 2003 and 2008 in Brazil. The SUS accounts for the healthcare of 190 million individuals, while private health plans account for 49.2 million (Porto, Ugá and Moreira, 2011; Silva et al., 2011; Ruiz, 2012).

Current ANS data indicate 47.9 million in December 2016, a fall attributed to the severe and prolonged economic crisis in Brazil from the beginning of 2015. More than 1.3 million Brazilians no longer had healthcare plans between March 2015 and March 2016, and only 617,000 in the first quarter (Villela, 2016). It should be noted that private agreements serve primarily a younger and healthier population, and they offer plans with different levels of free choice of healthcare providers. As the demand is stratified by the socioeconomic and occupational situation, the quality of the care and the facilities available to the employees of the same company can vary considerably (Paim et al., 2011).

The relationship between the public and private sector is a sensitive, strategic and controversial issue for the national health system because it involves a range of conflicts between economic and political interests. On the one hand, there is the argument that the state alone cannot and should not meet all demands. This argument is supported by the so-called “naturalizer” thesis, which presents the health insurance market as a fact of reality or prescribes its expansion as an ideal to be pursued by policymakers on the basis of a liberal economic conception. On the other hand, it is argued that the continued expansion of the private sector is subsidized by the state, potentially reducing its capacity to ensure public healthcare quality and universal access to services. The so-called “critical line of thought” argues that privatist historical grounds in the provision of care determine the persistence of a policy favourable to insurance and health plan companies contrary to the SUS principles (Santos, 2000). Pagano and Massarifilho (2014) state that the medical technology industry (both pharmaceutical and equipment) is the one that most profits from the current model of health insurance.

According to a survey by CREMESP⁸⁴ (Regional Council of Medicine of São Paulo) (2010), 93 percent of physicians received benefits of up to five hundred reais (approximately 145 USD) (magazines, free samples, etc.) from industry; 80 percent received representatives; 77 percent declared that they knew other doctors who received higher-value benefits (courses, national and international congresses, etc.); (...) 33 percent witnessed or heard of doctors who receive commissions for referrals or indicating unnecessary procedures, drugs, orthotics and prosthetics.

This relationship between the public and private sectors in Brazil “is an obstacle to planning healthcare actions because it establishes a dynamic of fragmented and opaque articulation” (Sestelo, Souza and Bahia, 2013: 861). The lack of coordination between the two sectors results in duplication of efforts and resources and conflicts over who should pay.

Also worthy of note is the growing practice of charging the beneficiaries of private plans for the care provided at SUS health centres, which changes the supplementary nature of the private insurance to being complementary. This is even more serious if one considers that, in theory, in a universal public policy with high taxes paid by the population, private plans should not even exist. In this case, the strengthening of public structures and services should be the main goal.

However, as health practice has evolved and is now established in Brazil, private plans are a priority for the people who can afford them, and who often deprive themselves of other expenses to have this guarantee. The exclusive dependence on public health ends up being the choice of those who do not really have another option, as evidenced by the fact that the regions with the highest purchasing power (South-East and South), as well as the Federal District, have the highest coverage.

According to ANS data (2009), private health plans in Brazil are offered by the 1,525 companies operating in the sector, of which 1,122 are hospital-based and 403 exclusively dental. These operators are classified into four different categories, which receive subsidies from the State in the form of fiscal and contributory waivers. In the case of cooperatives, 19.7 percent are medical and 8 percent dental.

The holding of a market share by cooperatives may be related to reduced costs or higher quality products. As regards operator revenues – which in 2008 were 59.1 billion BRL – 35.6 percent were obtained by medical cooperatives. Unimed is the most representative in the sector. When the variable analyzed is the number of plans registered per segment, of the 25,219 plans registered in the ANS 50.3 percent were from medical cooperatives (Teixeira, 2009).

The role of cooperatives in the Brazilian health system

Brazil has the largest cooperative medical system in the world. Health cooperatives are dedicated to the preservation and promotion of health and they today operate in four distinct areas: medical care, dental care, and psychological assistance. It has been one of the fastest growing branches in recent years and seeks to offer an alternative to the expensive health plans. Health cooperatives comprise 250,000 professionals, who serve 24 million people. Brazil has 849 cooperatives of health professionals and 250,000 members. The sector (which is present in 85 percent of the national

⁸⁴ <http://www.cremesp.org.br/>

territory and handled 36 billion BRL in 2016) represents 32 percent of the private health market. In the context of supplementary healthcare, cooperatives occupy the second position, covering 29 percent of the total number of operators.

A study issued in 2013 by the ANS on the qualification of operators acting in the market shows that 400 cooperatives received good to excellent ratings. In the evaluation of the Organization of Brazilian Cooperatives (OCB), the success of health cooperativism is due to its strong acceptance in society; socially responsible posture; higher remuneration and valuation of professionals in the area; non-governmental organizations and public bodies; diffusion of values and cooperative principles; and solidarity. Health cooperatives grow towards significant changes in governance by adopting professional criteria in their executive management.

Unimed cooperative - Brazil

As already mentioned, in the second half of the 1960s, healthcare in Brazil was characterised by a high degree of effervescence due to structural changes in social security aimed at extending medical care to the population. However, given the lack of resources for healthcare, the INPS began its activities amid many difficulties in the implementation of its purposes. The military government authorized the formation of “group medicine companies” (*medicina de grupo*) – for-profit enterprises or companies operating private healthcare plans – based on the retention of 5 percent of the minimum wage of each employee, in order to bear the costs of medical insurance in organizations. This situation induced medical companies to concentrate their investments in Brazil’s capital and most important cities and to underpay professionals, thus generating overall dissatisfaction among the population and the medical class (Albuquerque, 2012).

History and context

“The foundation of the Unimed Cooperative started from the mobilization of the class union leaders in reaction to the group medicine companies created by lawyers, businessmen or medical groups not linked to the movement of the category” (SIC). According to Edmundo Castilho, founder of Unimed and president of the Union of Doctors of Santos at the time: *“In 1967, in Santos, we created the first Unimed because we did not want commercialization. We wanted ethics, respect for users, and we defined the attendance in the office (...), socializing means and maintaining the liberal characteristics”*. So-called “liberal medicine” was associated with better quality of the care provided: *“The associated doctors, being the owners, would receive fair remuneration for their work in exchange for a high standard of care for users”* (Akamine, 1997: 37; Duarte, 2001). Initially, the group had 23 members (doctors), who signed the foundation act. Unimed Santos was the first health cooperative in the Americas and gave rise to the Unimed System. In 1977, there were already 60 Unimed cooperatives.

Life cycle

The system of Unimed cooperatives has gone through three stages of evolution: growth and expansion (1967-1998), maturing and reunification (1999 to 2007/2008) and reorganization, strengthening and sustainability (2009-2014). Today, the Unimed Cooperative System is the largest healthcare network

in Brazil and the largest cooperative system of medical work in the world, with over 114,000 members and 348 cooperatives.

Besides cooperatives, other enterprises are linked to Unimed: 114 hospitals and 18 day-hospitals, laboratories, ambulances and hospitals accredited to ensure quality in medical service and in complementary diagnosis, providing assistance to more than 19 million beneficiaries across the country. It is noteworthy that Unimed is present in 84 percent of the Brazilian territory and it is significant within the country (in small and medium-sized municipalities), becoming a key differentiator in relation to performance of managed care. It totals 4,686 municipalities, holds 29 percent of the national health insurance market and generates 95,000 direct employees.

In Brazil, the National Policy for Cooperatives classifies cooperative societies among single, central, or federations of cooperatives. The individual cooperatives are those constituted by the minimum number of twenty individuals, being exceptionally authorized the admission of legal entities whose purpose is the same or a related economic activity, or even a non-profit one. Such cooperatives provide services to members, with fields of activity defined by statute. The central cooperative or cooperative associations are constituted by at least three individual cooperatives which can, exceptionally, accept individual members. The cooperative confederations are constituted by at least three federations of cooperatives or central cooperatives. The federations' action in the provision of services, the monitoring of activities, and institutional representation of the single cooperatives is expressly defined in their statute.

The Unimed System is coordinated by the National Confederation of Medical Cooperatives (Unimed of Brazil), which is the owner of Unimed's trademark and the coordinator of its political and institutional activities. The system also comprises Unimed Mercosur, the Confederation of Unimed Cooperative Federations of the South of Brazil.

The role of the Cooperative Confederation is the guidance and coordination of the affiliated Unimeds' activities. Besides the confederation, federations and individual cooperatives, the Unimed system also has "Unimed *Participações*" (Participations), which is the holding that controls the companies: Unimed *Seguradora* (Insurer), Unimed *Administração & Serviços* (Management and Services) and Unimed *Corretora* (Broker). The fundamental purpose of Unimed *Participações* is to represent the interests of the cooperative members and of the Unimed system in the conduct of business (Albuquerque, 2012).

Unimed *Seguros* (Insurance) is the institutional trademark of Unimed *Seguradora*. It manages a portfolio of over 6.1 million insurers, with 33 products in the segments of life, health and welfare insurance. The purpose of Unimed *Seguros* is to market pension plans for the cooperated physicians of Unimed System across the country. One of the most significant activities in the cooperative medical sector is professional training, which is a responsibility of the Unimed Foundation. Professional training is not restricted to physicians, but is extended to directors, managers and employees, enabling them to make changes in the operating environment (Albuquerque, 2012).

Core business model

The medical cooperative is an organizational form in which physicians are both partners and service providers. In some cases, they may be employees of the cooperative and receive wages as auditors or physicians in their own hospitals. Nevertheless, most of them are members, with payment proportionate to their production (quantity and type of procedure) (Duarte, 2001). *“From the managerial point of view, the cooperative format is a complication, since Unimed must comply with the law on cooperatives and also with the health insurance law. However, if Unimed were a private company, it would already have been bought and probably would not be what it is today, even because the procedures of democratic management and the reinvestment of the results in the projects and in the partners made possible its expansion and capillarization”* (SIC).

However, many physicians belonging to the cooperative reproduce a business vision expressed mainly by: 1) prescription of unnecessary examinations and procedures, a situation in which the physician wins as a provider – when s/he has his/her own structure (clinic and hospital) – and/or as a professional; 2) the improper benefits arising from the above-mentioned relationship with the medicine industries. Faced with these costs, which have become exorbitant, Unimed has expanded its network of hospitals and clinics and has acquired its orthoses and prostheses, which is reducing costs. However, it is still necessary to improve the medical audit and to increase control of the examinations requested. The judicialization of the demands of the beneficiaries and the expansion of services to be provided by the operators by definition of ANS has also burdened Unimed, and these are topics of discussion among the actors involved.

As regards goods and services, the Unimed System’s vision is to be “a reference in healthcare”. Therefore, the System offers a number of products and services covering different areas (healthcare, management and technology). As an example of this diversity and segmentation, Unimed of Brazil (i.e. the Confederation) offers many solutions. Firstly, there are solutions for helping Unimeds take care of their beneficiaries: Family Benefit (care remission plan), Active Solution (telemonitoring and management of chronic patients), SOS Unimed (pre-hospital), Unimed Phone (24-hour medical guidance). The following management and business solutions are also available to Unimeds: Job and Salary Consulting, Sustainability Consulting, Organizational Diagnosis, Sending SMS (MSG), Market Information (SIMM), Video Conferencing (SINAL), Medical Audit (SOMA), Actuarial (ÚNICA), and others. For external and internal customers there is the SOU (occupational medicine). To ensure the sustainability of the Unimed brand, the Confederation has a unit monitoring the economic-financial and operational health of Unimed cooperatives, with dedicated staff assisting in the management of Unimed’s operations in the market as a health insurance provider, rendering all legal, accounting and regulatory assistance.

With regard to human resources, the alignment of the organization’s strategy, processes and expectations with people management practices and the roles of managers and employees is the first step in enabling each party to deliver the expected result and to add value and quality to the cooperative, so that the contributions of professionals who work there can be recognized. To this end, the Confederation has disseminated throughout the system the Management Skills Model, which is the market practice among the best and most recommended by ANS to certify the quality of the operators. This model aims to standardize and support, in an integrated manner, the various people

management practices: select, hire, develop, evaluate, recognize, reward, retain and take better care of people. A group of leaders from more than 20 Federations of the Unimed System, of different sizes and operating in different regions, jointly built this model using a participatory method which included workshop discussion and reflection, in a process of social innovation. There are skills common to all employees and career paths, which reinforce the cooperative identity: inter-cooperation, customer focus, focus on results, continuous improvement, knowledge management, communication and emotional intelligence.

In addition, Unimed has recently implemented three projects that may be considered innovative: 1) focus on primary care through the family physician, which is already a guideline of SUS, but not commonly used in private services. The Unimed Foundation will provide training to physicians; 2) Home Care, with the provision of nursing and physical therapy at home; 3) electronic medical records, which will concentrate all patient information in an integrated and accessible way.

As regards voluntary work, it exists only at the Unimed Institute, which is dedicated to the development of social actions aimed at the community. There is a tendency for these actions to expand in the coming years.

With respect to communication strategy, Unimed of Brazil has joined efforts to standardize corporate communication and strengthen the Unimed Brand. To do so, Unimed sets guidelines for communication, goals, attitude, responsibilities and orientations. Communication should be built in adherence with principles that enhance the corporate image of the brand: commitment and respect for human beings and life; appreciation and motivation of work teams; promotion of gender equality and respect for diversity; transparency with all stakeholders; and respect for the law. In order to ensure efficient communication, Unimed of Brazil addresses two types of audience: internal (directors, medical cooperatives; nurses; employees; contractors and providers) and external (clients, public agency, public authorities, trade unions, partners and media). The Unimed System also has a crisis management system to cope with emergency situations that may damage its image and brand reputation.

Besides standardizing and strengthening the Unimed brand, the Confederation seeks to define guidelines and structures; create a culture of integrated communication; enhance Unimed's institutional image and reputation; guide and integrate the Unimed System's communication actions; register the communication process; develop planning; identify the actions and campaigns that can be conveyed together to optimize efforts and resources; monitor, control and evaluate the implementation of activities through systematic measurement of expected and achieved results by means of communication performance indicators.

Unimed of Brazil's communication strategy for the entire system also extends to the virtual environment. The Unimed System features a Digital Media Committee responsible for proposing planning and communication strategies in social media, together with the Federations, and to evaluate how they will be pursued within the Unimed System. Brazil's Unimed monitors social media in order to obtain information about how the Unimed brand is mentioned on social networks.

With regard to resource mobilization, verticalization – or investing in own resources and services – may in certain situations be of great importance for the economic and financial balance of the healthcare companies. However, it can also be an initiative that adds tremendous value to the brand and to the perception of customers when they choose a particular health plan. This has been a competitive advantage in the market. Currently, Unimed is the second largest hospital network in Brazil. The overall resources of the system are the following.

Figure 4. Network of Unimed System Own Resources

113	General hospitals
19	Day hospitals
199	Emergency cares
94	Laboratories
118	Diagnostic centres
93	Drugstores
8,561	Hospital beds
172	Day hospital beds

Source: Unimed of Brazil

The assessment has been carried out annually by a renowned contracting research institute in Brazil (Datafolha). In the survey on the population, the 2016 results showed that the Unimed brand is approved by about seven out of ten users. The strongest point is the quality of the accredited physicians and, secondly, the extent of the network of laboratories, clinics and physicians. Other highlights are the service, the quality of the employees, and the effectiveness of the emergency room. The recommendation index of Unimed brand is high (75 percent), reaching 88 percent for those who have used the services.

In the survey of physicians, Unimed is the most important health plan for 45 percent of those who provide private healthcare services, with 75 percent evaluating it as excellent or good. The brand value is mainly associated with payment (timeliness), the demand for patients, and less bureaucratic processes. Research shows that the Unimed System is fulfilling one of its strategic goals, which is to generate work for the members with decent conditions to practice good medicine.

Institutional/governance structure

The operation of the Unimed System is based on the observance and fulfilment of the Unimed Cooperative System Constitution, which is the contractual instrument fixing concepts, principles, operational standards and rights and duties of its members. The Unimed Cooperatives System (see Figure 5) consists solely of medical cooperatives entitled to use the Unimed name and brand. The common goals of the Unimed Cooperative System are protection of the Unimed brand; national exchange; and protection of the area of action of the Unimed cooperatives. In order to achieve its

objectives, the Unimed Cooperative System also encourages inter-cooperation with the Unimed System of credit cooperatives, especially in regard to:

- the establishment of bodies to deal with matters concerning the identity of cooperatives or their logos: regular use, preservation and extinction;
- the conduct of any kind of partnership, such as events, publications, magazines, television programmes, seminars, conventions and other;
- if applicable, the unification of theses on the doctrinal and institutional cooperativism in the national and international scene;
- reciprocity in the use of the specific activities of each of these cooperatives by the others.

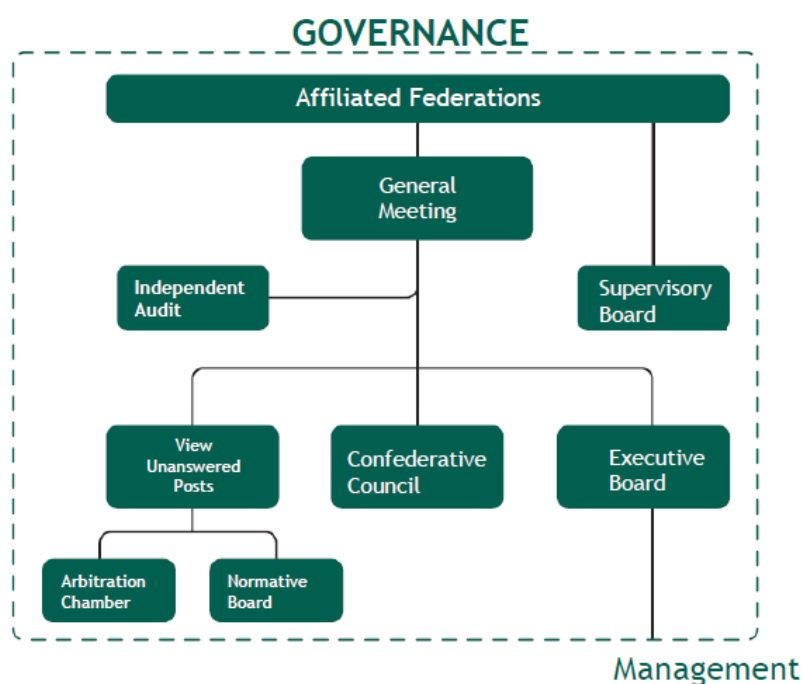
As for governance, Unimed follows the specific organizational model of cooperativism, characterized by the association of people or groups with a common interest that cooperate voluntarily to meet economic, social and cultural needs through a collectively owned and democratically managed enterprise. One of the main features is the participation of cooperative members in decision-making (each worker, one vote) and the division of income according to work and not capital. Unimed of Brazil, in accordance with Law no. 10.406, of 01/10/02, is governed by the following legal instruments: special legislation on cooperative societies (Law No. 5764 of 12/16/1971); by-laws; legal rules; Constitution of Unimed Cooperative System; and other standards agreements within the Cooperative System.

Recently, in response to increased competition in the health sector and the new requirements of regulatory bodies, Unimed of Brazil has implemented a professional management and established, in 2010, its Organizational Development Plan (PDO). The plan resulted from the adaptation of the Corporate Governance to cooperative purposes and features. One of the strategic objectives was to “deploy the cooperative governance model” with a view to a transparent and equitable management, with the definition and clarity of processes and roles throughout the company. The dissemination of this governance model aims to contribute to the pursuit of operational excellence, with the result that *“the Unimed brand grows stronger and medical work is increasingly valued, competitive and modern”* (SIC).

The Cooperative Governance model adopted by Unimed of Brazil rests on the following principles: transparency, accountability, corporate responsibility and equity. The cooperative governance also considers all stakeholders: Confederative Council, independent audit, Supervisory Board, Community, The Committees, Contributors, Suppliers and Customers, Executive Board, Regulatory Agencies.

The governance structure of Unimed of Brazil used for its management and control is composed of the following bodies:

Figure 5. Governance structure



Source: Unimed of Brazil

Ordinary or Extraordinary General Meeting: constituted by the delegates of the Confederative Council, it is the supreme organ of the Confederation, within the legal and statutory limits, having the power to decide matters related to the purpose and to take resolutions appropriate to their development and defence.

Confederative Council: this is the participatory governing body of the Confederation in the field defined by the Social Statute, and it is formed by all the Presidents in office of the Confederation.

Executive Board: it manages the Confederation through the following boards: Presidency; Vice presidency; Market Development Board; Board of Exchange; Board of Health Management; Board of Regulation, Monitoring and Services; and Director of Administration and Finance.

Unimed Forum: it is the body responsible for safeguarding the principles of the Unimed Cooperative System; maintaining the integrity of the system and the harmony among the companies that make it up; and ensuring integrated actions.

Arbitration Panel: composed of 21 judges, who are elected by the Confederate Council of Unimed of Brazil in the first meeting after the Annual General Meeting (AGO) to elect the board of Unimed of Brazil, seven Federations leaders, seven leaders and seven technicians of the Unimed Cooperative System, for a term of four years.

Normative Body: composed of the President of Unimed of Brazil, the president of the National Confederation of Health Cooperatives and the presidents of the Federations and Unimed National Center.

Supervisory Board: it consists of three members and three alternates, all coming from the Unimed System of Cooperative Societies.

Independent Audit: independent body responsible for verifying the financial accounting. It evaluates the effectiveness of controls compliance with legal requirements. Appointment and removal from office on the Independent Audit board is responsibility of the Executive Board.

Communication Channel: available at Unimed Portal, it is intended for internal and external audiences to make suggestions, criticisms and complaints in order to demonstrate credibility with all its stakeholders.

Structured Meetings: Unimed of Brazil holds periodic management meetings to promote transparency and/or accountability. They are described in the following table:

Table 37. Management periodic meetings

Meeting	Objective	Frequency	Participants
General Meeting	Define the business related to the social objective and make resolutions appropriate to its development and defence	Annual General Meeting once a year Extraordinary General Meeting on request	Federations and CNU CEOs
Confederative Council	Discuss national and international rules, business plan follow-up and general budget	6 times a year and on demand	Federations and CNU CEOs
Fórum Unimed	Taxes and contributions deliberations, national standardization of procedures, establishment of penalties for violation of duties	On demand	Normative Chamber: Presidents of Unimed do Brasil, Federations and CNU Arbitration Chamber: 21 arbitrators
Executive Board meeting	Decisions about Unimed do Brasil directions	Weekly	Executive Board
Fiscal Council meeting	Verify the company's financial and economic-financial statements	Up to 8 times a year	Comptroller Members of the Fiscal Council
Directors of System Companies (Unimed Cooperative Societies and Unimed Joint Ventures)	Common interest discussions and sharing decisions about joint actions	monthly	Directors of the Companies of the System

Source: Unimed of Brazil

External relations

There is constant dialogue with national and international institutions that promote and strengthen the cooperative movement. The Brazil Unimed acts as the national representative of the health branch of the OCB, integrates the Technical Group of the Advisory Health Council (which has the function of suggesting guidelines, analysing strategies and forwarding the resolutions of the coordination collegiate) and supports important discussion forums in the country. There are also representatives in the Brazilian Federation of Banks (Febraban), in the Custody and Financial Settlement of Securities (CETIP), in the Brazilian Institute of Corporate Governance (IBGC), in the Federal Accounting Council (CFC) and in the Coalition Health Institute (ICOS). There have been recent meetings with the federal government to negotiate new credit lines. There is ongoing contact and partnership with government agencies and regulatory bodies for the sector's sustainability and quality of services.

Internationally, Unimed belongs to the following organizations: International Cooperative Alliance (ICA), Cooperatives of the Americas (ICA Region) and International Health Cooperative Organization (IHCO). Currently the president of Unimed Foundation, Dr. Eudes de Freitas Aquino, is the first vice-president of Cooperatives of the Americas, vice-president of IHCO and member of the Board of the ICA.

Economic data

Table 38. Earnings 2014, 2015 and 2016

	2014	2015	2016
Revenues	52,877,398,116 BRL	58,187,457,227 BRL	64,868,768,805 BRL
Net worth	6,306,565,579 BRL	6,503,316,775 BRL	8,652,673,097 BRL
Short-term indebtedness	48.16%	49.28%	46.38%
Current liquidity	1.20%	1.16 %	1.22%
Claims	83.83%	83.59%	84.67%
Combined claims	98.51%	97.38%	97.99%
Administrative costs	10.21%	10.05%	9.78%
Assistance Expenses per capita	152,25 BRL	167,57 BRL	205,36 BRL
Average Ticket per capita	184, 87 BRL	203,80 BRL	211,32 BRL

Source: Unimed of Brazil

Table 39. Main sources of funds

Revenues from healthcare operations	54.763.613.624 BRL	82%
Other operating income	9.828.906.535 BRL	15%
Financial income	1.986.603.961 BRL	3%
Asset income	256.581.559 BRL	0%

Source: Unimed of Brazil

Impact analysis

The Unimed System has made large investments. In 2015 alone, Unimed invested more than 1.9 billion BRL, an amount 30% higher than in 2014.

Table 40. Investment in internal and external public of the Unimed System

	2012	2013	2014	2015
Internal Public – cooperated and Unimed Employees	1,122,335,395 BRL	1,208,600,452 BRL	1,410,349,815 BRL	1,831,930,627 BRL
External Audience–community	318,357,834 BRL	347,570,839 BRL	68,913,675 BRL	84,225,776 BRL
Amount invested	1,440,693,229 BRL	1,556,171,292 BRL	1,479,263,490 BRL	1,916,156,403 BRL

Source: Unimed of Brazil

Final considerations

Despite undeniable progress in the universalization and democratization of public healthcare policy in Brazil, the dynamics between the public and private spheres have favoured the expansion of private health plans. The cooperative sector now plays an important role, and UNIMED is the main cooperative active in the sector. However, there are a number of controversies surrounding this issue. Brazilian people pay high taxes for universal public health, but they still have to pay for private plans to receive quality healthcare, which ultimately reproduces inequality and historical social segregation in the country.

The Canadian Healthcare System ⁸⁶

The challenges related to the health of Canadians reflect the vast size of Canada, the climate, history, cultural diversity, and complexity of the governance system. The Canadian health system is characterized by the acceptance of the 20th century assumption that, instead of focusing on prevention and on the promotion of health, all resources should be committed to the provision of medical treatments, with the result of health loss because of injury or illness.

Canada is the second largest country in the world, with the world's longest coastline and a variegated geographical landscape encompassing Arctic tundra, expansive prairies, isolated islands, rural areas and settlements accessible by land only when the ice-roads are frozen alongside vibrant cities and industrial complexes. This results in a population density of 3.7 people⁸⁷ per km², making Canada one of the world's most sparsely populated countries; moreover, the presence of over 50 language groups makes for vast cultural and linguistic heterogeneity.

Geography and economic status influence access to wellness education, health services and medical facilities and services. Residents of remote areas, people without the financial means to travel to health and medical facilities are all at risk of being unable to access needed⁸⁸ services. Diverse ethnicity and languages present unresolved challenges in identification of health and medical needs and in delivery of services⁸⁹.

The concept of a publicly-funded health service led to the Canada Health Act being adopted in 1984, which was broadly based on the UK pattern with its focus on physicians, nurses and hospitals. Through taxation, the Federal government collects funds from Canadians under the Canada Health Act through the Federal Ministry of Health. Funds are then allocated to the Provinces and Territories to provide residents with medically necessary hospital and physician services without paying out-of-pocket. Under the Canada Health Act, the Federal government also provides direct healthcare services to some population groups, including: First Nations⁹⁰ people living on reserves, Inuit, serving members of the Canadian Forces, eligible veterans, inmates in federal penitentiaries, and some groups of refugee claimants. All other services are delivered by 13 Provincial and Territorial systems. Globally the system is committed to the provision of reasonable access to medically necessary hospital and physician services without paying out-of-pocket.

Nevertheless, some limitations in the way of universal healthcare still exists, such as the existence of a fee-for-service billing to access the services of some medical professionals such as Family

⁸⁵ Report based on the contribution of Joan Kotarski and Vanessa Hammond, First Ownership Co-operative (Canada) and Jean-Pierre Girard (Canada-Quebec).

⁸⁶ Report based on the contribution of Joan Kotarski and Vanessa Hammond, First Ownership Co-operative.

⁸⁷ <http://www12.statcan.ca/census-recensement/2011/dp-pd/hltfst/pd-pl/Table-Tableau.cfm?LANG=Eng&T=101&SR=1&S=10&O=A>

⁸⁸ www.kidsnewtocanada.ca/care/barriers

⁸⁹ www.ncbi.nlm.nih.gov/pubmed/25102218

⁹⁰ First Nations is the name attributed to populations of Indigenous peoples inhabiting Canada.

Physicians and Nurse Practitioners, the higher focus on rehabilitation than on prevention (e.g. it is easier to access rehabilitation after surgery than affordable access to a community pool or fitness class), and the exclusion of vision and dental care from publicly funded plans. Long wait times, especially for diagnosis and treatment of mental illness⁹¹, for diagnosis and surgeries typical of an aging population (knee and hip replacement, cataract and prostate surgeries) are widespread. On one hand, shifting the focus and investment of the system towards the promotion of health and towards services that would pre-empt the need for hospitalization would be kinder, more effective and less expensive⁹². A focus on home care, especially for seniors⁹³ and those with disabilities⁹⁴ have not been adequately addressed. On the other hand, some problems faced by First Nations are not met, like e.g. the lack of facilities and services for care of physical and mental illness⁹⁵.

The Cooperative Approach to Health

Cooperatives can incorporate federally, in any of the ten Provinces or three Territories. The process is relatively open, straightforward and affordable. Cooperative developers, accountants and lawyers operate across Canada. There is no legislative prohibition or encouragement at the federal level regarding the legal form of organizations delivering services funded through the Canada Health Act. Except for some restrictions in Ontario, there are no provincial or territorial prohibitions regarding cooperative ownership of health or medical services, whether within or outside the services funded through the Canada Health Act. No organization can require a payment, such as a membership fee, for access to any service funded under the Canada Health Act.

The concept of cooperative delivery of services in the wellness, health, social services, medical and related services was active in Canada decades before the establishment of the Canada Health Act. The first cooperatively operated health services were established in Québec in 1944. In 1960 the Cooperative Commonwealth Federation led by Tommy Douglas, won the provincial election in Saskatchewan based on the promise of North America's first publicly funded medical service. The ensuing turmoil led to a doctors' strike and then, in 1962 to the formation of the Community Health Services Association Ltd. Saskatchewan by a group of pro-medicare citizens, including doctors. The sector was established (Panayotof-Schaan, 2009).

Tracking the growth of the sector has been hampered by two factors: lack of consistent tracking systems for cooperatives across Canada and lack of a widely-accepted definition within the cooperative Sector. The lack of consistent cross-country analysis by Cooperative Registrars, combined with inconsistencies between definitions used within the Sector and those applied externally have hampered understanding of the scope of the Sector and development of an accurate

⁹¹ www.fraserinstitute.org/studies/waiting-your-turn-wait-times-for-health-care-in-canada-2016

⁹² www.cna-aiic.ca/~media/cna/files/en/the_costs_performance_canadas_health_system_e.pdf?la=en

⁹³ www.cma.ca/En/Lists/Medias/the-state-of-seniors-health-care-in-canada-september-2016.pdf

⁹⁴ www.cna-aiic.ca/~media/cna/files/en/fact_sheet_11_e.pdf?la=en

⁹⁵ www.thestar.com/opinion/commentary/2015/10/08/first-nations-health-crisis-is-a-canadian-problem.html

list of Sector cooperatives in the Cooperative Secretariat. The problem was exacerbated by the Secretariat's move from Agriculture Canada to Industry Canada, and serious under-staffing, in 2013.

The Role of Co-operatives and Mutuals in the Health System

The formation of health cooperatives has been a response to a community-based challenge or opportunity, unique to that situation. Even in Saskatchewan where several cooperatives were formed in response to the physicians' strike, the four remaining cooperatives reflect the differing priorities of their communities. In most of Canada, health cooperatives are focused on the delivery of services, not on the insurance aspects of medical and healthcare.

Health Co-ops Canada was established in 2011 at a time of much need for co-ordination but with little support from the cooperative sector at large and no support from government at any level. Despite the challenges, Health Co-ops Canada has gained considerably from being able to network, learn, and understand the sector. Many, but not all, of the health, wellness, social service and medical cooperatives outside Québec are members of Health Co-ops Canada. Based on the definitions used by Health Co-ops Canada, we estimate that there are over 120 Sector Cooperatives in Canada. Of these approximately 20 provide services that are covered by the Canada Health Act. In all Provinces and Territories, cooperatives in other sectors that are not supported by the publicly funded system have a significant impact on access to clean water, adequate food, safe housing – basics for the wellness of their communities⁹⁶. Members of Health Co-ops Canada provide a wide range of services such as ambulance and mobile wellness and health services, home care, employment and life-skills support for persons with disabilities (physical and mental), housing support, medical services, complementary and integrative services.

Saskatoon Community Clinic

History and background

The province of Saskatchewan is the heart of prairies between the provinces of Alberta and Manitoba, with the United States of America to the south and the North-West Territories to the north. The land area of the province is 651,900 km² with numerous lakes in the northern third and higher ground in the south. Saskatchewan's population of only 1,300,000 is mostly centred in three large cities in the southern part of the province. Saskatoon had a population of 265,300 in 2016 and is the third fastest growing city in Canada. While Saskatoon is growing, the disparity between rich and poor is growing also. The city faces gentrification of some of the core neighbourhoods which forces the residents to move further away from necessary services. Many of the smaller communities in Saskatchewan are isolated. A number of the First Nations communities lack services in indigenous languages and services that respect indigenous culture. Income inequality is increasing as provincial finances are under increasing pressure.

Founded in 1962 in response to the doctors' strike, the Saskatoon Community clinic has been in existence for 55 years. It began in a donated space and eventually moved to its present location in

⁹⁶ http://www.ic.gc.ca/eic/site/693.nsf/eng/h_00037.html

downtown Saskatoon. Formation of the cooperative resulted directly from the loss of medical services caused by the strike. As the province was rich in cooperatives, the advantages and process of forming them was familiar. The need for services was so great that many willingly purchased 1,000 CAD debentures, a considerable investment in the 1960s. Initially the only support was from the members, including the doctors who had to fight for hospital privileges. After two years of operation, credit unions provided some assistance. In the late 1960s, additional debentures financed construction of the Cooperative's purpose-built building. Later, the New Democratic Party Ministry of Health provided program funding. In 1972, in response to membership guidance, a new clinic was established in the low-income Westside neighbourhood. The need was great as there was no access to doctors in the inner city area. This small clinic served local, poor and aboriginal people. Recently the Westside Clinic moved to a much larger space where it now serves HIV/AIDS patients, has a methadone programme and many more services required by the population.

Saskatoon Community Clinic is member owned and currently operates facilities in two locations. The main clinic is in downtown Saskatoon serving all populations, while the Westside Clinic is in an older neighbourhood and serves mainly Aboriginal and poorer populations, thus facing more and more stress on the system as the indigent population grows. The cooperative was established in answer to the doctors' strike which was launched when the provincial government decided to implement universal medicare in the province.

The cooperative estimates that Saskatoon Community Clinic serves approximately 10,000 patients in its main clinic and variable numbers in the Westside facility, where there are drop-in visits. The cooperative's services include but are not limited to: doctors, nurse practitioners, registered nurses, x-ray and lab services, physiotherapy, pharmacy, nutritionists, occupational therapist, counselling, HIV/AIDS care, methadone treatment, and outreach counselling. In order to fully serve the client/members, Saskatoon Community Clinic partners with community organizations such as the University of Saskatchewan and the Saskatoon Health Region.

Life cycle

There has always been ongoing evolution at the Saskatoon Community Clinic in response to the changing needs. New programming, new ways to provide healthcare, and new voices in the community constantly move the cooperative forward. The Community Clinic is not a stagnant healthcare facility, but an evolution of primary healthcare and community outreach into the 21st century. Looking to the future, the organization's Board has developed a twenty-year plan to address the current needs and plan ahead for the foreseeable future of the community as it continues to evolve.

Core business model

The services offered at the two clinics include 17 full-time equivalent physicians, three nurse practitioners, physiotherapists, occupational therapists, nutritionists, counsellors, outreach workers in addition to laboratory and x-ray services, a for-profit pharmacy, HIV/AIDS testing and programming, mother and baby clinics, and chronic disease management groups. Almost all of the personnel is employed by the cooperative, unlike some other cases, in which personnel contract to use the facilities

and services provided by the cooperative. The Saskatoon Community Clinic receives its funding from the government Ministry of Health and has a small surplus from the pharmacy, which helps to support ongoing programming.

Saskatoon Community Clinic also partners with the University of Saskatchewan to provide a SWITCH program (Student Wellness Initiative Towards Community Health) that provides two additional evening clinics in the Westside facility. This program provides students in healthcare schools the opportunity to work one-to-one with mentors in a clinical setting. The clinic provides the facility and staff to teach students, in a safe setting, what poverty is really like. The program provides the clinic with extra clinical time and builds a relationship with potential future staff.

Institutional/governance structure

Membership is open to all. The Saskatoon Community Clinic is governed by the membership through an elected Board of nine members which is responsible for all governance and hiring and oversaw all operations through the Executive Director until the Carver Model was adopted. The ED oversees the management team. The Medical Director supervises and co-ordinates the team of salaried doctors.

External relations

The Saskatoon Community clinic is in partnership with the Saskatoon Health Region, the University of Saskatchewan, the Saskatoon Tribal Council and various non-governmental agencies throughout the city in order to better serve the community. Saskatoon Community Clinic is consulting with the Health Region about wait times at the hospital Emergency Department (ER). According to the organization, it could be possible to reduce the number of people visiting the ER if they had additional funding to increase hours with University student providing some Saturday clinics. Saskatoon Community Clinic is affiliated with various federations across the country, including Health Co-ops Canada, Saskatchewan Health Co-op Federation, and the Canadian Association of Community Health Clinics.

The Victoria Health Co-operative

History and background

In 1888, Victoria was chosen as the capital city of the province of British Columbia. The city is situated on the south end of Vancouver Island, off the west coast of Canada. The population of 86,000 makes it the seventh most densely populated city in Canada. Victoria is the heart of the Capital Region District with over 370,000 residents. Of these, over 74,000 do not have a Primary Medical care provider. Victoria is a wealthy city but has a homeless population of over 700. The relatively gentle climate is a magnet for many who live on the streets across Canada. This population requires considerable support, placing pressure on health, medical and social services. Victoria is a retirement destination with Canada's highest percentage of residents over 80 years of age, also stressing medical resources.

The Victoria Health Co-op was established in 2008 but its roots go back to community discussions starting in 2000. It is located in James Bay, one of the oldest areas of Victoria. The cooperative was

established in 2008 to provide Complementary, Alternative and Integrative (CAI) treatments. The first 18 members were Complementary, Alternative and Integrative (CAI) practitioners committed to making a wide range of health, wellness and healing modalities available, and others who valued those services. The modalities offered include naturopathy, chiropractic services, osteopathy, counselling, art therapy, foot care, reflexology, acupuncture, acupressure and kinesiology. Very soon the members realized that they had much to offer to the community, especially those who were on tight budgets. Members established wellness programs for Middle School (age 12-14) students, residents in social housing and other vulnerable groups. They provided programs such as Choices for a Healthy Lifestyle even if You Are on a Tight Budget, with sessions nutrition, entertainment, transportation, glamour etc. These health and wellness programs were entirely outside the Canada Health Act, received some community funding to cover costs such as food, but were delivered by volunteers.

Early in 2010, the Board learned that a clinic that had been run by a community organization for over 40 years would be closed due to changes in funding. This would leave over 5,000 patients with no primary medical care. After a feasibility study and commitments on behalf of the doctors, the member-owners voted to take over the operation and established the Co-op Health Centre in September 2010. It now serves over 7,300 patients and counts with approximately 550 members.

Today the Victoria Health Co-op has three aims. The first priority of the member-owners reflects the original aim and is the provision of, and access to, complementary, alternative and integrative services. Access by low-income members is ensured through the efforts of the practitioners and the generosity of members. This is completely outside the tax-funded medical system. The second priority is outreach services through host organizations serving vulnerable groups in the community. Programs include Choices, HansKai and Back to Basics. Leadership is provided by volunteer members of the Victoria Health Co-op. The cooperative sees this work as being at the core of healthcare, working with groups and individuals to help them to attain optimal wellness and health. The third priority is the Co-op Health Centre through currently providing medical services to over 7,300 patients under the BC Medical Services Plan. Expenses include rent, salaries for the Medical Office staff (MOAs), and all the inevitable costs of operating a medical centre such as communications, cleaning, supplies and insurance. The doctors bill the MSP and pay a percentage to the cooperative. Due to the severe shortage of doctors and therefore the low billings, this revenue frequently leaves a shortfall. Because of the Canada Health Act it would be illegal to require Health Centre patients to join the Co-op. Despite extensive advertising, many of the patients have not yet, after seven years, realized that the Health Centre would have been closed if it had not been rescued by the cooperative. All of the MOAs and CAI practitioners have joined, and some of the doctors.

Life cycle

The cooperative's challenge is to try to balance its primary wish regarding access to CAI services, community outreach, and running the Co-op Health Centre. The membership is now approximately 550 and the patient roster is at the Co-op Health Centre is over 7,300. The six Family Physicians and one Internist (specializing in patients with multiple, complex conditions) are all part-time, working

in several other locations some days each week. The CAIs and Co-ordinator offer their services to members at the Monthly Members Wellness Clinics, while the members and community support the Co-op Health Centre and the efforts of the Board to keep the cooperative functioning.

Because of the work pressure related to the Co-op Health Centre, the cooperative is not currently able to offer the Choices program or Back to Basics and neither was in the past two years. However, in co-operation with Health Co-ops Canada, the Victoria Health Co-op introduced the Hans Kai⁹⁷ program to British Columbia, hosted the country's largest Hans Kai training session, and worked with other cooperatives interested in using the program as it is, and others needing to adapt it to the special needs of their membership. It is anticipated that this aspect of the work will continue. For the past year, the cooperative has offered walk-in consultations for the registered patients two mornings a week. The VHC has also been active in educating the business, community development and cooperative sectors about the work of health, wellness, social service and medical cooperativism across and beyond Canada.

The VHC is currently developing a new Community Outreach Program, "Being Ready". The aim is to serve residents who have no immediate family on whom to rely should they become incapacitated, and to serve their friends and neighbours who are faced with solving complex problems. It will help them to ensure that the need for resources such as a Health Advocate and holder of Power of Attorney are identified and that the resources prepared and all involved are informed. The program is also aimed to friends who are wondering how to deal with potentially unsafe driving, how to deal with concerns about medication, nutrition, leanness, how to ensure appropriate social stimulation, how to ensure appropriate spiritual care, how to deal with end-of-life preparations, funeral arrangement, handling a will, or lack thereof and everything that has not yet been considered. The VHC recently submitted a proposal to Island Health for a Nurse Practitioner to be assigned to the Co-op Health Centre in order to absorb some of the patients whose primary care provider has retired or moved. As this would be a full-time position it would make a significant impact on the number of patients the cooperative could accommodate, and would bring a new and advanced set of skills. The additional personnel would help the Co-op Health Centre to be open at least one evening a week, or on Saturdays. This is especially important in an area in which both parents in most families work full-time and evenings and weekends are the only times available for health or medical appointments.

Core business model

The VHC provides a wide range of services outside the Medical Services Plan of British Columbia including complementary, alternative and integrative modalities ranging from acupressure and art therapy to child psychology, kinesiology and nutritional counselling to Reiki. For the practitioners, the VHC offers a range of marketing channels. The VHC manages a Health Access Fund to enable low-income members to access these services. The cooperative runs a range of community outreach services focusing on health and wellness education but, in reality, offering social interaction and a

⁹⁷ Peer supported wellness program aimed at adults and youths.

healthy meal as the main, if unacknowledged, benefit. It operates a medical centre, the Co-op Health Centre, caring for 7,300 patients under the British Columbia Medical Service Plan.

The VHC is introducing a pharmaceutical management tool to provide reviews for the benefit of physicians and patients at the Co-op Health Centre. The VHC strongly encourages members to participate as fully as possible and attempts to educate the MDs regarding the co-operative definition, values and principles, especially egalitarianism.

Institutional/governance structure

The VHC is an open membership cooperative. Any legal person (a human person, a business, any entity that can sign a contract) can apply for membership and is subject only to the approval of the Board. There are no geographical limits. The member-owners elect up to nine Board members on the basis of one-member-one-vote at each Annual General Meeting. Any member-owner can stand as a candidate for the Board. Board members usually focus on one aspect of the work of the cooperative and undertake tasks related to that area such as financial management, recruitment of members and practitioners, development of marketing materials, making presentations in the wider community, participation in the wider cooperative sector.

External relations

The VHC is linked to, and supported by, a network of wellness, social services and health cooperatives across Canada (through the Health Care Cooperative Federation of Canada) and globally (through the International Health Cooperative Organization) and the larger cooperative sector in Canada through the BC Cooperative Association and Cooperatives and Mutuals Canada. VHC also has a close working relationship with Fairfield United Church, which has sponsored many events; the James Bay Community Association, from which it rents space for the Co-op Health Centre; Island Health; the Division of Family Practice; the Members of Parliament (federal) and Members of the Legislative Assembly (provincial) and city politicians; and with other cooperatives in the region. As a step towards supporting the local cooperative community, VHC invites all to have free display space at the AGM and gives them an opportunity to present a door prize.

VHC is developing relationships with the College of Physicians and Surgeons of BC, the BC Nurses Association. Through the CAM practitioners there are good relationships with their professional bodies.

Economic data

The Co-op Health Centre revenue in 2016 was 351,288 CAD. The Health Centre is a constant drain on the resources of the cooperative. However, the VHC serves over 7,300 people who would otherwise have no access to consistent medical care. Although there is always a shortage of doctors, the cooperative has been able to attract and retain a break-even team by ensuring that doctors can focus entirely on caring for their patients with no responsibilities for operating the business.

Impact analysis

The VHC has raised the awareness of cooperatives in Victoria, for example by arranging for the Mayor to declare the “Victoria Co-op Day” and expanding the AGM into a display opportunity for all area cooperatives from Adrenaline Motorcycle to Olio Arts, the agri-food cooperatives and the credit unions and insurance cooperatives, including major co-op groups including Federated, Home Hardware, Pharmasave and Best Western. The VHC has also facilitated interaction between CAI practitioners and clients, including making these services available to low-income individuals. Moreover, the organization has provided a range of community outreach programs at no cost to the participants. These include Back to Basics, Choices and Hans Kai. The VHC continues to attempt to access funding, possibly under the provincial Medical Services Plan.

TeamWerks

History and Background

TeamWerks is located in the city of Thunder Bay, in Ontario, one of the ten provinces of Canada. The great majority of Ontario’s population and its arable land are located in the south of the province. Thunder Bay stretches along the western end of the north shore of Lake Superior and is the most populous municipality in Northwestern Ontario, with a population of just over 110,000 inhabitants. The total population of Ontario is 13,600,000, but this northern zone has only 732,914 residents in an area of 843,853 km², with 80% of the total land mass of the province being occupied by approximately 12% of the population. Many of the settlements are extremely remote with very small populations, a situation that makes access to any type of service problematic. In addition to the remote location are the issues of brutal winters, poverty, lack of education and the impact of generations of enforced enrollment in residential schools.

TeamWerks was incorporated in 1998 in Thunder Bay. TeamWerks Cooperative is a social enterprise owned and operated by consumers of mental health and addictions services. The social enterprise is a key component of the St. Joseph’s Care Group as it provides consumers of these services a wide range of employment, education, volunteer opportunities and peer-to-peer supports. As one of the largest worker cooperatives in Ontario, the TeamWerks Cooperative operates a number of businesses, with 25 worker members and 25 clients on placement. These businesses serve the public on a daily basis.

The TeamWerks Cooperative theoretically has a catchment area that stretches far to the north towards Hudson Bay and to the borders with Québec to the east and Manitoba to the west. It addresses the high unemployment rate for those with serious mental illness and addictions, and the lack of opportunities to access skills training with ongoing supports for those with serious mental health illness. TeamWerks programs include providing work experience in nine enterprises.

Prior to 2000, TeamWerks had been a sheltered workshop run by St Joseph’s Care Group, a complex care organization providing mental health, addictions and other rehabilitation services. It was then transitioned to being a client/worker controlled, supportive Worker Coop. This change was decided and carried out by members and clients accessing mental health and addictions services, working with staff, management and other supporters. Staff, financing and capital for growth were provided by St

Joseph's, as is access to the larger employment program, which provides clients a full range of supported employment services. This is an ongoing relationship as a partnership was established with the St Joseph's Care Group and Employment Options program. The cooperative reflects changes in the mental health and addiction services the agency provides. It continues to evolve so as to ensure that it operates based on best practices such as Psychosocial Rehabilitation and client centred supports.

Core business model

TeamWerks address the high unemployment rate for those with serious mental illness and addictions, and lack of opportunities to access skills training with ongoing supports for those with serious mental health illness. The cooperative's response to these challenges includes provision of employment, peer support, skills building and training opportunities, general employment skills training and technical training related to each of the enterprises, work opportunities in the nine different businesses: a Café, Shredding, Scanning, Water, Wood Working, Assembly Services, Car Wash, Moving and Recycling Businesses.

The cooperative model has empowered clients in receipt of mental health services through actual ownership of the enterprises. The partnership and links to other services, both community based and clinical, is a new and replicable model. The unique partnerships, mental health recovery and clinical supports are innovative, witting well with the cooperative model and the client centred care, empowering the clients. The partnership and direct link to other mental health services, both community based and clinical, is a new model that can be replicated.

Institutional/governance structure

The cooperative forms part of the overall employment program, supported by St Joseph's staff. The Board is elected by the member-owners and guides all business and service activity, and evaluation of services as well as overall mental health support. Membership is open to clients of the Employment Options program. As members, they receive a share and ownership stake in the cooperative.

The St Joseph's Care Group is directed in part by community stakeholders and funders who indirectly impact the decision making process. Business decisions within the cooperative and new business development are evaluated by members with the support of St Joseph's. Resource mobilization for the nine individual enterprises of TeamWerks are evaluated annually in terms of business versus social value. Overall corporate decisions are made in conjunction with St Joseph's and level of support reviewed annually. Service delivery adapts to new best practices such as Psycho Social Rehabilitation.

External relations

TeamWerks is a member of the Ontario Cooperative Association and Health Cooperatives Canada. The cooperative is directly and indirectly connected to other employment and mental healthcare agencies in the region, and to private business through the sale of goods and services as well as work placements.

Economic data

TeamWerks receives its funding from the St. Joseph's Care Group to cover infrastructure costs and some capital acquisition. Social enterprises pay for all operating costs. It receives no grants.

Due to Ontario legislation, because the cooperative holds share capital and carries out no charitable (unfunded or volunteer) work, it cannot access types of funding that are accessible to non-profit or charitable organization.

The Matawa Cooperative and the Four Directions Cooperative

History and background

The Matawa Cooperative in Northern Ontario and the Four Directions Cooperative in Manitoba have both been planned to address issues related to health services and medical care for indigenous (First Nations, Inuit, Métis) communities. The combined indigenous populations of the two areas is between 15,000 and 20,000 of whom approximately a half live on reserve and a half in urban areas. The average life expectation is lower than the national average due to the higher birth rate combined with the life span being approximately 18 months less than the national average.

Although the organization and approaches of the two cooperatives are very different, the issues and their root causes are similar. The Matawa Cooperative is being set up to serve the nine Matawa communities, all located north of Thunder Bay: Aroland, Constance Lake, Eabametoong, Ginoogaming, Long Lake, Marten Falls, Neskantaga, Nibinamik and Webequie. Almost all First Nations communities lack or are at risk of lacking potable water, a large enough territory to hunt and gather traditional foods, education (both indigenous and western), employment opportunities, and services, particularly services in the Ojibway language. All compounded by the impact of the residential school system. All the Matawa communities are small and remote, four accessible only by air. The same is true of First Nations communities in Manitoba.

The aim of the Matawa Health Cooperative is to provide services within each community based on the specific priorities of the community as identified by its Health Director. The work will be coordinated by the Board of the cooperative, consisting of the nine Health Directors, with support from the Matawa Office in Thunder Bay. Funding this work will require working with at least two departments of the federal government plus the provincial government and other health and medical organizations.

Four Directions Centre for Social Health Inc. is the driving force for the cooperative initiative Four Directions Cooperative Centre for Trauma Recovery Inc., aimed at supporting long-term wellness within trauma survivors transitioning from Child Welfare. Its mandate is to support indigenous families by providing "cooperative solutions to collective social problems". Its focus is to provide tools for sustainable wellness to youth approaching independence.

Both Four Directions and the Matawa cooperatives are in the traditional Ojibway territory in what is now the province of Manitoba and the north-western part of the province of Ontario. The area served, or to be served, by these two co-operatives is approximately the same as France, over 1,200,000 km², but with the population of only 15,000 to 20,000. Cooperative members and clients are divided into

four main groups, those who live in urban areas and those on reserve, and then according to the province in which they live. Four Directions works only in Manitoba and Matawa in Ontario. Matawa First Nations members living in urban areas live primarily in Thunder Bay, and to a lesser extent in Geraldton, and Sioux Lookout (all in Ontario). The communities on-reserve are generally very small with few services and poor access to larger centres due to remoteness and difficult terrain. Generally, no public transport is available. Five of the Matawa First Nations are remote communities and can only be reached by plane or, if the weather conditions permit, winter road. For Four Directions, their members are in Teulon and Winnipeg, both in Manitoba.

The problems faced by First Nations are often not met by national institutions. In addition to sub-standard living conditions, in many of the remote communities, lack of facilities and services for care of physical and mental health, and even lack of access to potable water for some First Nations, have driven many to relocate into urban areas including Thunder Bay, Winnipeg, even Toronto or as far away as Victoria (British Columbia) because of its much milder climate. Many of the smaller communities are isolated. A number of the First Nations communities lack clean water, food that is affordable and nutritious, safe housing, and travel services to locations where health and medical services are available. Weakness in these physical aspects of the social determinants of health have serious consequence.

Possibly even more significant are the issues related to the social and cultural aspects of the social determinants of health including lack of services in indigenous languages and lack of services that respect indigenous culture. Much has been written about the serious situation of health services in Thunder Bay and its catchment area. Overall, the situation is very serious. A July 20th 2017 report by the Canadian Broadcasting Corporation (CBC) was headlined “Thunder Bay district residents prone to more health problems” and states that Statistics Canada numbers show higher rates for several illnesses compared to elsewhere in the province. Additional details are provided in a CBC article on a new report by Health Quality Ontario on the health challenges in Northern Ontario.

Issues in the populations served by both cooperatives include lack of services to promote health and prevent illness and injury, the effects of poverty and, of prime concern, the ongoing impact of the residential school system. There is an epidemic of HIV/AIDS and an increase in the use of opioids and crystal meth that is not being addressed by the government but which the cooperatives are addressing, despite the limited resources available. Issues of mental health and addictions have become so serious that suicide among young indigenous people has also reached epidemic proportions, even to the extent of young people creating “suicide pacts”. This is particularly tragic in small communities where residents are aware of the struggles of all in the community.

Life cycle

Four Directions was formed in 2009. It presently serves children and youth in collaboration with Anishinaabe, South-East, Dakota Ojibway, Nisichawayasihk Cree Nation, Peguis, Interlake, Gimli and Selkirk Child and Family Services (CFS) and Victim Services. In addition to its current programs, Four Directions plans to provide residential care to reduce ongoing harm associated with grief, loss and trauma. In the past, Four Directions delivered the much needed Elephant series, a free and open

grassroots event that provided opportunities for interpersonal and community connection. Through addressing difficult social health issues that affect the communities, their members learnt, shared and grew from personal stories and information surrounding survival, change and hope. Topics included suicide awareness, family violence, stress and parenting.

The Matawa First Nations Management group, guided by the Chiefs and the Health Directors of the nine communities decided in 2015 to establish a cooperative to raise the level of health and medical services in the nine communities, and coordination with services available in Thunder Bay. The population to be served totals around 10,000, split almost evenly between those on reserve and those who have moved to urban centres, mostly in Thunder Bay. Access to mental and physical and health promotion services and treatment has been unpredictable on the reserves and in urban centres. While the situation has always been unsatisfactory, the growing awareness of the disparity between services for First Nations and for other Canadians, and particularly the serious increase in mental illness, has received much publicity and increased the pressure for action.

The need for Four Directions was first recognized by Amy Waluk, who brought others into the discussion and planning process that led to the incorporation of the cooperative. The cooperative is successfully delivering a range of services and simultaneously searching for funding to establish a residential program and make the Elephant Series available regularly.

The process of establishing the Matawa cooperative is somewhat complex due to the remote location of several of the communities and the varying jurisdictions. However, progress is being made, an ED identified and an agreement reached that the Health Directors of the nine communities will form the Board. The incorporation process is well underway.

Core business model

Four Directions practices under the belief that it takes a strong and healthy village to not only raise a child but also to maintain wellness in an independent person. Its goal is to provide participants with abundant opportunity for personal empowerment. Four Directions provides half-day workshops in which psycho-educational training topics are delivered in a manner designed to engage the participant emotionally, physically, spiritually and intellectually. Four Directions serves children and youth from Anishinaabe CFS, South-East CFS, Dakota Ojibway CFS, Nisichawayasihk Cree Nation FCWC, Peguis CFS, Interlake CFS, Gimli CFS and Selkirk CFS. Staff include a certified Victims Services Service Provider. Therapeutic support for victims of crime can be compensated through Manitoba Justice Victim Services.

The Four Directions Cooperative Centre for Trauma Recovery is a new initiative designed to assist youth along their journey of recovery from the residual effects of adverse life events. The goal of trauma recovery is to reduce ongoing harm associated with grief, loss and trauma. Throughout program duration, cultural sensitivity will be followed. The program will include equine facilitated learning, expressive arts, practical First Nations cultural teachings, greenhouse interaction, psycho-education, mindful practices (yoga, martial arts, dance), group and individual counselling, mentor-led continuing care.

The Matawa Cooperative is still being established. Nevertheless, much thought has been given to the work to be undertaken in terms of health priorities and the organizational process. Decisions about the health and medical care priorities will be made in each community and brought by the nine Health Directors to the Board, where the overall priorities will be set based on acuteness of need, availability of funding, active support within the community and availability of human resources, either locally or reliably from a major centre, including partnerships.

Some issues have already been identified. For instance, the Matawa Cooperative aims to increase the focus on health promotion including access to healthy food, preferably by setting up food centres, ensuring that exercise is seen as a normal and accessible activity, that sexual health is well understood, and most importantly that the women in the community are equipped to be community leaders in health promotion. Further relevant issues to be tackled include addressing drug addiction (including opioids), smoking and alcoholism, ensuring good prenatal and baby care, streamlining access to diagnosis and treatment of illness and addressing issues of mental illness, in particular the current epidemic of suicide among young people.

Coopérative de solidarité santé de Contrecoeur, Contrecoeur, Canada⁹⁸

History and background

Located sixty kilometres from Montréal in the Montérégie region of Québec, in the early 2000s, the municipality of Contrecoeur counted 6,000 inhabitants and was located near the town of Sorel-Tracy (35,000 inhabitants), in an area that had known a strong industrial development from the beginning to the middle of the twentieth century, but was at the time rather in a dynamic of transformation of its economic activity and dealing with significant consequences in terms of job losses and other issues.

In 2001, a citizen unsatisfied with the delivery of front-line health services in the municipality of Contrecoeur began a door-to-door campaign to share his wish to solve the problem by setting up a solidarity cooperative⁹⁹ in the field of health. At that time, there were already some health cooperatives active in other regions of Quebec as a citizen solution to a lack of medical staff. Regional and national media, print and television media had echoed these initiatives, which proved to be an original solution to address unmet needs in what was the primary health network: clinics owned by doctors or pharmacies and the public network (known as the CLSC).

The citizens of Contrecoeur responded favourably to this initiative, the project took shape, the various preparatory steps were taken, and the cooperative was formed on September 20, 2002. The down payment required to take out a loan to build the building to accommodate the services of the cooperative was 80,000 CAD. The amount was raised by citizens by subscribing for shares, in addition to the contribution of an organization dedicated to supporting development projects, the

⁹⁸ Case study completed in June 2017 by Jean-Pierre Girard.

⁹⁹ This is the multistakeholder cooperative version of Quebec. At that time, solidarity cooperative must have at least, users and workers members but it could also include support members.

Marguerite d'Youville Local Development Center¹⁰⁰, which contributed with 20,000 CAD in shares and that of the municipality of Contrecoeur to the tune of 50,000 CAD. Funding was provided by the local Caisse Desjardins in the form of a loan guaranteed by a program devoted to the social economy of a Québec government corporation called Investissement-Québec. In addition, Investissement-Québec also subscribed for 125,000 CAD in capitalization as share¹⁰¹.

At the end, the cooperative benefited from the support obtained from an organization dedicated to supporting the establishment of new cooperatives, the Regional Development Cooperative (CDR) Montérégie (named after the region)¹⁰². This organization has thus supported the implementation of an action plan and the administrative functions.

The cooperative began its activities by renting a room to a doctor with his secretary. Then, upstairs rooms were leased to a psychologist and a private clinic specializing in sports medicine and labour, the Integrated Medicine Clinic or simply, in French, CMI¹⁰³. This clinic already had facilities in other municipalities, including Montreal itself.

From 2004 to 2007, the cooperative operated solely with the volunteer contribution of the board members and with the help of a paid secretary. The number of user members grew to 1400 in 2007. However, in that year, a financial dispute with the entrepreneur who had built the building housing, the cooperative and the various professionals of health confronted the cooperative with the choice between bankruptcy or the imposition of an annual membership fee. At a special meeting of more than 350 members, it was agreed to have a compulsory annual fee of 50 CAD, including taxes, per member, an amount to be paid in addition and on a recurring subscription basis of qualifying shares. This decision resulted in the departure of 700 members, but 700 others decided to retain their membership status and thus subscribed the required amount of the membership fee. Strategic planning has been put in place to redress the situation of the cooperative. This was how Ms. Chantal Dubuc was hired as coordinator. Ms. Dubuc eventually became Executive Director. A few months later, a new doctor decided to join the cooperative on a 5-day/week basis, which facilitated the cooperative service delivery and ensured its foundation for better development.

From 2010 to 2017, the cooperative continued the recruitment of doctors, adding three new ones, thus reaching the total of nine in 2017. Interestingly, one of the last recruited physicians decided to join the cooperative because of the particularity of this business model, and because of the values carried out by the cooperative.

In addition, following the guidelines of the Dossier Santé Québec, delivered by the Ministry of Health and Social Services¹⁰⁴, the cooperative has computerized patient files and by 2016 70 percent of the

¹⁰⁰ *Centre local de développement* in French. The program supporting this type of organization was abolished in 2014 by the Quebec government.

¹⁰¹ There are both qualification (or social) shares and preferred shares.

¹⁰² The CDRs, which are present in various regions of Québec and supported by the Government of Québec, were merged in 2016 to form a single entity, the Quebec regional development cooperative (CDRQ), but which still has regional offices: <http://cdrq.coop/>

¹⁰³ The CMI still exists in 2017: <http://www.cliniquecmi.com/>

¹⁰⁴ See www.dossierdesante.gouv.qc.ca

existing patient records were digitized and all new patients can now see their scanned files as soon as they are registered.

Life cycle

In the years following its formation, the cooperative went through some turbulent periods, including the critical financial situation in 2007 and the validation of the contribution system or fee system in 2010, in addition to the pressure to recruit new doctors. In the eyes of its general director, the cooperative is now in a phase of financial stability, staffing and development of a successful business model. It has thus reached a good pace of development, to the point that it is unlikely to have any room for expansion in the present building.

Core business model

As is the case for the majority of health cooperatives in Quebec, the cooperative's business model is to manage the spaces of the building that houses the offices of various health professionals and to offer itself services. Its revenues are thus mainly coming from the cost of rents, the secretarial service it provides to professionals, the sale of services to members and clients, and sometimes supplementary funding for programs, as was the case with the experimentation of the Hans.

In addition, except for the services covered by the Quebec health insurance plan, which is in line with the Canada Health Act (universal health coverage for all citizens), clients either bear the costs directly or support it through private insurance. In this business model, membership is not required to be a client. However, it does offer certain advantages, in particular in terms of cost savings (a 10% saving for the physiotherapist, prioritization during consultations with the psychologist and discounts for the Reversa clinic) and participation in democratic life.

The cooperative finds itself in a special status with the building it occupies. It is in fact tenant, and bound by a long-term lease and cannot move. At the end of this lease, in 2054, it will give the building and the land to the owner of a pharmacy that also occupies a part of the spaces¹⁰⁵.

For its administrative role, the cooperative thus has a team of seven employees: one person in the general management, five people in secretary roles, receptionists, staff supporting the digitization of files and a person in the maintenance.

Institutional/governance structure

The Contrecœur health cooperative has two categories of members: user members and support members.

¹⁰⁵ It is a pharmacy affiliated with the Brunet Group, a major chain owned by Mc Mahon distributors itself under the control of one of the three largest grocery chains in Canada, Metro Group: <https://corpo.metro.ca/fr/a-propos/activites-pharmaceutiques.html>

Thus, in the membership this cooperative also welcomes SME societies and the general and vocational college (CEGEP) of the region¹⁰⁶, since they are using the services of the cooperative, particularly in the field of pre-employment health examinations.

The cooperative has a board of directors gathering nine people. In 2016, this council met eight times. The board does not have a committee that reports to it. Its members are elected at the annual meeting.

External relations

The cooperative maintains good relations with the municipality. Moreover, without making explicit reference on its website, the municipality has listed the contact information of the health cooperative in the list of recognized organizations and associations operating in the health sector¹⁰⁷. In an annual golf tournament, the municipality gives back an amount to the cooperative, which amounted to 7,000 CAD in 2016. The municipality also facilitates the meeting of the cooperative with other companies active on the territory. Thus, the cooperative can present its activities, in particular those intended for SMEs (for example, a pre-employment health examination for any new employee, a benefit not covered by the public health insurance scheme).

It also maintains fruitful links with the regional public hospital covering the territory or the Hôtel-Dieu hospital in Sorel.

The cooperative is a member of the Quebec Federation of Cooperatives for Home and Health Services (FCSDSQ). Its Executive Director is the Vice-Chair of the Board of Directors. Its links with local actors are also expressed through collaboration with an organization facilitating the presence of young people in the labour market. For example, collaborating with the Carrefour Jeunesse Emploi (CJE), the cooperative can refer students for summer jobs.

Economic data

As of November 30, 2015, the financial profile of the cooperative was as follows:

- Revenues: 280,000 CAD¹⁰⁸
- Expenses: 294,000 CAD¹⁰⁹
- Qualification shares: 28,4604 CAD¹¹⁰
- Class A Preferred Shares: 195,000 CAD¹¹¹
- Negative reserve: 175,000 CAD

¹⁰⁶ It is a unique academic model in North America, and therefore unique in Quebec. It is a compulsory level in the school curriculum of a student between high school and university. The case that is referred is that of the CEGEP of Sorel-Tracy: <http://www.cegepst.qc.ca/>

¹⁰⁷ <http://www.ville.contrecoeur.qc.ca/wp-content/uploads/2014/07/Copie-de-Organismes-2017-05-15-Jos%C3%A9-3.pdf>

¹⁰⁸ Either as the primary source, rental income for 121,000 CAD and contribution revenue for 117,000 CAD. The annual fee is now set at 70 CAD, taxes included, per member.

¹⁰⁹ The main item of expenditure is salaries for 176,000 CAD of administrative staff.

¹¹⁰ To qualify as a member. These shares are valued at 10 CAD/share. Each member must subscribe eight shares for a total of 80 CAD.

¹¹¹ Owned by three partners: Investissement Québec (125,000 CAD), the municipality of Contrecoeur (50,000 CAD) and the CLD (20,000 CAD)

The reserve is therefore negative, but the cooperative has a high level of capitalization, amounting to 479,640 CAD, which gives it a margin of maneuver and allows to avoid a cash crisis. A future agreement to manage a protocol between physicians and the Department of Health should allow the cooperative to generate surplus from operations.

Policy environment

The cooperative has built a solid reputation in its sector, which means that the political environment is very favourable to it because of its excellent relationship with the municipality, but also with provincial and federal elected officials, who know the cooperative and are proud of its accomplishments. As a result, the MLA (provincial level) is very involved in making donations on demand and always responds to invitations from the cooperative for various events.

Coopérative santé Robert-Cliche, Beauceville, Canada

History and background

The origin of the Robert-Cliche health cooperative project stems from a very structured and organized approach. It is based on a Québec policy that has been taken over by organizations representing and developing the environment that have translated the identification of the needs of the population living in the Regional County Municipalities (MRC) into a concrete solution in a cooperative way and have managed to rally all the stakeholders to make it a success.

Located approximately 30 kilometers south of Quebec City and extending for about 100 kilometers to the American border, the Beauce region is known for its entrepreneurial dynamism. Several SMEs have developed over the decades with recognized success. The Beauce region is divided into three MRC. These supra-municipal structures bring together the municipalities of a given territory and aim at encouraging consultation between elected representatives in joint projects related to the organization and development of the territory. One of the three MRC of Beauce region, the one located in the middle of the region – the MRC Robert-Cliche – in consultation with another organization devoted to the development of the community – the Local Development Centre (CLD)¹¹² – led in 2003 and 2007 consultations among the 10 municipalities of the territory. From these consultations, it turned out that there was a major stake in access to medical resources. The case was particularly striking for workers who struggled to consult doctors outside office hours thus complicating work-life balance.

As a follow-up to this popular consultation, meetings were held with the general practitioners and the regional public health agency, the Beauce Health and Social Services Centre (CSSSB), to explore the issue further. A few observations emerged:

- The absence of relief in the medical profession and, in doing so, the congestion of the time slots. General practitioners also highlighted the appropriateness of reorganizing service points through the modernization of the technical platform and the use of information and communication technologies.

¹¹² Abolished in 2014 by the Quebec government.

- In the public health system, an increase in the waiting time for emergency services at the regional hospital (located some thirty kilometres south of the MRC in the territory of another MRC) and a decrease of the services to the public clinic (CLSC) of the territory due to a decline in numbers.

To complete the picture, it turned out that on the medical side there had been no recruitment of new doctors since 1994 and that more than half of practicing general practitioners had 30 years or more of practice, thus approaching retirement. Moreover, in comparison to the situation prevailing in the territory of the two contiguous MRCs (MRC Beauce-Sartigan and MRC Nouvelle-Beauce), the MRC Robert-Cliche was the most lagging in this matter.

To find a solution, on initiative of the MRC and the CLD, various stakeholders were invited to bring their contribution by the local Desjardins Group (a financial services cooperative) and by a regional cooperative development support organization¹¹³. The solution that emerged from these consultations was to involve as many people and organizations as possible in an inclusive and participatory structure such as a solidarity cooperative¹¹⁴. This comprehensive and mobilizing approach aimed to make citizens and health service providers accountable for the role they could play in the organization of health services in the MRC¹¹⁵. This decision was followed by the formation of the cooperative in March 2008 with the initial hiring of two employees.

Barely 3 months after its founding, the cooperative had 700 members. In 2009, a lease of space was signed with the CHSLD de Beauce Foundation¹¹⁶ for a period of 10 years, with the possibility of automatically renew it for another ten years. Investments for 350,000 CAD were required for the development of these clinic locations, including eight physician offices, an examination room and administrative offices. From this first clinic in operation located in one of the two main centres of the MRC, Beauceville, an agreement was also concluded to ensure the collaboration of a practicing physician in a small clinic located in the municipality of Saint-Victor. However, with the retirement of the practicing physician, this clinic closed in 2014.

The extremely close ties with the main institutional actors in the community and the commonly held view of the urgency of taking action to correct the shortage of medical staff had a decisive impact on the support provided at the birth of the cooperative. Thus, the actual start-up of the cooperative benefited from a program of the Ministry of Employment, which assumed the costs of the coordination and of the administrative assistant for the first two years. There was funding from the youth component, a Canadian program for cooperatives (Cooperative Development Initiatives¹¹⁷), local Desjardins financial services cooperatives and the MLA. For its part, the cost of the infrastructure was borne by programs administered by the MRC and the CLD. However, from the outset, individual members of the cooperative were also called upon for funding. Thus, in addition to

¹¹³ It was then called the Coopérative de développement régional Québec-Appalaches.

¹¹⁴ The solidarity cooperative is a cooperative that has at least two categories of members.

¹¹⁵ Memory pp. 3-4 (unpublished).

¹¹⁶ Linked to public health establishments, this foundation is non-profit.

¹¹⁷ Shut down in 2012

the subscription of shares¹¹⁸, they were invited to pay an annual contribution to support costs related to the administration of the cooperative.

Life cycle

After having made great strides since its constitution in 2008 – setting up a good recruitment strategy for doctors, moving and operating two clinics, signing management agreements with physicians and public health authorities – the Robert-Cliche health cooperative is now in a consolidation phase. The attention of the next few years will again focus on the recruitment of doctors with the announced retirement of doctors during the current fiscal year.

Core business model

The cooperative's business model is a front-line healthcare service offering two clinics with various health professionals, mostly physicians. The latter are paid for on a fee-for-service basis by the public health insurance scheme and therefore pay rent to the cooperative in addition to the remuneration of medical secretaries. Because the public network remunerates them, there are no fees paid by the citizens for their consultation.

There is no obligation to be a member of the cooperative to consult the doctors. However, one of the benefits of being a member is when consulting the walk-in clinic. The member can be informed about the approximate waiting time for the consultation rather than having to present himself at the opening of the walk-in and crane for many hours.

Until recently, the cooperative provided complementary services not covered by the public health insurance system, such as blood tests, but a decision by the Ministry of Health ended out the service in January 2017¹¹⁹. Apart from depriving the cooperative of a significant income, this decision also forced members to move or deal with other resources to obtain these services.

Through management agreements with physicians through the GMF and another with the regional public health organization, the cooperative is thus managing several human resources (a dozen), with the exception of doctors who retain their status as individual entrepreneurs. It is important to note that this cooperative has a non-profit status, which exempts it from paying taxes¹²⁰.

Institutional/governance structure

Like the other solidarity cooperatives in Quebec, the Robert-Cliche health solidarity cooperative is characterized by more than one category of members. As of May 4th 2017, the profile of the partnership was as follows:

¹¹⁸ That is 70 CAD per adult. Family status is accepted.

¹¹⁹ <http://www.msss.gouv.qc.ca/professionnels/soins-et-services/frais-accessoires/>

¹²⁰ In order to achieve its status, the registered cooperative will not pay a dividend or pay interest on the shares. This recognition of a non-profit status is made by Revenu-Québec, the agency of the government of Quebec responsible for the collection of taxes.

- 4,501 user consumer members: a natural person who uses the services provided by the cooperative;
- 11 user producer members: doctors or other health professionals providing professional services within the cooperative;
- 21 supporting members: supporting members commit themselves to providing financial (or other) support to the cooperative by sponsoring programs, providing equipment, financial resources, services, etc.
- 18 worker members: people who work in the cooperative¹²¹.

External relations

As has been demonstrated since its inception (2008), the cooperative has developed links with a multitude of local and regional actors. This has resulted in commitments to provide financial support for its activities, or suppliers and rebates to members of the cooperative. This support is echoed on the portal of the cooperative.

Through the GMF management agreement, there is a link with the Ministry of Health. The agreement for the management of personnel lent by the public network also links it with regional public health authorities (CISSS CA).

The cooperative is also a member of the Quebec Federation of Health and Home Care Cooperatives. It regularly participates in its activities and exchanges with other health cooperatives in Quebec and elsewhere in the country. In addition to its reputation, it is invited to the Canadian and international forums.

Economic data

The consultation of the financial statements as of December 31st 2016, shows total revenues amounting to 538.000 CAD. The main sources of income are annual fees (paid by members) and rental (rent charged by tenants), which respectively amount to 258.000 CAD and 99.000 CAD. The income from services, including incidental expenses such as vaccines, blood tests, nitrogen treatment, in addition to advertising revenues, amounts to 76.000 CAD.

As mentioned in this report, the cooperative has benefited from many contributions since its inception. One that stands out is the Desjardins financial services cooperatives. It is estimated that, since the foundation of the cooperative, the Desjardins Goup has contributed with 200.000 CAD to the cooperative's activity

Membership fees amounts to 100 CAD, 70 in refundable units and 30 in contributions. Thereafter, the annual cost of the contribution varies from year to year as decided by the Board of Directors according to the needs of the cooperative.

¹²¹ Part in italics, as specified on the portal of the cooperative: <http://www.coopsanterc.com/fr/membres>

Policy environment

Since its inception, the cooperative has taken advantage of several public policies or programs to finance human resources and infrastructure. In addition, as seen in the GMF and CISSS agreements, it is still linked to public bodies for financing or loan agreements.

Coopérative de solidarité SABSA, Québec City, Canada¹²²

History and background

The Solidarity Service Cooperative with a low threshold of accessibility – commonly known as the SABSA cooperative – was set up as a non-profit organization¹²³ in December 2011 by five founding members. Among these, there were health workers concerned by the size of the HCV (Hepatitis C) and HIV/AIDS epidemic among vulnerable populations in two popular neighborhoods of Quebec City – the Saint-Roch and Saint-Sauveur districts – in what is known as the Lower Town. SABSA was born to offer this clientele a tight framework and a greater psychosocial and medical support.

This approach was therefore intended to be an alternative to the resources currently in place in the immediate environment: 1) a public clinic (CLSC), struggling with limited hours and reduced staffing due to cuts in the public health system; 2) private clinics, which were more remote and thus less geographically accessible and whose approach, too often based on a walk-in model¹²⁴, was dehumanized and incapable of taking into account the psychosocial dimensions or the impact of social determinants on the health of vulnerable individuals. In addition, access to specialists, for example, a gastroenterologist for cases of hepatitis C, was not easy through hospitals because of the requirement to refer initially to a general practitioner and the tight schedule of these specialists. In short, in these circumstances, people with hepatitis C or HIV/AIDS often preferred to avoid consultations, which, far from curbing the effects of the pathologies, favoured their aggravation. From 2011 to 2014, the care of this clientele was therefore given on a voluntary basis by members of the cooperative in a small room in the Saint-Sauveur neighborhood. During its early years of operation, SABSA leaders found that beyond the needs of this high-risk clientele, residents in these neighborhoods also had difficulty accessing front-line health services because of scarce resources or distances.

The cooperative was approached in 2014 by a team of researchers to conduct research on the impact of interventions. This team, known as the Integrated Primary Care Team (ESPi in French) and led by a professor from the Faculty of Nursing at the Université de Montréal and involving researchers from Université Laval in Quebec City, facilitated the link between this project and a powerful union of nurses, the Fédération Interprofessionnelle de la Santé du Québec (FIQ). In defending this profession and seeking to promote alternative and less expensive ways of delivering primary healthcare services to the model of physician clinics, particularly the nurse practitioner model in primary care (IPSPL) or specialized nurse practitioners, the FIQ decided to financially support SABSA for a pilot project

¹²² Case study completed in May 2017 by Jean-Pierre Girard.

¹²³ In Quebec, a cooperative that agrees during their implementation stage not to pay a rebate or pay interest on the shares may be recognized by the tax authorities as a non-profit organization and therefore exempt from paying tax. This is the case of this cooperative.

¹²⁴ Without patient management approach. Consultations are usually quick.

linked with the evaluation carried out by the ESPi research team. The FIQ committed on two occasions to supporting SABSA, each time providing a sum of 150,000 CAD. In addition, the FIQ convinced an insurance company owned by Desjardins Group to contribute to the support of the cooperative's activities with a significant amount in the form of a donation.

The support of the FIQ was therefore also a political struggle. While in other Canadian provinces, including Ontario¹²⁵, the role of IPSPLs is well recognized and mostly integrated into the healthcare system, this was not the case at that time in Quebec. In fact, by 2014, there were barely a hundred of these nurses, while in other provinces there were several thousand. This demand was therefore part of the aspiration of this profession to take a greater place in the Quebec healthcare system, a space primarily occupied by the medical profession, generally not willing to share this market.

With these additional resources, the cooperative was able to remunerate some of its staff, including an IPSPL, in addition to hiring an administrative support person and a coordinator while continuing to offer services by volunteer nurses. These premises have also made it possible to move into new facilities—located on a large and easily accessible artery, straddling the two popular neighborhoods – and to offer services not only to its priority clientele – people suffering from hepatitis C and HIV/AIDS – but also to the residents of the lower town of Quebec by becoming a local clinic. This expanded vocation therefore led to a new cooperative clientele, for example, pregnant women, young fathers or mothers and children. In addition, the cooperative was lent specialized equipment by pharmaceutical companies to improve the quality of its services.

The central idea of this initiative is therefore that users of the walk-in clinic do not meet a physician, but a nurse practitioner in primary care, who can prescribe certain diagnostic tests and medicines, apply medical treatments, and so on. If necessary, the nurse practitioner can also refer to doctors.

With an easier access, additional resources and openness to residents, and not just to people with hepatitis C, HIV/AIDS or addictions, the cooperative has seen its traffic grow rapidly. The publicity was very much word-of-mouth, but also benefiting from local media coverage, rather sympathetic to this atypical form of first-line health service delivery, and quite effective in reaching people with less access to the health system. Over the months, public health practitioners practicing in hospital or CLSCs and general practitioners or specialists, such as gastroenterologists but also social workers or psychologists sent their patients, especially vulnerable ones, to the cooperative. This was also the case for doctors practicing in GMF¹²⁶. The response to this attendance took form through the work of paid nurses, but also of other nurses working on a voluntary basis. For example, a nurse practicing in the public health system, in a hospital not far from the clinic, agreed to volunteer a few hours a week for the cooperative, because the social dimension of the intervention matched his/her values.

¹²⁵ Canada's most populous province.

¹²⁶ Based on Quebec Health Ministry, a GMF (translation) *is a family medicine group. It is a group of family physicians who work closely with other health professionals. This organization of work allows clients to have easier access to healthcare and social services. Each physician takes care of his own patients, who are registered with him, but all FMG physicians have access to all medical records. Thus, a person who presents himself for a consultation can be seen by another doctor than his own. If necessary, he/she may also meet with a nurse, social worker or other health professional from the FMG for various follow-ups.* As a counterpart the GMF received an amount from the Ministry for this agreement. Ref: <http://www.sante.gouv.qc.ca/systeme-sante-en-bref/groupe-de-medecine-de-famille-gmf/>

Moreover, from the outset, the cooperative was firmly committed to provide free access to its services to the whole population, without making any discrimination between members of the cooperative and non-members. In strict compliance with this desire for access by any citizens without financial constraints, the end of the financing of the FIQ in 2016 forced the cooperative to temporarily suspend, in May, the walk-in component of its proximity clinic. In an attempt to solve this major problem, the cooperative employed a great amount of its time and resources in order to pursue two objectives: 1) conducting a major socio-finance campaign and 2) being recognized by public authorities in order to receive partial or full funding for its operations. These two goals required the cooperative to embark on an intense media campaign aimed at alerting the general public about the issue of its survival and the need to integrate the organisation into the public network (for financing) – while at the same time retaining its originality, its specificity and its organizational autonomy – and to put pressure on the Minister of Health and Social Services¹²⁷ to obtain a firm commitment on his part.

SABSA took advantage of the voluntary support of several actors. For the media campaign, a communication firm supported the cooperative with its expertise in the field.

The socio-finance campaign also benefited from a technological platform developed by an organization called *La Ruche*. An artist gave a canvas for the purpose of a draw. Ultimately, after months of sustained efforts, which saw a steady commitment from the members of the cooperative's board of directors, a high media visibility¹²⁸ – not only in the local, but also in the national media – a keen interest raised by the Quebec parliament (*Assemblée nationale*) opposition parties¹²⁹, and the visit of the Minister of Health on two occasions, the minister accepted that part of the cooperative's expenses be borne by the regional public health system. At the same time, the socio-financing campaign aimed at reaching the sum of 250,000 CAD was also successful¹³⁰. In 2017, the cooperative was able to move work spaces to the ground floor of the building it is renting, thus facilitating access to its services for people with reduced mobility.

Life cycle

The early years of the cooperative were very eventful. As we have seen in the previous section, following its constitution, after a rather short period of activity (2011-2014), in 2014, the FIQ's *ad hoc* financial support drove the cooperative to another stage of development with the opening of the local clinic. The two years that followed (2014-2016) were intense and saw the adaptation of its business model in order to address other clients – a clientele that was no longer composed uniquely

¹²⁷ Being a radiologist, the Minister of Health is not known for his openness to atypical forms of delivery of health services. Since taking office in 2014, he has led a vast reform of health structures in Quebec, aiming to reduce the number of establishments through a fusion process, greater centralization of the decision-making process and a significant increase in the remuneration of doctors.

¹²⁸ So the FIQ organized a press conference about the survival of the cooperative:
<https://www.youtube.com/watch?v=FWv0pXjCMaA>

¹²⁹ Interestingly, as part of a leadership contest for the main opposition party, the *Parti Québécois*, one of the candidates, produced a video posted on YouTube that clearly presented the project while advocating for the generalization of this model in other regions of Quebec: <https://www.youtube.com/watch?v=rwJugVY>

¹³⁰ Within a few days of the deadline, a significant amount was missing, but an anonymous last-minute major donation made this successful.

of adults with hepatitis C or HIV/AIDS, but also of other residents of the neighborhood, along with other health issues. The cooperative also operated to find new ways of working with the professionals of the public health network. However, with the end of the financing coming from the the FIQ in 2016, the requirements needed to receive stable funding committed the cooperative to a very intense action aimed at obtaining the commitment of the public health network to support a part of its expenses, which was obtained in autumn 2016. On another front, the cooperative had to carry out a popular campaign of subscriptions and develop communication skills to receive public support. The success of these actions represented a milestone in the life of the cooperative, opening a new era characterized by the public recognition of its functions and by an increase in the support received by the public. This is not a trivial result, because the cooperative model in health is still relatively marginal in Quebec if compared to the major chains of pharmacies, which over the years have become major players in the ownership of medical clinics.

Thus, in mid-2017, seven years after its birth, the cooperative has managed to take the start-up phase with strong demands, especially in terms of mobilizing the community and a commitment by many volunteers of its *raison d'être*. Its situation is now relatively stable, but the choice of maintaining free services for all its clientele¹³¹, irrespective of whether the person is a member or not, will still require underwriting campaigns, since public funding is not sufficient to meet all needs.

Core business model

Several dimensions of this service stand out, but the most important remains undoubtedly the humanist approach. The client is not confronted with an impersonal organization. In addition, unlike clinics where doctors are fee-for-service, nurses' remuneration at SABSA does not put pressure on them to increase the number of consultations that they can provide in a certain time. Nurses take the time they need to listen to the patient, to dialogue with her/him, a practice that is driven by the desire of integrating a psychosocial component in the therapeutic approach. Moreover, part of the work is carried out by volunteer nurses who have no such pressure, as they give time by choice, not by obligation. Nurses working for the cooperative are not pressured by the employer to accelerate the pace of consultations and are not constrained by such and such a procedure more or less relevant to the well-being of the patient.

The willingness to listen to patients is also expressed on the board of directors of the organization, as there is also a representative of the users on it¹³².

Finally, there are several *grey zones* regarding the role and the duties of the various operators working for the cooperative (paid staff, volunteers, etc.). This requires a great deal of flexibility, but there is also a great deal of confrontation between the stakeholders. In short, it is stimulating, but unstable.

¹³¹ Another case in Quebec, the Robert-Cliche health cooperative, shows that the contribution of the members in the form of an annual contribution can represent a significant financial contribution, i.e. approximately 300,000 CAD.

¹³² Developed in more detail in the section about governance.

In Quebec, in 2017, The SABSA cooperative is the only one of its kind in its business model, which seeks to provide free services, without the presence of doctors, in addition to having a high sensitivity to vulnerable populations.

Finally, SABSA participates in the public immunization campaign, but receives no funding (immunization is offered free of charge) and does not charge any cost, unlike clinics and nursing clinics.

Institutional/governance structure

SABSA is therefore a solidarity cooperative, an organization with three categories of members. The associative base of the cooperative as of December 31st 2016 was composed of:

- 18 worker members
- 250 user members
- 284 support members

The members are represented on the board of directors according to the following composition:

- three worker members
- one user member
- one support member

As of December 31st 2016, the cooperative was chaired by a volunteer worker, a nurse. The board of directors presents a very consultative and participatory management style, that opposes the bureaucratic processes and the technocratic logic. This organization works “following the common good sense”, to use the words of its coordinator.

External relations

Born out of a healthcare professionals’ initiative, which was rather out of step with the formal healthcare system, since its birth in 2011, SABSA has increased its contact with a wide range of stakeholders, community organizations in the neighborhood, media and other important players¹³³. The links have naturally been forged with other health professionals in both directions: the external professionals recommend clients to the cooperative - recognizing its unique added value because of its psychosocial approach – and vice versa, in order to ensure follow-ups and takeovers.

As a result of the funding agreement with the regional public health network, SABSA also is in regular contact with the CIUSS de Québec. More recently, the cooperative has benefited from the loan of resources. In terms of research, this cooperative has attracted interest from various academic, nursing, and pharmacy research groups. Representatives of the cooperative are also the subject of frequent invitations to conferences, forums and other activities aimed at making their work and the cooperative’s operational model known. The cooperative is also in close contact with several

¹³³ These various partners are clearly highlighted on the portal of the cooperative: <http://www.coop-sabsa.com/partenaires/>

community organizations in its neighborhoods for a complementary action to support various issues in the daily lives of its patients: housing, food security, employment, psychological support, etc.

The cooperative is also a member of the Quebec Federation of Cooperatives for Home and Health Services and the Quebec City Community Economic Development Corporation.

Economic data

The cooperative has made a tremendous leap in its revenues. While in 2013 it operated with barely 30,000 CAD in annual revenues, for the years 2015 and 2016, revenues were instead in the range of 500,000 to 550,000 CAD. In addition, there is a contribution in the form of a service, which is respectively 66,000 CAD in 2015 and 179,000 CAD in 2016.

In 2016, revenues came from contributions given by private companies (about 19 percent), union contributions (associated with the FIQ) (13 percent), fundraising revenues or grants (36 percent), grants (seven percent), Conference revenues (one percent) and contributions in the form of services (24 percent).

Policy environment

Coming to the world on the margins of the official health system, it is through fighting and representation that the cooperative has been recognized for the purpose of funding by the public health network. In this sense, SABSA did not benefit from any particular policy.

Coopérative de solidarité de services à domicile du Royaume du Saguenay, Saguenay, Canada

History and background

Since 1997, in Quebec, a network of about 100 social economy enterprises in home services (SEEHS) has been providing services primarily to seniors to enable them to remain in their homes or dwellings for as long as possible instead of moving to an elderly residence, with the implications for uprooting. These SEEHS are divided into non-profit organizations and cooperatives. In the latter case, the majority adopted the form of solidarity cooperative (multistakeholders cooperative), thus generally comprising three categories of members: user members, worker members and support members.

Most SEEHS have specialized primarily in domestic assistance service (DAS) such housekeeping service, meal preparation, large households, civic support and accompaniment. There are few examples of SEEHS that have followed a very entrepreneurial approach, namely, to try to develop the service offer further outside their basic activity (DAS) or clienteles (nature of the services offered, intervention environments, partners) and provide assistance for daily life (ADL) of elderly such as helping for washing, dressing, eating, going to the bathroom, moving around, etc.

The case of the Coopérative de solidarité de services à domicile du Royaume du Saguenay (CSSDRS) is an example of such case. Located in the city of Saguenay, Quebec, which is located approximately 450 kilometres from Montreal, this cooperative, developing service agreements with various public bodies, increased its activities by adding its ADL component to its DAS service offer, including other kinds of services like cafeteria operations, became the largest organization of its kind not only in

Quebec, but in the entire Canada. Born in 2009, by the merger of two organizations operating in contiguous territories, the CSSDRS provided employment to more than 250 people, thus becoming a major employer in the Saguenay-Lac-Saint-Jean region. In addition, this cooperative owns a 28-unit residence for the elderly. It offers 290,000 hours of services on an annual basis. Finally, it has 7,000 members. Its CEO is also involved in many organizations, which have developed a vast network of contacts.

Life cycle

At the Economic and Employment Summit held in Quebec in 1996 – which brought together business leaders with government representatives, the trade union movement and civil society, including the community and women's organizations – participants expressed their concerns about the problems of unemployment and social exclusion, which prompted the government to create the Work and Economy Cluster. Four working groups were set up within the cluster, including the one on the social economy¹³⁴. The purpose of this group was to establish an action plan to create jobs in the social economy. One of the projects selected consisted in the creation of a vast network of collective enterprises for domestic help throughout Quebec - social economy enterprises in home services (SEEHS)¹³⁵ - according to the following goals and features (Vaillancourt and Jetté, 2009):

- Creation of sustainable jobs, not jobs for integration;
- Creation of job positions mainly held by women¹³⁶;
- Contrasting illegal work and undeclared casual work;
- Targeting customers who are mainly seniors and, secondarily, active households;
- Public policies supporting the provision of services by giving exclusivity to social economy enterprises;
- Public policies supporting the demand for services by making it eligible for funding by a program¹³⁷;
- The legal status of enterprises may be that of cooperatives or NPOs.

For the promoters of this initiative, it was above all a matter of providing an additional mean to help the elderly to stay at home. In this way, it was possible to offer useful services that allowed elderly people with a slight loss of autonomy to remain at home rather than move to a residence. It is generally recognized that, if the person's condition permits, it is better for that person to stay at home rather than being moved to a residence. In this way, it is possible to preserve the social links that the person has developed over the decades with the neighborhood. In the context of an aging population, this

¹³⁴ The group naturally took the name of *Chantier de l'économie sociale*. The corporation of the same name was incorporated in April 1999 as a not-for-profit organization and has since become an important Quebec forum for consultation and representation of social economy enterprises evolving in various fields. <http://www.chantier.qc.ca/?module=document&uid=867>

¹³⁵ The name in French is *entreprises d'économie sociale en service à domicile* (EÉSAD)

¹³⁶ Echoing the demands expressed in a report on the challenge of creating quality jobs for women published in 1996: "Between Hope and Doubt: Report of the Steering and Consultation Committee Social economy (*Entre l'espoir et le doute: rapport du comité d'orientation et de concertation sur l'économie sociale*)". This report was drafted in the wake of the Women's March against Poverty in June 1995: "Bread and roses" (*Du pain et des roses*)

¹³⁷ This will be the role of the PEFSAD.

issue is not trivial. Moreover, apart from community-type dwellings (a non-profit or cooperative organization) or low income housing (LIH), the cost of a private residency care can be an important obstacle for people with modest incomes. The SEEHS initiative also targeted people aged between 18 and 64 identified by a public health centre called the Local Community Health Centres (CLSC in French) and by active households. The cooperative has undergone significant steps since its inception in 2009. To face its constant development, an adaptation of its hierarchical structure was undertaken in 2014.

Core business model

As mentioned on its portal, the mission of the cooperative is “*to provide daily and domestic support services for the entire population, in their living environment in the territories of the Chicoutimi and Jonquière health centres. Thanks to a competent and professional staff, it ensures continuous quality services recognized in its environment*”.

As of March 2017, in addition to offering services to clients living in their homes (homes or dwellings) in the Jonquière and Chicoutimi sectors of the City of Saguenay, the CSSDRS operates in personnel management services, the stewardship of cafeterias and, more generally, service to the residents of seven residences for the elderly. One of these residences is owned by the Municipal Housing Office (OMH) and the cooperative operates the Sainte-Famille pension, which now hosts 28 units. People living in the Saint-Famille pension are in the stage preceding the placement in the Public Long-term Care Hospital Centre (CHSLD), a public structure for elderly people who experience the loss of physical and/or cognitive autonomy (for example, people suffering from Alzheimer's disease). Two of the facilities are entirely reserved for people who experience loss of autonomy, while a third is only partially reserved for them. The other four residences host semi-autonomous users.

In addition, the cooperative has a service agreement for the care of six residences, each housing nine persons with physical disabilities. The cooperative manages daily monitoring on a 24 hours/day, 7-day/week basis. These residences belong to the OMH and the Saguenay-Lac-Saint-Jean Integrated Centre for Health and Social Services (CIUSSS) pays for the services.

Finally, in terms of statistical data, the picture is as follows:

- Number of members: 7,000 members, the vast majority of which are user members. The cooperative also has worker and supporting members.
- The three categories of members are represented on the board of directors of the cooperative. It is a member of the user group who chairs the board of directors.

Institutional/governance structure

The cooperative has a board of directors gathering 11 persons. In addition, in terms of governance, it also has an audit committee that acts as an executive committee and reports to the board of directors.

External relations

Over the years, the cooperative has developed very good relations with other organizations or public structures in the health network, notably because of the involvement of its executive director in many organizations for the past 18 years. This involvement includes:

- Member of the Board of Directors of the Quebec Federation of Cooperatives for Home and Health Services (F.C.S.D.S.Q.)
- Member of the board of directors of the Mutual of the SEEHS
- Member of the National Updating Table (PEFSAD)
- Member of the Support Table for the Independence of the Elderly (S.A.P.A.)
- Member of the committee at the Ministry of Health for the deployment of ADLs (assistance to daily life)
- Member of the board of directors of a regional organization that assists employment (Cible Action)
- Member of the board of directors of the regional cluster in social economy (place of consultation of the actors of the social economy)

Economic data

As for 2017:

- Number of employees: 250¹³⁸
- Number of hours provided on an annual basis: 290,000
- Turnover: 8.1 million CAD
- Balance sheet data:
 - assets: 1,813,291 CAD¹³⁹
 - liabilities: 1,289,515 CAD
- Own capital: 523,776 CAD

Political environment

The cooperative has excellent relations with the various levels of government, whether on the local scene or with the provincial and federal deputies.

¹³⁸ Both union units are still in place. These unions are affiliated with the FTQ, the biggest Union in Quebec (in terms of members).

¹³⁹ Including the property of a residence for the elderly.

Introduction

Japan is at a front line of ageing in that the proportion of elderly persons (aged 65+) will rise from the current 27 percent to 40 percent in 2040. The ratio of them to the labour force is estimated to rise to 56 percent in 2020 when dementia patients will exceed 4.1 million. The rapid ageing will create a number of problems, such as a shrinking work force, rising health and elderly care costs, and a shortage of service delivery. After accomplishing universal healthcare in 1961 and universal long-term care in 2000, Japan has achieved a high-performance level in health and elderly care, but it is now struggling to sustain such a system in terms of service delivery and finance. To provide more coordinated health and social services in communities and to cope with the rising costs due to rapid ageing and advanced medicine, the government has issued policies to reduce hospital beds by leading specialized hospital functions ranging from acute to chronic phases of patients, and to establish ‘integrated community care’ (ICC) combining health and elderly care by 2025 when the baby boomers cross the 75 years old threshold. In Japan, the public sector and non-profit sector used to dominate health and elderly care delivery, but now the for-profit sector operates the elderly care business. In the cooperative sector, *Koseiren* were set up by agricultural cooperatives while health or medical cooperatives were organized as consumer cooperatives. *Koseiren* hospitals and clinics were established in rural areas with more ageing populations and scarce service provision. They have promoted health check-ups for farmers and created a network of health and elderly care. Health cooperatives emerged to provide healthcare at an affordable price in urban areas and promoted members’ health education/check-up activities in collaboration with healthcare specialists. They expanded to cover long-term care as a natural extension, in an endeavour to build healthy communities by creating networks of health promotion, medical care and elderly care. These cooperatives have developed distinct strategies to meet the unmet needs by adapting to the changing socio-economic environment and mobilizing resources in the communities. In short, health cooperatives have created a viable model of health promotion and the ICC.

Socio-economic Context of Health and Elderly Care

A rapidly ageing population is one of the main problems affecting Japan in terms of health and elderly care services. Universal healthcare was accomplished in 1961 when the entire country was covered by eight health insurance schemes. The Japanese healthcare system is characterized by service delivery based on dominant private providers and mixed financing by social insurance, taxation and patients’ co-payments. The service providers are predominantly private hospitals/clinics, and public institutions play residual roles. There used to be very weak coordination among them, which at times caused failures in accepting acute and emergent patients. Combined with consumers’ free access to medical institutions, this situation resulted in the heavy congestion of patients in large hospitals and “3 minutes of diagnosis after waiting 3 hours”. The gatekeeper functions of general practitioners (GPs) were not implemented while hospital services were not structured according to the functions

¹⁴⁰ Akira Kurimoto, Professor at Hosei University, Tokyo

of acute, rehabilitative and chronic phases. The uneven distribution of doctors in regions/departments (particularly in remote areas, pediatrics and obstetrics) and the increasing workloads of doctors/nurses were often cited as serious problems. The health insurance system had been built in line with professions such as workers in companies, public servants, farmers and so on. The generous social welfare policy for the elderly (e.g. free healthcare) was initiated in the early 1970s. However, it became impossible to maintain such a system when the oil shock drastically lowered growth rates and the demographic shift resulted in sharply increasing medical costs for the elderly.

It was said that the Japanese healthcare system had succeeded in attaining higher performance (higher life expectancy, lower infant mortality, etc.) with relatively lower medical expenditure in the GDP, but it had encountered many problems. From the 1980s onwards, the government pursued policies to contain rising medical expenditure by increasing patients' co-payments from 0 percent to 30 percent and reducing the number of doctors/beds, but this policy caused negative effects described as "healthcare collapse". Widely discussed was the problem of "social hospitalization", which meant that elderly people continued to occupy hospital beds after no medical treatment was needed because they could not have the appropriate long-term care. The government introduced a medical insurance system for the latter-stage elderly aged 75+ in 2008. It was financed by tax (50 percent), transfers from other insurers (40 percent) and co-payment (10 percent). Medical expenditure surpassed 40 trillion JPY, adding 1 trillion JPY p.a. due to a rapidly ageing population and advanced medicine.

Elderly care had been the family's responsibility in the Confucius tradition. Hence, public intervention had been limited to residual services for the poorer social strata. The Social Welfare Act stipulated that the state and municipalities had primary responsibility for ensuring the provision of welfare services including elderly care in both facilities and communities. In the 1970s the generous welfare policy was accompanied by the discourse on the "Japan-style welfare society" relying on traditional care by family members (mostly women). However, that policy was soon abandoned after the oil shocks. In 1990, the revised social welfare laws enabled municipalities to outsource in-home services to non-public providers. In 1995, the Social Security System Council recommended restructuring the entire social welfare system. The Long-term Care Insurance (LTCI) Act took effect in 2000. Modelled on the German system with some modifications,¹⁴¹ it allowed non-public providers to enter the social welfare business, although in-facilities care was still restricted to municipalities and social welfare corporations. It was largely financed by insurance and tax while the user's co-payment was set at 10 percent of expenditure.

141 The LTCI system was built on the underlying principles of generalization of welfare services, user-centered mechanisms based on choice and contract, municipality-based finance and regulation, normalization by improving in-home services, in-kind benefits rather than cash benefits, and a multi-dimensional system for providing services.

Table 41: Types of services provided under the LTCI Act

Facility services	Community-based services	In-home services
Welfare facilities for the elderly (special nursing homes)	Regular/on-demand home visits	Home-visit care
	Home visits at night	Home-visit bathing
Healthcare facilities for the elderly (intermediary bodies)	Communal day care for dementia patients	Home-visit nursing
Sanatoria (chronic hospitals)	Small/multi-functional care homes	Home-visit rehabilitation
	Group homes for dementia patients	Outpatient day care
	Prevention services	Outpatient day rehab.
		Short stay
		In-home care management

The universal long-term care system achieved great success in terms of service provision and access to elderly care. The service providers and facilities sharply increased as both non-profit and for-profit providers entered the elderly care business. The certified persons eligible for services increased from 2.2 to 5.8 million during 2000-2013 while the service users increased from 1.5 to 4.2 million. Accordingly, the overall cost rose from 3.6 to 10.1 trillion JPY during 2000-2015. In addition, the number of elderly persons with dementia in need of care is estimated to have grown from 2.8 million (9.5 percent of 65+) to 4.7 million (12.8 percent) during 2010-2025. Therefore, the government revised the LTCI Acts and introduced reforms prioritizing preventive care provision and charging board/lodging costs in 2005. Once again, how to ensure the LTCI system's sustainability by containing rising costs while enhancing user satisfaction became the critical issue.

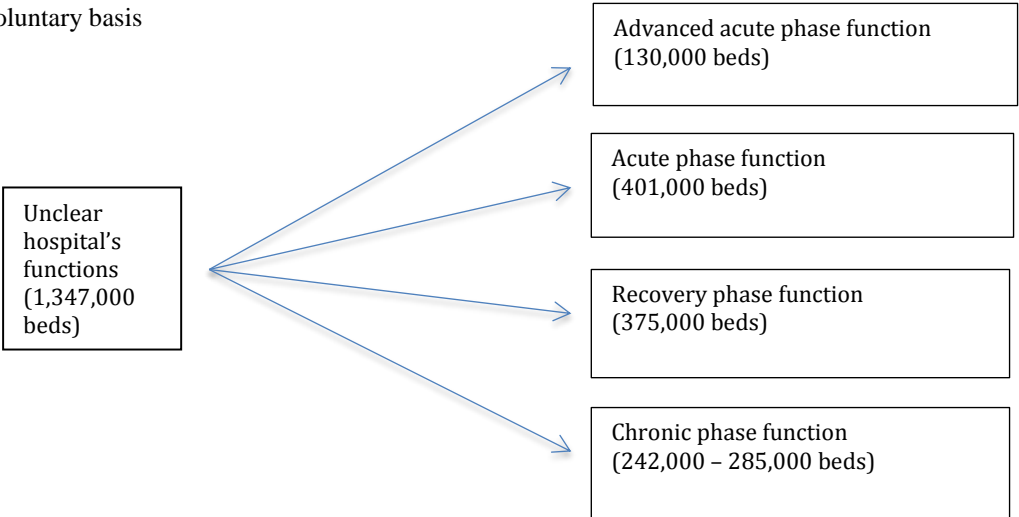
The government introduced the idea of Integrated Community Care (ICC) in 2011. The Ministry of Health, Labour and Welfare (MHLW) intended to build the ICC system by 2025 when the baby boomer generation will cross the 75-year-old threshold. The ICC is a network of entities furnishing five kinds of provision (housing, medical care, long-term care, prevention services and livelihood support) in an integrated manner in communities so that people can continue living in their home towns/villages until the end of their lives with a sense of security once they are in severe need of long-term care. It assumes an approximate range of a junior high school district as a network space. According to the Act to the Amendatory Law to the Related Acts for Securing Comprehensive Medical and Long-Term Care in the Community passed in 2014, the ICC should be constructed by municipalities on the basis of independent and original ideas of the communities concerned. It is intended to reduce public expenditure and address the elderly in urban areas, while it depends on the planning of municipalities and the initiatives of service providers. The Law also aims at ensuring an efficient and effective medical provision system in communities (related to the Medical Care Act)¹⁴². Medical institutions are required to report the medical care functions of hospitals (for advanced acute,

¹⁴² Prefectures are responsible for drawing up community medical programmes, including number of beds, secondary (acute and hospitalizing) medical districts and tertiary (advanced) medical districts. The intention is to counter rising medical costs based on the premise of supplier induced demands.

acute, recovery, and chronic phases) to prefectural governors. On the basis of these reports, the prefectures formulate the Community Health Care Visions. Hospitals are urged to specify functions aimed at reducing the number of hospital beds and medical costs.

Figure 6. Estimated ideal number of hospital beds in 2025 according to functions

2013-2025 (In total 1,150,000 – 1,190,000 beds)
 Choose functions on a voluntary basis



Source: Cabinet Secretariat, 2015

Cooperative Roles in Health and Elderly Care

Within this institutional framework of health and elderly care, the areas of service that can be undertaken depend on the service provider’s corporate status. The public-sector organizations (state, prefectures, municipalities, public medical institutions¹⁴³ and social insurance institutions) can undertake all kinds of health and elderly care. The non-profit sector organizations include social welfare corporations (SWC regulated by the Social Welfare Act), medical corporations (MC regulated by the Medical Service Act) and others (NPOs and voluntary organizations). Both SWC and MC can operate facility-based and in-home/community-based services, while other non-profit and for-profit providers can operate only in-home/community-based services.

143 It is designated by the Minister for Health, Labor and Welfare in accordance with the Medical Service Act. It includes the Japanese Red Cross, *Saiseikai* Imperial Gift Foundation and *Koseiren*.

Table 42. Services to be undertaken by types of providers

	Healthcare services	Elderly care services	
		Facility-based services	In-home/community-based services
Public sector	✓	✓	✓
Social Welfare Corporation		✓	✓
Medical Corporation	✓	✓	✓
Other non-profits			✓
Cooperatives	✓	(✓)	✓
For-profits			✓
Individual GPs	✓		

Cooperatives are regulated by different supervisory ministries under the separate legislations. The Agricultural Cooperative Act (1947) provides for healthcare and welfare businesses for the elderly (Article 10) while the Consumer Cooperative Act (1948) also provides for healthcare and welfare businesses for the elderly and handicapped persons (Article 10). JA *Koseiren*¹⁴⁴(Prefectural federations of agricultural cooperatives for health and welfare) and health cooperatives (or medical cooperatives) are engaged in healthcare, while other types of cooperative can operate a range of elderly care services under the LTCI Act (Kurimoto and Kumakura, 2016). *Koseiren* and health cooperatives are allowed non-member usage for up to 100 percent of member usage because of the nature of health and elderly care, which cannot exclude non-members¹⁴⁵. The former were designated as public medical institutions with asset lock in 1951, and no corporate tax has been charged since 1984; while the latter are not allowed to distribute surpluses to members and apply the lower corporation tax rate as cooperatives.

144 JA stands for Japan Agricultural co-operatives.

145 The Consumer Co-operative Act totally prohibits non-member's use while other co-operative laws allow use by non-members to the extent of 20-25% of member's use. However, health co-ops could trade with non-members with no limit based on the provision of Art. 19 of the Medical Practitioners Act indicating "doctors must not reject medical treatments without justifiable grounds when called up". The amendment of Consumer Co-operative Act in 2007 limited the scope of non-member trade for the use of co-op services up to 100% of members' trade.

Table 43. Services undertaken by types of cooperative

	Healthcare	Elderly care	
		Facility-based services	In-home/community-based services
Health cooperatives	✓	(✓)	✓
Consumer cooperatives			✓
Koseiren	✓	✓	✓
Agricultural cooperatives			✓
Worker cooperatives			✓

The Industrial Cooperative Act (1900) provided for multi-purpose cooperative societies for credit, supply, marketing and production (later replaced by services). The first cooperative clinic was opened by a rural cooperative in Aohara-mura, Shimane Prefecture in 1919 in order to provide health services to farmers at reduced costs. Tokyo Medical Cooperative was set up by Dr. Inazo Nitobe and Dr. Toyohiko Kagawa as the first medical service society in 1932. Doctors' associations had strongly resisted cooperative healthcare as infringing their professional monopoly.

After the Second World War, in 1948 *Koseiren* federations were founded by agricultural cooperatives to provide healthcare for their members, and they were designated as public medical institutions in 1951. 47 out of 114 *Koseiren* hospitals operate in municipalities with fewer than 50,000 inhabitants while 20 of them are the only hospitals operating in such municipalities. They provide various forms of support for farmers through the training and dispatch of doctors, travelling clinics and health promotion activities. Since they provide services for the general public, some *Koseiren* hospitals/clinics have been converted into municipal ones, and vice versa.

Health cooperatives had different origins; the constitution of medical cooperatives from the outset under the Consumer Cooperative Act (e.g. Tottori Medical Cooperative), the transformation from GP clinics (e.g. Tsugaru Health Cooperative transformed from Dr. Tsugawa's private clinic), the transformation from other corporations including medical service societies or medical corporations (e.g. Tokyo Medical Cooperative), and the separation from existing multipurpose consumer cooperatives (e.g. Tone Health Cooperative separated from Gunma Worker's Consumer Cooperative or Northern Tokyo Medical Cooperative from Workers Club Consumer Cooperative). In 1957, the Health Cooperative Association (HCA) was set up by 12 medical cooperatives to coordinate their activities at the national level as a specialized organization of the Japanese Consumers' Cooperative Union (JCCU).

The Japanese health cooperative model is characterized by the following elements:

- Multi-stakeholder membership with dominant consumers
- Member's activities for health promotion

- Pursuit of healthy communities by networking health promotion, healthcare and elderly care

The membership is predominantly composed of users or consumers. The UN survey on co-operative organizations in the health and social care sectors in 1997 classified the Japanese health co-operatives as user-owned. The majorities of members are healthy consumers who want to be prepared for health risks (diseases or accidents), and want to lead healthy life. At the same time, health/elderly care professionals, including doctors, nurses and care workers are also involved as members. In this regard, health co-operatives are multi-stakeholder membership organizations involving both service users and providers. According to the statistics for 2015 compiled by the HCA/HeW Co-op, out of 2.9 million members, 37,437 (1.3 percent) are employees (FTE), including 2,225 doctors and 12,478 nurses. The process of foundation varies from one cooperative to another, but in most cases founders involved both residents who wished to have access to healthcare and professionals who wished to provide healthcare to citizens. Health cooperatives have encouraged consumer members to take part in health promotion activities through health learning and check-ups in *Han* groups and branches, and distribution of monthly newsletters containing useful information on health and healthcare, while members will go to see doctors if any irregularity is found.¹⁴⁶ More active members have been trained as voluntary “health advisers” through correspondence courses and lectures. Health promotion activities have been coordinated by branch committees and health advisors. These activities are combined with comprehensive medical examination and professional healthcare at cooperatives’ healthcare facilities. Health cooperatives have promoted medical check-ups by making full use of municipalities’ health promotion schemes and offering lower fees for optional examinations so that even poorer people can take part. Such initiatives have resulted in an uptake of health check-ups by members higher than the national average and the increased use of health cooperatives’ services. In 1991, the HCA adopted the “Medical Cooperative’s Charter of the Patient’s Rights” to mitigate problems associated with asymmetric information between doctors and patients and to facilitate users’ self-determination pertaining to healthcare.¹⁴⁷ It has also sought to build healthy communities by combining health promotion, medical care and long-term care since the 1990s. In 2010, the Japanese Health and Welfare Cooperative Federation (HeW CO-OP Japan) was established as a successor to the HCA, separating from the JCCU.

Case Studies on the *Koseiren* and Health Cooperatives

Hereafter, one case study on *Koseiren* and three case studies on health cooperatives are presented to showcase the distinct business models that have been developed to meet unmet needs by adapting to the varied and changing socio-economic environment and mobilizing resources in the communities.

¹⁴⁶ *Han* groups are neighbourhood groups consisting of 3-10 members who conduct self-checks of blood pressure or salt/sugar contents in urine using simple devices, initially assisted by health workers or voluntary health advisers. The branches are organized in school districts to coordinate health-related activities in communities.

¹⁴⁷ It consists of a) right to be informed of diseases, medical care plan and drugs, b) right to determine a suitable medical care plan, c) right to patient's privacy, d) right to learn about their own disease, prevention and treatment, e) right to receive necessary and optimum medical service at any time, f) responsibility of participation and co-operation. It was updated as “Health Co-op’s Charter for Lives” to be followed by patients and health workers in 2013.

The author conducted semi-structured interviews with leaders and/or managers of the following cooperatives in 2016-2017:

- 1) Saku Central Hospital Group of JA Nagano *Koseiren*
- 2) Health Cooperative Saitama
- 3) Minami Medical Cooperative
- 4) Himeji Medical Cooperative

Case 1: Saku Central Hospital Group of JA Nagano *Koseiren* ¹⁴⁸

History and background

Nagano Prefecture is located in the central part of mainland Japan with a population of 2.2 million. It has limited arable land, being surrounded by mountain ranges. Its economy is based on services and manufacturing while agriculture is limited to growing apples and highland vegetables. The commitment to education may result in the highest longevity and workforce ratio (overall, elderly persons and women). Saku City is in the eastern part of the prefecture and its population including southern villages amounts to around 125,000. There used to be a lack of adequate healthcare for farmers in remote areas.

The predecessor of Saku Central Hospital was built in 1944 as a part of the state-led agricultural cooperative *Nogyokai*. Dr. Toshikazu Wakatsuki joined the hospital with 20 beds in 1945.¹⁴⁹ He was elected as a founding leader of the workers' union and then as hospital director by the votes of all employees in 1946. He started implementing his idea of "getting among farmers" by launching regular visits to doctorless villages and organizing "hospital festivals"¹⁵⁰ while he undertook the pioneering operation for spinal caries as a surgeon. Saku Hospital joined the Nagano *Koseiren* in 1950, while it rebuffed the political purge of doctors by collecting around 45,000 signatures of residents. It hosted the first conference of the Japan Society for Rural Medicine in 1952, where Dr. Wakatsuki was elected as a chair. Saku Hospital opened a clinic in Koumi and renamed itself as Saku Central Hospital (SCH) in 1954-55. SCH has grown as a core hospital in the region, being designated as a doctor training institution, an emergency hospital, a remote area hospital, an AIDS treatment hospital and a dementia centre over the decades. It obtained hospital accreditation from the Japan Council for Quality Health Care¹⁵¹ in 1999, while Koumi Branch Hospital was built after the closure of the Red Cross Hospital in 2005.

148 An interview was made with Dr. Satoshi Izawa, Director Superintendent of Saku Central Hospital, at the head office on April 5, 2017.

149 Wakatsuki graduated from the University of Tokyo's medical school when he was committed to Marxism. His original idea "into the farmers" derived from Russian *narodniki*'s "v narod" that meant the intellectuals should serve the ordinary people but it was later changed to the idea "getting among farmers" that became the basic philosophy of Saku group.

150 Saku Hospital Festival is held in May every year and has 20,000 visitors. It is a kind of exhibition to display information on diseases, prevention and healthcare. The professionals and health leaders conduct health check-ups, health counseling, dramas and films and so on.

151 It was founded as a public interest foundation in 1995 to conduct the third-party evaluation and accreditation of hospitals aimed at supporting voluntary quality improvement efforts by hospitals.

In 1952, Saku Hospital initiated collective health check-ups by sending doctors/nurses to villages, where they performed mini-dramas to raise farmers' awareness. Yachiho Village decided to conduct health check-ups covering all villagers and nominated dozens of farmers as voluntary health leaders who undertook health promotion activities in collaboration with *Koseiren* hospitals from 1959 onwards¹⁵². It was proved that prevention had precedence over treatment since the medical costs of the elderly in the village had been lowered to around two thirds compared with the national average. Collective health screening was extended to the entire prefecture in 1973, and health examination cars were introduced to facilitate on the spot check-ups. SCH concluded the agreement on home care to serve the ageing population with four villages in 1986 and set up the Community Care Department in 1995. It established a healthcare facility for the elderly as a national model in 1987, while six visiting nurse stations were set up until 1998.

Life cycle

Saku Central Hospital became the largest hospital and employer with more than 1,000 beds, accounting for one third of all beds in Saku City. However, changing socio-economic circumstances, such as the shift of the industrial structure, decreasing/ageing population, advanced medicine, and people's changing expectations in regard to healthcare necessitated drastic restructuring not only in the modernization of outdated buildings/equipment but also in the entire structure of health and elderly care provision. The SCH group started the restructuring process in 2009 when an agreement to separate primary and advanced healthcare was reached among the Nagano Prefecture, Saku City and Nagano *Koseiren*. Accordingly, Saku Central Hospital was renovated and downsized to the general hospital with 351 beds, while the Advanced Care Center with 450 beds was launched in 2014. The latter is equipped with state-of-the-art specialist medical services and advanced emergency care facilities including a doctor helicopter.

Core business model

The SCH group's business model can be described as a doctor-led comprehensive healthcare provider for the rural population. It has placed emphasis on prevention and mobilized doctors/nurses to conduct health check-ups and inform farmers about their health. It has been regarded as a model of rural medicine and often received public subsidies as a national model of community healthcare attracting wide attention from governments, medical professionals and academics. It has expanded to address the elderly population since the 1980s but a large part of the elderly care functions are undertaken by the JA Nagano-Kai as the social welfare corporation¹⁵³. SCH operates the Community Care Department to promote home care, coordinating its own clinical departments/local organizations and the Medical-Elderly Care Coordination Office to promote linkage with local hospitals/GPs and elderly care facilities.

The Saku group has the following facilities:

¹⁵² This was much earlier than the WHO's Declaration of Alma-Ata on primary healthcare in 1978.

¹⁵³ JA Nagano-kai was founded by prefectural agricultural co-op federations in 1994 to run LTCI-financed facilities such as special nursing homes, day care centres, home help stations, group homes for dementia patients, and so on.

- Saku Central Hospital providing general/rehabilitative/psychiatric care
- Advanced Care Center providing advanced and acute care
- Koumi Branch Hospital and Clinic providing general care (99 beds)
- Six visiting nurse stations providing nursing care at home
- Two healthcare facilities for the elderly to prepare for inpatient's coming home (174 rooms)
- Central Kitchen Saku providing meals for patients and staff in 8 facilities
- Rural Health Training Center providing seminars for medical professionals
- Japan Institute of Rural Medicine researching on farmers' diseases/accidents

Institutional/governance structure

Saku Central Hospital group is one of ten hospital groups of Nagano *Koseiren*, which is owned by 16 agricultural cooperatives (JAs) in Nagano Prefecture. Nagano *Koseiren* have a dual board system; the supervisory board composed of JA representatives as policy makers, and the management board composed of 5 executive members entrusted with running day-to-day business operations. Dr. Isawa is represented on the Nagano *Koseiren*'s management board. This system was introduced to ensure professional management while reflecting interests of collective ownership of farmers. In this case, the individual cooperative member is linked only in an indirect manner while most medical professionals are not involved in the governance. The SCH group has played a leading role in clinical governance, the health supervision of farmers, and the recruitment and training of doctors/nurses.

The SCH group has a specific governance structure consisting of the Hospital Steering Committee, which is composed of 22 persons representing the hospital departments and 22 persons representing the workers' union, while the chairperson has a casting vote as chief executive (Dr. Izawa). This structure of co-determination originated as part of the democratization process in 1946 and continues to date. The committee meets every month to deal with clinical and organizational matters. The direct involvement of volunteers is rather limited in comparison with health cooperatives, but 25 volunteers are involved in helping patients in the hospitals and healthcare facilities for the elderly.

External relations

Saku Central Hospital group belongs to Nagano *Koseiren* as the largest member of the National *Koseiren* in terms of number of hospitals and influence. It has established a nurse training college, a health check-up centre, and the Institute of Oriental Medicine in Saku, which now serve all hospitals under the Nagano *Koseiren* while SCH supplies human healthcare resources. It has also influenced the government in formulating public policies for prevention, rural medicine, and integrated health/elderly care.

Its influence has expanded beyond Saku and cooperatives. Dr. Wakatsuki has conducted field studies on farmer's lives and established the concept of potential diseases largely caused by their ignorance

and patience, which led to the Asian model of rural medicine¹⁵⁴. Based on the 12th National Agricultural Cooperative Congress resolution to establish activities to protect farmer's livelihoods and health in 1970 (Basic Plan for Life), National *Koseiren* implemented nationwide life planning and health promotion activities for farmer-members¹⁵⁵. SCH is also a founding member of the Japan Network of Health Promoting Hospitals & Health Services (J-HPH) since its inception in 2015.

In 1994, SCH set up the International Health Department to train medical professionals from the developing countries. It accepted 1,010 health workers from 73 countries in Asia and Africa funded by the JICA during 1999-2014. In 2013, the international health seminar attracted 50 doctors/nurses and students from all over the country who were interested in contributing to healthcare in the developing countries.

Economic data

As for the fiscal year 2016 (budget)

Turnover: 28.4 billion JPY (91 percent comes from the healthcare business)

Net profit after taxation: deficit 608 million JPY

Number of employees: 2,337

Policy environment

Basically, there is no difference among public finance measures, the treatment fees paid to medical institutions under the health insurance system and the LTCI system constitute the bulk of income covering 70 percent of the costs, while the remaining 30 percent comes from the patient co-payments. The costs above the ceiling of high-cost medicine are paid by the insurers. Because Saku Hospital is a public medical institution, it does not pay corporation tax for its income deriving from healthcare services. From time to time, it has received public money to implement government model projects, including 333 million JPY as subsidies for the regeneration of community care during 2011-2012.

Case 2: Health Cooperative Saitama¹⁵⁶

History and background

Saitama Prefecture is located north of Tokyo metropolis with a population of 7.3 million, while its south-east side is densely populated as a suburb of Tokyo. Its economy is based on services and manufacturing, while its agricultural output is still ranked as 6th largest in Japan. Despite the large population, it has the lowest level of healthcare resources in terms of numbers of hospital beds and doctors/nurses.

154 Based on these practices and studies, Dr. Wakatsuki founded the Japanese Association of Rural Medicine in 1952 and helped to set up the International Association of Agricultural Medicine in 1961.

155 National *Koseiren* took the initiative to set up the Foundation for Preventing Hypertension and Stroke in 1963 (one year later renamed the Foundation of Preventive Medicine for Adult Disease).

156 An interview was conducted with Mr. Tamiki Saito, Managing Director, and Mr. Yoshiaki Morioka, Executive Director, at the head office on April 17, 2017. This Co-op is different from Saitama Medical Cooperative that belongs to Tokushukai Group, a medico-welfare complex.

Dr. Kei-ichiro Oshima evacuated to the doctorless Ooi Village in 1945 and opened a clinic to give healthcare to the villagers under the health insurance federation. This clinic was successful but it was threatened with closure when it was sued by the federation. Nevertheless, it survived because of a petition by residents who formed a health promotion association. It was transferred to the Iruma Medical Cooperative set up by 300 residents under the Consumer Cooperative Act in 1954. The cooperative form was adopted since it enabled user participation. After 1950, other clinics were founded by residents wanting to ensure access to healthcare at affordable costs in large and medium-sized cities where the supply of health services could not meet the sharply growing demands generated by rapid urbanization. However, many of them had to delay payments of employees' wages and rely on voluntary donations because some poor patients could not pay. In 1962, it was decided to transform these clinics into cooperatives with users' participation. These initiatives came from the bottom up, often associated with left-wing movements, while there was no political will and support of local authorities.

Life cycle

There were eight cooperative clinics facing difficulties due to small size and a shortage of medical staff. It was decided to create a single cooperative in the prefecture, and the first step was the foundation of Saitama Central Medical Cooperative through the merger of three cooperative clinics in the densely populated eastern part of the prefecture in 1975. Saitama Kyodo Hospital with 74 beds was constructed in 1978. Then in 1992, Health Cooperative Saitama was set up through the merger of all medical cooperatives to cover the entire prefecture. Saitama Kyodo Hospital was designated an institution for the clinical training of doctors in 1994. The hospitals were expanded and new clinics were opened, while visiting nurse stations and the department of "drugs for household delivery" started during the 1990s. Two healthcare facilities for the elderly were built in around 2000 when Health Cooperative Saitama entered the LTCI business. All facilities obtained ISO 14001 accreditation (environment management) and ISO 9001 (quality management) during 2002-2003 while they were designated as health check-up institutions to prevent adult diseases by health insurance associations in 2007. The course for health promotion instructors was organized in 2008, while the members' activities as livelihood supporters and supporters for dementia patients started in 2011. Health Cooperative Saitama also opened a medical education and training centre to develop human resources. The financial and voluntary resources were mobilized at each stage by raising share capital and participating in the planning of new facilities. In 2013, the district structure based on existing health/elderly care facilities was reorganized into regional networks covering several districts to address the coordinated provision of medical and elderly care and strengthen the commitment to public policies in the prefecture's regional medical zones. The Research Institute for Community and Health (RICH) was set up in 2013. Health Cooperative Saitama launched "free/low charge medicine" to help low-income patients in 2015¹⁵⁷.

157 This programme can be started by reporting to governors when concessional patients exceed 10% of all patients due to economic difficulties based on the Social Welfare Act. In this case, medical institutions cannot be remunerated for services by health insurers while they can benefit from tax concessions. Co-ops have no extra benefit since they are already tax-concessional.

Core business model

Health Cooperative Saitama business model can be described as a comprehensive health and elderly care provider supported by active member participation. Its central hospital has developed the capacity to meet diverse needs and has become a clinical training institution, an emergency hospital, a health promotion hospital, and a hospital for free/low charge medicine. It has started to train generalist/family doctors as gatekeepers and opened a new department specialized in this function. Other hospitals and clinics have extended healthcare services to meet local needs and developed primary/secondary care services including treatment at home. Health Cooperative Saitama has increased the capacity to deliver long-term care by opening elderly care centres and healthcare facilities for the elderly. The professional function of health and elderly care is backed by active member participation in governance, the planning/financing of facilities, evaluation of the quality of services and voluntary work in communities.

Health Cooperative Saitama has the following facilities:

- Saitama Kyodo Hospital providing general/rehabilitation/acute care (401 beds)
- Saitama Nishi Kyodo Hospital providing general care (50 beds)
- Chichibu Seikyo Hospital providing general/rehabilitation care (75 beds)
- Kumagaya Seikyo Hospital providing general care (106 beds)
- 11 medical/dental clinics providing primary care and treatment at home
- 2 healthcare facilities for the elderly (100 beds each+ 80-100 outpatients)
- 18 elderly care centres including visiting nurses/home helpers/short stay/day care
- Nursing home for the elderly (30 rooms)

Members participate in the cooperative's activities to support its operations through the voluntary organizations mentioned in the next section. They also take part in construction committees when new hospitals/clinics are planned, the internal audit group for ISO certification, "simulated patients' programme" to educate young professionals attentive to patients' voice, the ethics committee to examine ethical matters pertaining to medical treatments and so on. Patients are also invited to evaluate the quality of services supplied through annual questionnaires on their satisfaction with services. There are 32 self-help groups of patients attached to hospitals/clinics.

Voluntary activities are also encouraged; 19 groups with 426 volunteers attached to health/elderly care facilities, 558 livelihood supporters to help with household chores, and 1,176 supporters for dementia patients. More than 120,000 copies of monthly cooperative newsletters are distributed by around 10,000 members, while local newspapers are also published and distributed at branch level.

Institutional/governance structure

The membership is 237,000 in 2015, which accounts for 8.3 percent of all households of the prefecture. It includes 2,250 employees including 134 doctors, 536 nurses and 318 care workers. The

governance structure of the cooperative is built on the annual general meeting of delegates (AGM) that decides policies and elects the board members/auditors. There are 500 delegates representing users in districts and 30 delegates representing employees. They meet additionally twice a year in 28 districts/blocs to discuss the policies to be decided at the AGM. The board consists of four medical professionals, five executive officers, one external director and 23 lay members who represent districts, thus reflecting the multi-stakeholder membership structure. It meets every month to take decisions on implementing policies. There are six auditors representing user members.

Besides this formal body, Health Cooperative Saitama has developed voluntary organizations to promote its members' activities. There are four levels of organization; 3,073 Han groups, 158 branch committees, 11 district councils, and four regional networks. Han groups meet to discuss health problems and conduct primary health check-ups in the neighbourhood. At the branch level corresponding to school zones, 1,260 committee members organize monthly community salons for chatting among residents, and prepare local health festivals. At the district level corresponding to municipalities, the district councils organize diverse member's activities on their own initiatives. At this level, 16 user panels composed of users and professionals discuss how to deal with users' complaints expressed in person or collected in suggestion box. At the regional level, the region's steering committees coordinate district councils and facilities to address to the public policies.

External relations

The relationship with public authorities had been generally weak since the cooperative had often resisted the public policies of restructuring health and elderly care mainly due to financial concerns but both sides came closer to solve the pressing problems associated with the aging population. Health Cooperative Saitama concluded the agreement on watching the elderly for safety confirmation with 30 municipalities. The cooperative's plan to increase 49 beds for intensified home care in Saitama Nishi Kyodo Hospital was accepted by the authority. The cooperative's staff is represented in the municipal healthcare council in Chichibu City located in the mountainous area.

Health Cooperative Saitama has been a leading member of the HeW Cooperative Japan presenting the best practices both in clinical functions and health promotion activities. It joined the HeW CO-OP's Family Medicine Development Center in 2005 as a training institution for general physician specialists or family doctors. Its hospitals were accredited by the Japan Council for Quality Health Care (JCQHC) since 1998 while the cooperative joined the Japan Network of Health Promoting Hospitals & Health Services (J-HPH) in 2015 when it was established.

Its facilities are also playing an important role to help the poorer social strata through affiliating with the Min-Iren (Japan Federation of Democratic Medical Institutions) that promotes egalitarian value through no extra charge for single bedrooms and "free/low charge medicine". Health Cooperative Saitama has given counselling to those unable to afford medical expenses through medical social workers and undertaken the "free/low charge medicine" programme. It also joined "food drives" in which redundant food is collected at schools/workplaces and donated to local welfare organizations and food banks.

Health Cooperative Saitama promotes collaboration with consumer cooperatives. Its facilities contract health check-ups for the employees of the latter, while its members jointly run community salons. They co-hosted the Health Festa, which had 50,000 participants. After the East Japan Earthquake and Tsunami, Health Cooperative Saitama continued sending medical workers in the rescue phase and volunteers in the reconstruction phase to local cooperatives in the devastated area, while it extended help to refugees who evacuated from Fukushima and lived in Saitama prefecture since 2011. It organized health counselling for provisionally released foreigners together with a non-profit organizations¹⁵⁸.

Economic data

As for the fiscal year 2015:

Turnover: 20.7 billion JPY (79 percent comes from healthcare, 20 percent comes from elderly care)

Net profit after taxation: 207 million JPY

Share capital: 6.2 billion JPY (Equity capital ratio: 43.3 percent)

Number of employees: 2,252

Policy environment

The same rule of public finance measures is applied to health and elderly care, while the cost of “free/low charge medicine” is voluntarily paid by the cooperative. Health Cooperative Saitama received JPY 30 million in 2015 as public subsidies associated with acute care and so on. Health Cooperative Saitama enjoys lower rates for corporation tax and fixed property tax as a cooperative.

Case 3: Minami Medical Cooperative¹⁵⁹

History and background

Nagoya City is Japan’s fourth largest city with a population of 2.3 million and a central city in politics, economy, culture and transportation in Chubu region. It is located in the Tokai industrial zone, where world-class manufacturers operate in the automobile (e.g. Toyota), space and aviation, steel and ceramics industries.

Minami Medical Cooperative operates in the southern part of Nagoya City and adjacent municipalities. In 1953, a small Hoshizaki Clinic was set up by health workers and students who dedicated themselves to social work to help poor people. The Isewan Typhoon killed more than 5,000 people mainly in this area in 1959 when health workers came from all over the country to help severely affected survivors. Minami Medical Cooperative was founded in 1961 by 308 residents and health workers who worked as volunteers and opened the first clinic. In 1965 Hoshizaki Clinic joined the Cooperative. During the 1960s-1970s cooperative clinics tackled air pollution-caused diseases (asthma, bronchitis etc.) and workers’ injuries in the factories through providing healthcare and

¹⁵⁸ They lack access to health services since they cannot work or move under provisions of the Immigration Control Law.

¹⁵⁹ An interview was conducted with Ms. Yaeko Nakamura, Vice President, and Ms. Kyoko Ohno, Manager of Community Mutual-support Center, at the head office on Nov. 30, 2016.

evidence for lawsuits against polluters. As such, the cooperative had worked to provide health services for residents and workers.

Life cycle

Minami Cooperative has expanded its facilities to meet the changing needs of communities through organic growth. The hospital was opened in 1976 and became the general hospital in 1992, while visiting nurse stations were built during 1996-1998. When the LTCI system started in 2000, Minami Cooperative expanded the elderly care business as a natural extension of healthcare and made substantial investments in facilities and trained care workers. The group home “Namo” for dementia patients and the cooperative’s first cluster “Yu Yu Mura” with day service/short stay facilities and multi-generation flats was opened during 2004-2005. Minami Cooperative obtained accreditation of the ISO 9001 (quality management) in 2005. The small/multi-functional home “Moyaiko”, the healthcare facility for the elderly “Anki” and the second cooperative cluster “Nonbiri Mura” with a group home and multi-generation flats was built in 2007-2009. The central hospital was moved to a new site and totally renovated as a general hospital based on user’s voice in 2010. The cluster of elderly care facilities and service houses “Yottette Yokocho” was launched in 2015. In these processes, members took part in planning, finding premises and raising capital (Table 43). Thus, Minami Cooperative started doctor-driven clinics and evolved into a user-driven health/elderly care complex with five functions assumed by the ICC system. The organizational culture also changed from ideology-led top-down activism to community needs-based bottom-up pragmatism because of active participation of middle-aged women in planning and problem solving.

Table 44: Member’s involvement in planning and building new facilities

Years	Facilities	Participation in planning	Participation in building
2003-04	Namo	“100 members gathering” monthly	Finding a vacant house and raising JPY 10 million
2004-06	Yu Yu Mura	“100 members gathering”	Raising JPY 170 million
2004-07	Moyaiko	Member’s voice in planning	Raising JPY 13 million
2004-08	Anki	Member’s voice in planning	Raising JPY 50 million
2006-09	Nonbiri Mura	“100 members gathering” monthly	Offering a vacant site and raising JPY 60 million
2006-10	Central Hospital	“1,000 members gathering” monthly in 10 groups	Recruiting 16,000 members Raising JPY 1,200 million
2012-15	Yottette Yokocho	Reflecting on dialogues with c. 10,000 people in communities	Recruiting members and fund-raising

Core business model

Minami Cooperative's business model can be described as a member-driven integrated community care provider involving elements of healthcare, long-term care, prevention, housing and livelihood support. The central hospital provides comprehensive care including emergency care year-round and palliative care for the terminally ill (hospice), and attaches the health checkup centre, midwifery home and fitness gymnasium, while a half of hospital beds are in private rooms aimed at improved amenity and privacy for patients.¹⁶⁰ It is accredited as a general hospital by the Japan Council for Quality Healthcare, while the smaller hospital is specialized in rehabilitation care. Medical care and long-term care facilities are closely linked, often in the same premises, forming health-welfare clusters. In particular, two cluster "villages" consist of group/small multifunctional homes attached to multi-generation flats. The service house is closely linked with group/small multifunctional homes, a day care centre and a home-helper station, while the visiting nurse stations attached to clinics offer home care combined with elderly care.

Minami Medical Cooperative operates the following facilities:

- Central Hospital providing general/emergency/palliative care (313 beds)
- Kaname Hospital providing general/rehabilitation care (60 beds)
- Eight medical/dental clinics
- Five visiting nurse stations
- One healthcare facility for the elderly
- Nine short stay/day care centres
- Ten group homes for dementia patients/small multi-functional homes
- Seven home helper stations
- Seven home care manager offices
- Two multi-generation flats (45 rooms)
- One nursing home-cum-service house for the elderly (78 rooms)
- Other facilities (1 health checkup centre, 1 midwifery centre, 1 fitness club, 1 daycare centre for sick children, 3 local drop-in spaces, 1 tourist agency)

In parallel with such an expansion of businesses, Minami Cooperative has promoted members' activities for health promotion through health learning and self-check. It has also mobilized various resources at each stage. Members are involved in volunteer groups that undertake various activities

¹⁶⁰ This practice collided with Min-Iren's policy, but JPY 6,000 per day as the extra charge is much cheaper than at other private hospitals and widely accepted by patients.

in collaboration with workers, and take part in training for voluntary dementia supporters. They often participate in fund raising to finance the investment for facilities. There are 16 self-help groups of patients attached to hospitals.

477 volunteers are registered in 26 groups attached to health/elderly care facilities to conduct concierge desks for visitors, running mini libraries, chatting with patients, providing transportation, gardening, cooking, hobby circles, assisting staff in day care, and so on, without any remuneration. They do voluntary work for self-fulfilment and pool small amounts of money to cover expenses by selling handicrafts. 45,700 copies of a monthly cooperative newsletter are distributed by 2,900 volunteer members.

Moreover, in 2011 Minami Cooperative started “mutual help sheets” to provide a social safety net in which the problems facing residents in daily life were recorded and the solution was made through livelihood support by staff/volunteers or local communities. During five years 700 sheets were collected while 550 members and 650 employees took part in the courses to become mutual help supporters. The local drop-in spaces were launched to promote mutual help in communities. These activities are coordinated by Minami Cooperative’s community mutual-support centre, renamed from the traditional “organizing department”. Thus, the cooperative has promoted community building based on mutual help through integrated community care.

Institutional/governance structure

The membership is 81,788 including 990 employees in 2015, which accounts for 1.06 percent of the population. The governance structure of the cooperative is built on the annual general meeting of delegates (AGM), which elects the board members and auditors. There are 352 delegates representing users in districts and 10 delegates representing employees. The board consists of four medical professionals, five executive officers and 27 lay members who represent districts, thus reflecting multi-stakeholder membership. It meets every month to make decisions to implement policies. There are four auditors representing user members.

To supplement such formal bodies, intermediate organs are installed between the board and membership; 1,229 Han groups and 88 branches in 12 blocs. Han neighbourhood groups meet on average 9.5 times a year, when members carry out physical exercise, tea/lunch parties, hiking/travelling, handicraft making, health checks etc. The branches coordinate welfare activities such as luncheon parties, health checks and exercise in school districts. Some branches organize community salons for prevention which are often registered as public spaces by municipalities, while the other branches conduct drop-ins for young mothers/babies or free health checkup/counseling for foreign residents. The user panels attached to hospitals/clinics consist of users and professionals to deal with customers’ opinions. The blocs coordinate branches and serve as constituencies to elect board members.

External relations

Minami Cooperative maintains regular contacts with the local governments, social welfare councils, community organizations, non-profits and so on. It gives scholarships to students in medical colleges/departments of universities and nursing schools, while it often accepts high school student visits. The cooperative is affiliated with HeW CO-OP and Min-Iren. The shop and cafeteria in the central hospital operate in collaboration with a retail cooperative and a university cooperative in the region.

Economic data

As for the fiscal year 2015:

Turnover: 10.6 billion JPY (healthcare 85 percent, long-term care 12 percent, others 3 percent)

Net profit after taxation: 47 million JPY (deficit of 70 million JPY estimated in 2016)

Share capital: 3.06 billion JPY (37,355 JPY per capita)

Number of employees: 991 (full-timers: 786)

Policy environment

The same rule of public finance measures is applied to health and elderly care, while Minami Cooperative built a new hospital on the site adjacent to the JR station when it won the public tender as part of a renewal plan proposed by Nagoya City. The cooperative enjoys lower rates for corporation tax and fixed property tax as a cooperative.

Case 4: Himeji Medical Cooperative¹⁶¹

History and background

Himeji City has a population of 536,000 and is located in the south-western part of Hyogo Prefecture. It is in the Hanshin industrial zone clustered with steel, electronics and chemical industries. Some large-scale public and private hospitals provide healthcare to meet the residents' needs while there was a gap in the provision of elderly care although the population aged more than 65 years old exceeds 25.3 percent.

Himeji Medical Cooperative was founded by residents in Himeji City in 1974. The first clinic was opened in the following year, while a small hospital was built in 1983. The cooperative tackled illness caused by air/water pollution, workplace injuries and A-bomb suffering. When the Hanshin area was hit by the Kobe Earthquake in 1995, Himeji Cooperative became a focal point of rescue operations, providing doctors/nurses and daily necessities sent from health cooperatives all over the country.

Life cycle

In view of the LTCI system that commenced in 2000, Himeji Cooperative entered the elderly care business by training home helpers, and it has constructed visiting nurse and home helper stations

¹⁶¹ An interview was conducted with Mr. Katsuhiro Kuroiwa, Managing Director, and Ms. Mayumi Sugioka, Board member, at the head office on Dec. 2, 2016.

since 1997. The Welfare Care Centres started as clusters of elderly care facilities in 2000. The small multi-functional homes were built from 2007 onwards, while regular visit/on demand services were launched in 2015. In this way, a network of health and long-term care facilities has been built and Himeji Cooperative has become the largest elderly care service provider in the city.

Core business model

Himeji Cooperative business model can be described as a community-based elderly care provider supported by smaller hospital and clinics. It is concentrated on elderly care through a network of facilities almost all designated under the LTCI system. These facilities are clustered in 10 “Welfare Care Centers” that cover the population within a two kilometers’ radius so that residents can gain easy access to the nearby elderly care services. Based on the assessment of patient’s needs, coordinated care services are provided.

Himeji Medical Cooperative operates the following facilities:

- Kyoritsu Hospital, providing general care (56 beds) for supporting home care
- Two medical/dental clinics
- Six visiting nurse stations
- Seven short stay/day care centres
- Eight group homes/multi-functional homes
- Six home helper stations
- Eight home care manager offices
- One home-visit bathing unit
- Two regular visit/on demand service units
- Two rental equipment units

Members often learn about prevention of dementia, medication, dental health, diet and nutrition etc. through lectures given by health workers, while they undertake regular health screening at the cooperative’s hospital/clinic at a reduced price. Every year, members are encouraged to undertake “challenges for good health” which they pledge to accomplish within 60 days in September-November¹⁶². 463 members took part in “challenges” in 2015.

Himeji Cooperative has promoted member’s “*kurashi-no-tasukeai-no-kai*” (mutual help groups for livelihood support) to help those who need cooking, sweeping, shopping and chatting at low charges (700 JPY per hour). This scheme was invented by the Kobe cooperative in the same prefecture and was disseminated among consumer cooperatives since 1983. Members also take part in voluntary work in facilities, meal delivery and open-air health checks in communities. More than 2,000 members/employees have taken courses to become supporters for dementia patients.

¹⁶² Members can choose pledges among 9 courses (good sleeping, no smoking, continued exercise, balanced diet, oral care, checking blood pressure, active brain, less salt, hobbies).

Institutional/governance structure

The membership is 20,498 including 850 employees in 2015, which accounts for 3.9 percent of the population. The governance structure of the cooperative is built on the annual general meeting of delegates (AGM), which decides policies and elects the board members and auditors. There are 208 delegates representing users in districts and 12 delegates representing employees. The board consists of five medical professionals, five executive officers and 20 lay members who represent branches, thus reflecting the multi-stakeholder membership. It meets every month to implement policies. There are four auditors representing user members.

To supplement such formal bodies, intermediate organs are installed between the board and membership; 140 *Han* groups/circles and 34 branches in five blocs. *Han* groups and circles undertake various activities such as health learning and check-ups, exercise, cooking, hobbies etc. The branches covering the area of school districts coordinate members' activities in communities. They function as constituencies to elect delegates, while 900 volunteer members distribute a monthly cooperative's newsletter to 13,500 members. At the bloc level, six user panels are organized to respond to members' inquiries on the services provided by Himeji Cooperative.

External relations

Himeji Cooperative held talks with the city mayor on deathwatch of elderly parents at home in 2014 and concluded an agreement on a community network for watching over the elderly in 2015. It also joined the municipal round table for building a system of livelihood support and the municipal council for linking healthcare and elderly care. It had extensive communication with the municipal departments for health/welfare, local social welfare councils, medical associations, and so on. Himeji Cooperative is affiliated with the HeW CO-OP and Min-iren. It maintains regular contacts with the Kobe cooperative, one of the largest consumer cooperatives in Japan.

Economic data

As for the fiscal year 2015:

Turnover: 4.3 billion JPY (healthcare 36 percent, long-term care 64 percent)

Net profit after taxation: 55 million JPY

Share capital: 385 million JPY (Equity capital ratio: 28.4 percent)

Number of employees: 856 (full-timers: 603)

Policy environment

The same rule of public finance measures is applied to health and elderly care, while Himeji Cooperative has developed communication with Himeji City in recent years and received 75 million JPY as subsidies for small multifunctional homes and group homes. The cooperative enjoys lower rates for corporation tax and fixed property tax as a cooperative.

Impact analysis

The socio-economic impact varies from one organization to another, since health-related cooperatives have emerged to meet different needs and evolved into quite diverse models. The Saku Central Hospital group has played a pioneering role in developing rural medicine primarily targeting farmers who had been suffering from the shortage of healthcare services. It has brought beneficial changes to farmers' mindsets on health and exerted great influence that extends beyond *Koseiren* and Japan. Its practices were often seen as social innovations by governments and later institutionalized as public policies.

Health Cooperative Saitama has developed a comprehensive network of cooperative health and elderly care in both urban and rural settings. It has built up the capacity of advanced healthcare, while it has promoted members' activities for health promotion. It has showcased democratic practices in which both users and professionals work together to attain the common purpose of building healthy communities.

Minami Medical Cooperative's initiatives were designated as one of the best practices of building Integrated Community Care system in a report sponsored by the MHLW because "both service providers and consumers utilize the cooperative way of business and work together to build communities as places of living, not limiting themselves to health and elderly care". Minami Medical Cooperative is seen as a community builder which is networking health/elderly care facilities and encouraging mutual support among residents.

Himeji Medical Cooperative has concentrated on elderly care for urban populations. As a result, it has a strong presence in a variety of elderly care facilities in Himeji City; 30.8 percent of small/multi-functional homes, 27.6 percent of home-visit bathing, and 23.4 percent of visiting nurses. It is also demonstrating the cooperative way to deliver health and elderly care in a participatory manner.

Conclusion

The Japanese health and elderly care systems have been built on private delivery and public finance. Healthcare is mainly delivered by private general practitioners or non-profit hospitals/clinics and the public sector plays a limited role, while elderly care is delivered by for-profit, non-profit and public sectors. Universal healthcare was accomplished in 1961, while universal elderly care was launched in 2000. In both systems, social insurance premiums constitute the main part of financial resources supplemented by taxation, while patients pay the residual 10-30 percent of the expenses.

Under such institutional arrangements, cooperatives are recognized as providers of full-fledged health and elderly care services by agricultural and consumer cooperative laws in Japan. *Koseiren* is a secondary organization owned by agricultural cooperatives, while health (medical) cooperatives are owned by consumers. In this sense, both are classified as user-owned cooperatives, although health and elderly care workers have membership in the latter case. Cooperatives have involved users in health promotion through health learning and check-ups, which have been highly appreciated by the government and the WHO. They have also sought to combine healthcare with elderly care over the decades, which led to the public policy of constructing the Integrated Community Care system several

years ago. In this regard, it can be said that cooperative health and elderly care have impacted on the whole society.

Saku Central Hospital group has initiated rural medicine by targeting farmers. It has built the capacity for comprehensive health services centred on clearly defined hospital functions, while it has developed primary healthcare in rural areas. It can be characterized as a pioneer provider of doctor-driven rural medicine targeting cooperative farmers and the rural population at large.¹⁶³

Health Cooperative Saitama has been a forerunner of the health cooperative model based on health and elderly care services in both urban/rural settings covering the entire prefecture and members' active participation in health promotion and planning. It started as doctor-driven clinic but soon transformed to user-driven cooperative and showcased the best practices of primary and advanced health/elderly care to other cooperatives under the HeW CO-OP Japan.

Minami Medical Cooperative started on the initiative of residents and health workers in the industrial zone and became an innovator of user-driven health/elderly care. It is showcasing active members' involvement in health promotion activities and planning of facilities. It is widely recognized as a best practice in building Integrated Community Care including housing and livelihood support.

Himeji Medical Cooperative has concentrated on the provision of elderly care services in the urban area where a sufficient number of hospital beds already exist. It became a leader as the long-term care service provider in Himeji City, while its limited health services back elderly care services. It is also characterized by the active participation and involvement of members in community care.

It is imperative for cooperatives to meet the changing environment and needs since they are facing the unprecedented challenges of the rapidly ageing population and swiftly advancing technology. While the international exchange of information and experiences has not been of great value, there is the hope that the Japanese experience can present some lessons to the counterparts working for health and elderly care in the world¹⁶⁴.

163 Based on these practices, Dr. Kawakami presented "Medico-Polis Vision" seeking community regeneration through the development of health/elderly care systems, training facilities and local industries.

164 The Canadian health co-ops are practicing *Han* groups invented in Japan while the Japanese health cooperatives are learning from the Dutch neighborhood care system (Buurtzorg) centered on visiting nurses.

Introduction

The Italian health system (NHS) is founded on the principles of universal coverage and non-discriminatory access to healthcare services. The system is financed through the use of general taxation. Initially established as a mixed system organized at both national and local level, the Italian NHS was extensively reformed in the 1990s (d.lgs. 509/92, d.lgs. 517-93, d.lgs. 229/99, L. 59/97, L. 127/97, d. lgs. 112/98 Legge Bassanini).

Following these reforms, the NHS became a regionally based healthcare system with 21 regional governments out of which 19 regions and two autonomous provinces. The national government controls funding and defines the composition of minimal coverage, while the regional governments are responsible for the planning and provision of services.

Over the past 20 years, the demand for health services has changed significantly due to longer life expectancy and the emergence of new chronic illnesses. However, regional and national policies have been unable to effectively address the new needs arising in society. This has entailed persisting regional differences in the provision of services and a local specialization in the treatment of specific diseases that has contributed to the so-called *patient mobility*, a phenomenon characterized by significant flows of patients to regions offering better care and treatment. The most targeted region is Lombardia, which hosts more than 20 percent of the total number of patients; instead, the regions with the highest share of patients seeking healthcare elsewhere are Campania (10.6 percent) and Lazio (10.00 percent)¹⁶⁶.

In this context, cooperatives have emerged to fill gaps in health services for patients with specific illnesses and to enable doctors to self-organize collectively. The national government has acknowledged the key role of cooperatives in this domain through their institutional accreditation. Institutional accreditation grants the status of healthcare provider to different types of private organizations, including diverse kinds of cooperatives: cooperatives specialized in healthcare, physician cooperatives, pharmaceutical cooperatives, and mutuals.

Italian Health System

The Italian NHS is organized on three levels: national, regional and local. At the national level, the Ministry of Health lays down the fundamental principles and objectives of the health system, establishes the package of essential healthcare basket benefits (LEAs) guaranteed to citizens, and distributes funds to the regional administrations. Regional governments are responsible for ensuring the provision of basket benefits through the local health authority (ASO, *Azienda Sanitaria Ospedaliera*) and the local health board (ASL, *Azienda Sanitaria Locale*).¹⁶⁷ In particular, the local

¹⁶⁵ Giulia Colombini, Giulia Galera, Euricse

¹⁶⁶ Source: Rapporto OASI pg. 136.

¹⁶⁷ Source: <http://www.salute.gov.it/>

health board provides public health services, community health services, primary care services, and specialist care either directly or through public hospitals and accredited private providers.

The long-term evolution of the Italian NHS has been complex and characterized by distinct phases. Italy promulgated the first health law in 1888, which was the first instance in which the Italian State affirmed the principle of *public responsibility* for ensuring health in work and life environments. In this first phase, the liberal governments developed the legal framework for a residual welfare system, in which families and non-profit organizations were given a leading role. In fact, public policies delegated to families and other intermediate organizations (e.g. mutuals, the so-called *Società di mutuo soccorso*) the task of caring for individuals not in extreme poverty. One important change introduced in 1890 was the transformation of private hospitals and nursing homes into public structures. During the 1930s, public health insurance became compulsory and started to incorporate aspects not directly connected with the labour market (e.g. after job activities), which in turn considerably increased public expenditure on welfare. In this phase, Italy witnessed the birth of social security authorities (*enti previdenziali*) as well as a series of mergers between mutuals accompanied by the reorganization of their activities. This transformation of the welfare system from a local to a national institution was mainly the result of a higher degree of public intervention. In the following years, the Fascist regime supported the development of a corporative system through which the State introduced the first health insurance scheme for workers and, at the same time, encouraged the spread of mutuals in the industrial, agricultural, and tertiary sectors.

After the Second World War, Italy introduced a NHS based on the principle of universality. In Italy the central government undertook the provision of health services as part of the process of constructing a national welfare state. Thus, health services were removed from mutual control, and the role of mutuals as welfare actors was downsized.

The NHS was introduced in 1978 and implemented during the 1980s. Its implementation was complicated and followed diverse evolutionary phases. In the northern regions, especially in the north-east, local administrations were able to exploit growing economic prosperity to consolidate the newly-established health system. Conversely, in Southern Italy fulfilment of the principle of universal coverage was jeopardized by widespread poverty and administrative inefficiency.

The NHS has proved increasingly unable to cope with new health needs generated not only by profound demographic changes (decline of the family's role in providing social support, and ageing of the population), but also by new forms of social exclusion. Extensive reforms were enacted to remedy the healthcare system's shortcomings in dealing with the above mentioned issues. Important changes in the organization of the healthcare system took place in the 1990s with the enactment of the 1992 bill *D.Lgs. 30 dicembre 1992, n. 502* (and the modifications introduced the following year by *D.Lgs. 7 dicembre 1993, n. 517*), whereby regions became responsible for the planning and financing of healthcare services. Regions were granted further autonomy by becoming the institutions that controlled the implementation of healthcare activities on their territory. All the above implies that, since the 1990s, Italian Regions have not only been autonomous, but also responsible for healthcare in their territories. Each regional government exercises a legislative function and manages the regional health system by planning health service delivery and defining the activities in charge of

local health administration units. Regional administrations are also responsible for the organization and delivery of healthcare services, the control of food safety, and the organization of medical research.

Finally, the constitutional reform of 2001 assigned a new role to Regions. Under the new regime, the national government is in charge of developing a common health plan for the whole country, which is set out in the National Health Plan (Piano Sanitario Nazionale) and states the national objectives in terms of prevention, care, and rehabilitation. The reform also introduced a basket of essential healthcare services (called LEA, *livelli essenziali di assistenza*), which must be furnished by all regions in order to guarantee a universal standard of healthcare. The National Commission for the definition and updating of LEAs is required to evaluate and update the following criteria: effectiveness, adequacy and consistency with the NHS's functions and objectives. The most recent revision of the healthcare basket benefits has taken place in January 2017. The healthcare basket benefits scrutinized by the Commission include collective healthcare, basic care, and medicine for community health such as vaccination programmes, outpatient specialist care, and hospital care.

Cooperatives and mutuals: roles in healthcare

Since its institution, the Italian NHS has often faced problems in increasing the scope of the health services offered mainly due to a chronic shortage of economic resources. For example, the NHS has been unable to respond to the increasing needs that have characterized the Italian context since the 1980s. The quest for higher efficiency has led to an evolution of the Italian NHS whereby regional governments are responsible for local healthcare facilities. However, a notable drawback of this arrangement is that these local facilities have never been able to ensure the same level of provision across all regions and provinces. These gaps have stimulated a bottom-up reaction within civil society along with a spontaneous and widespread mobilization rooted in the long-standing voluntary culture and self-help tradition dating back to the pre-war period. Beginning in the 1980s, most groups of volunteers chose to institutionalize their activities – consistent mainly in the provision of both health and social services – through the creation of new cooperatives.

In 1991, the central government enacted Law 381/1991 on cooperatives. This law defined the “social and health” (*socio-sanitario*) principle – later modified in 2001 with the DPCM 14/02/2001 – which specifies the three categories of services that cooperatives can furnish within the NHS. The first category comprises healthcare services with social relevance (*prestazione sanitarie a rilevanza sociale*), e.g. health promotion and disease prevention. The second consists in social services with healthcare importance (*prestazione sociale a rilevanza sanitaria*) like support for disabled persons. Finally, the third category of services comprises closely integrated social-health services (*prestazione Socio-Sanitaria a elevata integrazione sanitaria*) providing support in cases of addiction and terminal disease. After the reform of 2001, cooperatives found an institutional recognition of their work with the institutional accreditation introduced by the 2007 and 2010 budget laws (Financial Law of 2007 (No.296 / 2006) and Financial Law 2010 (Law No. 191/2009)).

In Italy, social cooperatives play a particularly important role within the healthcare system. Many social-healthcare services are delivered by type-A healthcare cooperatives. The Italian Law

distinguishes between Type-A and Type-B cooperatives. The former manages social-health services, training and lifelong education, while the latter manage activities aimed at the employment of disadvantaged people in industry, commerce, services and agriculture. Type-A cooperatives can collaborate with the public sector to complement the services offered by the NHS. Many of the integrated actions of these organizations are intended to improve the functioning of the public system, which is highly bureaucratised and sometimes unable to meet the needs of citizens.

Institutional accreditation grants the status of healthcare provider to private organizations, including cooperatives that operate in the health system. These include cooperatives specialized in health assistance (e.g. residences for elderly people); physician cooperatives, *i.e.* associations of physicians; pharmaceutical cooperatives, which mediate between the needs of customers and retailers; mutuals.

Another important role is played by cooperative federations, which mediate between cooperatives in the third sector and the public bodies. Recently, the role of healthcare cooperatives has grown considerably in Italy, to the point that there are now branches of national cooperative associations (such as Legacoop Sociali and Federsanità) operating in the health sector, whose aim is to co-plan innovative solutions in the healthcare domain for citizens. Federations involve social cooperatives, physicians' cooperatives, and mutuals in order to develop an integrated response to people's needs.

In addition to health cooperatives, it is worth mentioning that there are also many associations that are emerging to fill gaps in healthcare provision. Similarly, to cooperatives, thanks to their flexibility, associations are well suited to capture new health needs arising in society. A valuable example of an association performing a key role in the health domain in the South of Italy is the Calabrian Hepathology Association (ACE). ACE was founded in 1996 in the region Calabria, initially to carry out independent biomedical research aimed at improving the planning of prevention strategies for liver diseases and other chronic diseases.

Research on chronic liver-related diseases conducted by ACE corroborates that individuals with lower economic and educational backgrounds are exposed to increased metabolic and cardiovascular risks. Chronic-degenerative illnesses are generated among other factors by both inadequate life styles and dietary habits, which tend to be more widespread among lower income groups. In addition to its research effort, which has contributed to developing effective prevention strategies, the association has set up a centre of solidarity-based medicine, located in the outskirts of Reggio Calabria, the region's most populous city. The centre offers free access to a significant list of medical treatments and diagnostics, especially to people who cannot afford out of pocket services. All services are completely free of charge; it is up to patients to decide the amount they want to donate against the service delivered. Thirty people, including doctors, technicians, and administrative staff work voluntarily in the facility. Noteworthy is the inter-generational solidarity of retired doctors, who work free of charge. In addition to a significant number of volunteers, some full-time staff members have also been employed to ensure continuity of the service.

People from all social classes are now referring to this centre, precisely because the waiting lists are limited, and the association provides high quality health services, open to everyone free of charge. This shows that in some regions, especially in Southern Italy, where the national health service is not

able to meet all the needs of the population, there is space for organizations which, together with cooperatives and mutual societies, pursue a model of intervention that ultimately favours the development of a more effective public health system.

Organizations

We analysed five cooperatives operating in the health sector. In particular, we selected two organizations delivering health services in different regions, in order to study their connection with the health system. We also studied five organizations in the pharmaceutical sector operating in both retail and sales in order to determine their role in favouring service provision to members and citizens. Finally, we present the case of an emerging cooperative of practitioners, which exemplifies a relatively new phenomenon in Italy.

The organizations considered in the case studies are:

- S.P.E.S. Trento (Servizi pastorali educativi sociali), a social cooperative furnishing social-healthcare services to elderly people and operating at regional level.
- AGAPE Cooperativa, a social cooperative providing social-healthcare services for elderly people. It operates at local level.
- The Vallagarina Pharmacy Coop, a pharmacy cooperative operating in the drug retail sector.
- CEF – Coop Esercenti Farmacie, a pharmaceutical cooperative operating in the wholesale sector.
- COOP MEDICI 2000, a cooperative providing services to general practitioners and paediatricians.

Cooperativa S.P.E.S. - Trento

History and background

S.P.E.S. Trento is a social cooperative that delivers social-healthcare services to elderly people. It was established in 1924 as a religious association providing support to women. In 1975, the organization changed its legal form and became a cooperative; later in 1994, it was transformed into a social cooperative. During the 1990s, the cooperative managed two residential facilities where it hosted elderly people, mainly from well-off families. Using funds granted by the municipality of Trento, during the 1990s, the premises were transformed into a nursing home (*residenza sanitaria assistenziale*).

Life cycle

The most important transformation of the organization took place in 2000 following the appointment of a new general manager. The cooperative was granted institutional accreditation and started to collaborate with the NHS and began the procedure of obtaining quality certification. At present, the organization manages eight nursing homes, five of which are certified by the ISO 14001, a day centre and some territorial services (*servizi territoriali*). Each nursing home has different relationships with

local authorities; in some cases, the residence for elderly people is owned by the province and managed by the cooperative, while in other cases the cooperative manages private structures.

Core business model

In order to gain an idea of the business model of the cooperative, we focused on a facility for elderly people recently built in a village close to the city of Trento. The facility is called *Casa Famiglia* and hosts 90 people. The setting up of the residence's premises was made possible by fruitful collaboration among S.P.E.S., the local community, and the municipality, which also contributed to the building costs. In fact, the structure is completely new and equipped with technologically advanced instruments, such as physiotherapy equipment and facilities for elderly people who are not self-sufficient. Moreover, the building ranks in the highest energy efficiency class and is endowed with solar panels, a water harvesting system, and thermal insulation. It hosts a medical laboratory and a day care centre that the local community can access. In particular, the aim of the local community centre is to strengthen social cohesion through interaction between the community and the social cooperative.

An important aspect of the business model of S.P.E.S. is accreditation. In fact, the structure is accredited by the Region, which implies that the Italian NHS covers 50 percent of the final cost of the medical care services furnished by the cooperative, while the remaining expenses are covered either by the Province or by the final users.

Institutional/governance structure

S.P.E.S. Trento is governed by a board that decides the activities to be undertaken. The organization comprises forty members and four hundred employees. Nurses and physiotherapists are employed by the cooperative, while the doctors are private practitioners.

In *Casa Famiglia* there are three secretaries, and all the workers furnishing healthcare were employees of the cooperative, while the beauticians, the hairdressers, cleaners and canteen staff worked for external cooperatives. In the facility that we visited, there were also 30 active volunteers.

External relations

The general manager has set up training and counselling projects throughout Italy for other residences for elderly people. S.P.E.S. Trento is dedicated to exporting the CSS system, an information system developed by the cooperative itself, which it sells to other organizations. In particular, the system allows all practitioners (doctors and nurses) to access and update the medical records of their patients in real time.

Economic data

Total assets: 29,063,632 EUR

Revenues: 24,204,963 EUR

Production costs: 22,222,183 EUR

Result of the exercise: 1,760,952 EUR

For the cooperative, economic sustainability is of crucial importance: the director of *Casa famiglia* is constantly in search of new ways to accumulate savings and generate economies of scale. Moreover, one of the organization's goals is to promote energy self-sufficient structures so that they do not become a further cost, but rather a resource.

AGAPE Cooperativa

History and background

The Agape social cooperative operates in the health sector and furnishes social health services to elderly people. Agape was founded in 1984 in a village near Grosseto, in southern Tuscany, by the local priest with the help of members of the local community. The aim was to organize training initiatives for young students and disabled people. Since then, the organization of school camps has seen the participation of numerous groups of young people who find themselves in an environment where socialization is favoured and various training and entertainment activities are carried out.

Life cycle

In May 1997, in agreement with the health authority in Grosseto (ASL), Agape began managing a residence for elderly people in a village close to Grosseto. Since then, the cooperative has increasingly focused on the socio-health sector. Having to manage a limited number of patients (at first nine, then 11) the cooperative has been able to support its patients in all their needs, as closely as possible recreating a family atmosphere, spending time on taking adequate care of recipients, rather than pursuing simply commercial objectives. The relationship with ASL9 (until 31/12/2015 - now the Tuscan Local Health Unit) has been focused on maximum fairness, always receiving positive comments from the inspection bodies. In July 2008, the Cooperative took over the management of the "Little House of Divine Providence - Cottolengo" rest home – which currently hosts 18 patients, of whom four are non self-sufficient¹⁶⁸.

Since May 2011, AGAPE has hosted between 16 and 24 non-EU asylum-seekers in the rest home in collaboration with the Municipality. Initially the agreement was meant to expire on 31/12/2011, but it was later extended until 28/02/2013. This intervention, co-ordinated with the Prefecture, the Local Health Unit (ASL), the Police, and the Municipality, regulated by an agreement with the Healthcare Consortium of the Colline Metallifere District, provides catering services, accommodation, and some basic healthcare services for the refugees. On August 22, 2014, the Cooperative participated in an invitation to tender issued by the Ministry of the Interior through the Prefecture of Grosseto for the management of reception services for non-EU asylum seekers. AGAPE's bid was successful, resulting in continuation of the reception service for asylum seekers. The cooperative currently employs 31 people, 28 of whom have a long-term contract. Three of them work in the refugee centre.

¹⁶⁸ In the case of non self-sufficient patients the rest home has a convention with the local health authority, the Tuscany Local Health Unit, in order to furnish specific services to patients.

Core business model

The convention and the fees paid by the guests of the residences are the main sources of revenue for the organization. In particular, the Pioni residence hosts 11 guests whose stay is financed by the Region, while in the Scarlino residence there are 18 guests, of whom only four are publicly financed. Agreements with the regional health system are relatively recent and the reason why they are increasingly important for AGAPE is that the business model has changed. In fact, the structure was originally opened for self-sufficient elderly people, while now the needs of the community have changed and there is much more demand for assistance from non self-sufficient people. Moreover, the structure has changed from an autarkic human resources model to one relying extensively on the outsourcing of key services (e.g. external collaboration with nurses, cleaning services, and other external cooperatives). This has led to a transformation of the type of management and an increase in residence maintenance costs. Currently the cooperative is waiting to update the agreements with the Region concerning the public funds allocated to covering the costs of the services for non self-sufficient guests. In fact, subsidies are necessary to guarantee the sustainable provision of the service to those guests who would not otherwise be able to bear the full cost. The Region has not yet agreed to increase the number of contracted places and the cooperative is having difficulty in covering all expenditure.

A cooperative managing small structures for elderly people incurs very high costs (e.g. over 3,000 EUR per month per guest, and the costs for the structure amount to over 16,000 EUR per month). The cooperative struggles to attain economies of scale but the possibility of hosting asylum seekers helps it come closer to the goal of becoming more cost efficient.

Institutional/governance structure

There are three people on the council: president, vice president, and counsellor. Members are 20.

External relations

The organization joined the National Federation Confcooperative in 2002. It also has close relationships with the local authorities.

Economic data

Total assets: 761,811 EUR

Revenues: 1,111, 768 EUR

Production costs: -

Result of the exercise: 552 EUR

CEF – Cooperativa Esercenti Farmacie

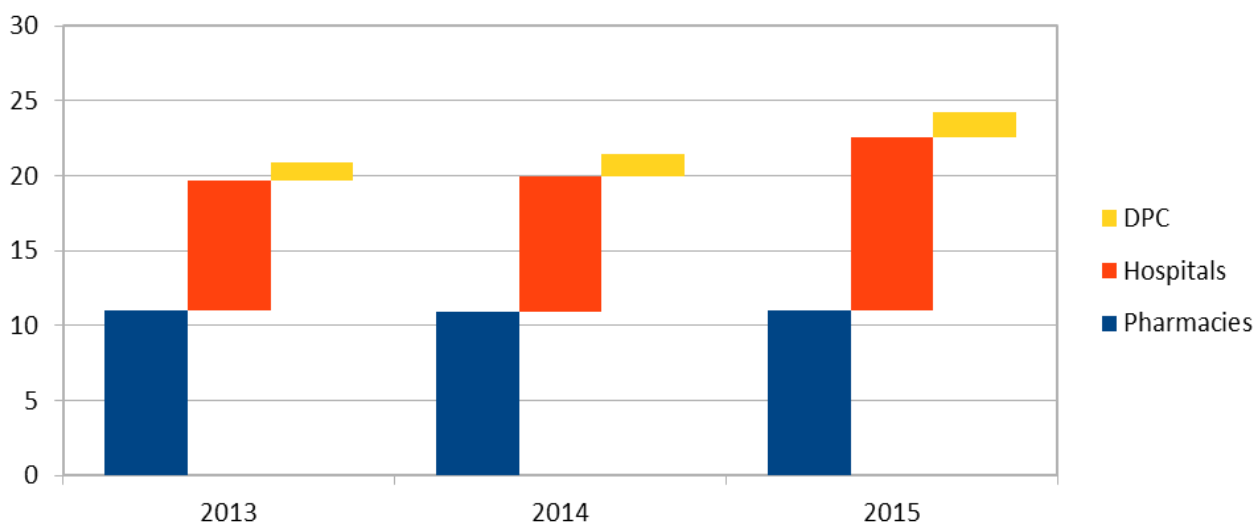
History and background

Cooperativa Esercenti Farmacie (CEF) is a pharmaceutical cooperative founded in 1934 in Lombardy on the initiative of seven pharmacists wanting to supply medicines and raw materials to pharmacies, rationalize purchases, and improve the quality of their service. Today it operates at a national level and has more than 2000 private pharmacies as members; CEF is a wholesaler that buys products and delivers them to partner pharmacies in a very short time, so that they do not need to stock large quantities. CEF has more than 80 years of experience. It started as a small wholesaler in Brescia and became the second group in Italy in the drug distribution sector, operating in 11 Italian regions with a national market share of almost 10.5 percent in 2016.

In Italy, 250 wholesaler cooperatives have been created in recent years with the aim of selling drugs to nearby pharmacists at prices lower than those they would pay individually to pharmaceutical companies. The advantage of distributors is that pharmacists are not obliged to buy major quantities of medicines and can order the medicines day by day directly from distribution cooperatives. Pharmacists can buy medicines at a lower price, they are supplied four times a day by the cooperative, and can thus reduce storage costs.

The distribution of drugs is a particularly complex sector. In fact, citizens can obtain drugs from a variety of channels, such as hospitals, local health bodies, or pharmacies, all of which can in turn have connections with wholesalers or pharmaceutical companies. The sector is changing, and recently wholesalers have begun to distribute drugs to hospitals (DPC). This situation is depicted in Figure 7.

Figure 7. Evolution of distribution of drugs (billions of euros)



Source: Federfarma 2015

Usually, wholesalers (in a single warehouse there may be up to 25,000 products) can deliver products to pharmacies, which require small orders on a daily basis.

Life cycle

In the pharmaceutical sector, over the past ten years, horizontal and vertical integration has taken place. The number of distributors is decreasing and likewise the number of pharmacy owners. Distributors like CEF earn a percentage on each item sold, and profit derives from operating on large volumes. In recent years, the State has promoted policies reducing price mark-ups for both pharmacies and distributors. As a consequence, small wholesalers have less and less resources to pay maintenance of the structure. In this context, in which many pharmacies have gone out of business or accumulated debt, for a small distributor the possibility of losing even a few members could pose a serious problem for its long-term survival. Therefore, wholesalers are becoming more concentrated and seeking to expand their activities. CEF has adopted this strategy and is now one of the largest distributors in the Italian market.

CEF is undergoing full expansion. It has eleven warehouses throughout Italy, which can also do “routing”. Which means that if a pharmacy asks for a product not available at the local warehouse, the latter automatically turns to the main facility in Brescia, which ships the product to its final destination. Because it is a national player working in multiple regions, CEF can serve many more pharmacies and compensate losses elsewhere if clients in a particular area are in difficulties. Warehouse acquisitions and mergers are strategies useful for entering a territory where it is possible to have a strong relationship with affiliated pharmacists. For example, mergers among cooperatives covering other cities and regions also acquire pharmacy associates for existing warehouses and thus make it easier to grow market share. In the past seven years, CEF has merged with (and in some case acquired) several other cooperatives across Italy: Cremona Alfarma, Roman Symphony, Pisa CEF, Bari FARPAS, VEBMAN FORM, NEW Warehouse, NEF Vicenza, CTF Bergamo.

Core business model

The cooperative was set up to increase the bargaining power of pharmacies with the pharmaceutical industry. In fact, CEF balances bargaining power between the pharmaceutical industry and small retailers, thus promoting the satisfaction of the needs of both users and pharmacists. When drug distribution was liberalized, competitors started entering in the market with competition prices dropped advantaging both customers and retailers. The advantage for pharmacists is that having a cooperative aggregating orders from many retailers brings them discounts higher than they could obtain alone, while allowing them to save on warehousing costs. In fact, large multinational distributing companies can deliver drugs at lower prices twice a day, while the cooperative can deliver up to four times a day thanks to its distributed geographical structure. It is therefore a convenient option for many pharmacists. The lower cost borne by retailers partly spills over to customers in the form of lower prices.

Institutional/governance structure

Every member can vote for the board of administrators; each member casts one vote.

External relations

The main stakeholders are the pharmacists: as members they are the owners of the company. CEF currently counts 2,000 partners, out of a total of 18,000 pharmacies operating in Italy. Shareholders become members by paying a fee. There are also other entities like local and national federations (e.g. Federfarma) or pharmacist unions representing private pharmacists. Other important entities are the regulators of the NHS, even though they do not have a direct relationship with pharmacies. In particular, CEF collaborates with the local health board (ASL) in the distribution of its pharmacies and hospitals.

Economic data

Total assets: 569,514,610 EUR

Revenues: 1,186,292,714 EUR

Production costs: -

Result of the exercise: 2,326,632 EUR

Policy environment

CEF is an innovator in the sector because it has created a service not conceivable until six or seven years ago. The benefits are enormous for pharmacists and for users, especially now that the NHS is changing. For example, the CUP (*Centro unico prenotazioni*, information desk to book health appointments) has long waiting times, and in some regions, pharmacists can take bookings thus contributing to improving the service. This is an important service for users. Moreover, CEF facilitates pharmacists in organizing awareness days on important topics (e.g. treatment and prevention of diabetes). In fact, CEF is the intermediary between pharmacists and the regional Centre of Diabetes, and together they can organize free visits of the pharmacy premises in virtue of an agreement with the NHS.

One of the features that distinguishes CEF from other wholesalers is technological innovation, especially in software development. Improvement of the IT system allows the cooperative to speed up the preparation of the materials to be delivered and to track all movements in its warehouses. This is important because the amount of products available has increased compared to 20 or 30 years ago, and the delivery relationship with pharmacists has changed from informal to more formal.

The Vallagarina Pharmacy Cooperative

History and background

Vallagarina is a pharmacy managed by a consumer cooperative, located in Avio in the province of Trento. Avio is a municipality of about 4,000 people bordering on the province of Verona. The cooperative manages a supermarket, a hardware store and a pharmacy. After a critical phase especially due to the lack of profitability of the supermarket, the cooperative decided to invest more

in the pharmacy. In March 2017, the Vallagarina Pharmacy Cooperative opened the MEDICORNER structure. It is a small space designed to bring the pharmacy closer to locals. The goal is to provide inhabitants with a health service comprising diagnostics, nursing and blood tests close to their home. For example, the pharmacy is equipped to perform electrocardiograms, cholesterol analysis, spirometry, holter electrocardiography and urine analysis. The facility also furnishes home-based services to people with reduced mobility: there are nurses available from Monday to Saturday from 8 a.m. to 10 a.m., and it is possible to book tests. The facility was designed together with UNIFARM, a drug wholesaler that combines diversified business and operates in the health system, with the aim to create small geographically distributed health centres. Avio's facility was organized in agreement with the privately run MEDICORNER programme, through which all available equipment and nursing training were provided.

Life cycle

The Vallagarina Pharmacy Cooperative has a distinctive structure. In the Italian system, pharmacies are usually either private or public, but in this case the pharmacy has elements of both: the Vallagarina Pharmacy Cooperative is a private pharmacy but with a public governance model. As ruled by a royal decree of 1902, the pharmacy is owned by the cooperative and employs two pharmacists. The peculiarity of the pharmacy is the fact that there is a director. The presence of a director, which is typical of publicly run pharmacies, makes Avio's pharmacy a hybrid structure, a rare case in Italy. The role played by this pharmacy is very important given the characteristics of the area, where the nearest medical centres are located ten kilometres away. The MEDICORNER project of the Vallagarina Pharmacy Cooperative is in its initial phase. It is possible to make reservations for specialist visits under the national health service through the pharmacy. The Vallagarina cooperative board is planning to expand the pharmacy and the spaces for the MEDICORNER activities. At this stage the pharmacy structure is not accredited, so tests are paid, although the cost of some tests is already lower than those provided by the national healthcare system. Costs essentially derive from the cost of the facility, the costs of the medical samples sent to a telemedicine centre, and the wages of nurses.

The pharmacy plays an important role in the overall budget of the cooperative and is the main source of income, followed by the supermarket and the hardware store. After a difficult phase, the Cooperative decided to invest more in the pharmacy to increase total income.

Institutional/governance structure

The cooperative has 2,300 members. Not all workers are members of the cooperative.

Economic data

The Vallagarina Pharmacy Cooperative could become the reference centre for local doctors. In fact, the perspective of the centre is to complement national health services in a territory where the system has lost its capillarity

Total assets: 5,928,516 EUR

Revenues: 7,005,737 EUR

Production costs: -

Result of the exercise: - 170.000 EUR

Medici 2000

History and background

Medici 2000 is a cooperative society based in the municipality of Siena, in Tuscany. It provides mutual services to general medical practitioners and paediatricians. The goal of the cooperative is to improve diagnostic tools available to doctors and indirectly the quality of the services that they deliver. The cooperative was born because the national collective agreement of these two groups of physicians (medical practitioners and paediatricians) allows them to form consortia using the legal form of cooperatives in order to help the work of the members. This type of cooperative can furnish services useful to doctors, such as joint management of premises and organization of appointments. Moreover, since the statute allows the cooperative to reach agreements with specialized physicians who can operate on the same premises as the coop's members and complement the services they provide, Medici 2000 can sign contracts for professional services (e.g. research and surveys), which are conducted by members of the cooperative who then bill Medici 2000 directly for their participation.

Medici 2000 was established in 2000 in order to improve the professional activity of family doctors and paediatricians that has undergone major transformations in recent decades. Once, family doctors in Italy worked individually, while today they are increasingly encouraged to be less isolated. For this purpose, the aggregation of several physicians enables to improve the quality and quantity of the services delivered through the sharing of tools that each physician alone could not afford. Prior to the healthcare reform, doctors did not require major instruments other than personal ones. Today a doctor must have a car, telephone service, and a computer network, and s/he must attend compulsory and optional compulsory courses to keep updated. In this situation, it becomes much more effective to act collectively rather than individually. For these reasons, a cooperative of doctors will come together and share the headquarters and the advanced instrumentation.

Life cycle

Since Medici 2000 was born until 2004, it did not have regular institutional meetings. The organization tried to make doctors aware of the importance of this cooperative while waiting for someone to realize the potential of the resource. At the beginning, there were 30 doctors and over the years more and more have joined, leading to growth and wider geographical coverage. Currently, there are over 220 doctors in the cooperative and they operate within the geographical perimeter of the ASL (Local health authority) of Siena¹⁶⁹.

¹⁶⁹ There are now three large ASLs in Tuscany. The cooperative operates in the ASL that covers Siena, Arezzo and Grosseto.

Over the past five years the organization has not been growing and is waiting for a national contract to be negotiated, which should regulate the role of the doctors. At present, the Italian law basically allows for two associative forms of doctors: group medicine, i.e. structures where doctors can share the space; and network medicine, which makes it possible to share and store patient data digitally. Both associative forms are optional and neither of them is granted legal personality. Hence doctor associations cannot produce invoices nor stipulate contracts. The next step consists in the Balduzzi Law (law of 158/2012), which stipulates that associative forms will no longer be optional; they will be compulsory, and will be called *Territorial Cooperation Associations*, or *Complex Units of Primary Care*. These two forms will have a defined geographic scope which will probably be determined to include between 25,000 and 30,000 inhabitants and will include 25 between doctors and paediatricians working in the field of care, who will need to aggregate and guarantee continuity of care seven days per week at every time of the day. These structures will be in charge of assisting chronic patients, filtering access to first aid, and intensifying territorial activities related to home care. This should be translated into a national collective agreement that doctors have been expecting since 2012. With the new legislation in place, since associating will become mandatory and the system's complexity will increase, doctors will need to rely on a subject that can offer the tools for their services. Usually the structures are provided by the ASL (Local health authority) or private subjects such as pharmacies.

The growth potential of the cooperative depends on the evolution of the legislative framework. The Medici 2000 cooperative owns nine medical centres, one of which is equipped with advanced diagnostic instrumentation that allows the Cooperative to rent the spaces to specialized practitioners.

If the Balduzzi Law is passed, the above business model will probably become more common and Medici 2000 will be a pioneer in the sector.

Core business model

The goal of the 190 members of Medici 2000 is to reduce the cost of the services that the members themselves have to procure. If doctors succeed in this, they can produce an economic advantage for themselves and their patients, improve the overall quality of the healthcare service, and also produce a professional advantage.

The cooperatives' services are targeted on patients who need short response times and medical trust, who would pay a higher price in the public system for the same service, and who often have private insurance which reimburses at least part of the treatment.

Institutional/governance structure

There is a board that plans organizational evolution, which is then implemented by the doctors. At an initial organizational stage, the primary need was to create a council, which started with five members and gradually expanded to seven to include physicians representing the various geographic areas of the province and chosen among affiliates. Apart from the physicians, the cooperative employs around 30 nurses.

External relations

The cooperative maintains important relationships with the national cooperative network. The president of the cooperative is also the president of SANICOP, an association of medical professional cooperatives, which includes also other cooperatives of physiotherapists, dentists, and psychologists. There are almost 100 cooperatives federated with the national cooperative federation Legacoop, and there is a project to constitute a branch within Legacoop dedicated to the health sector.

Economic data

Total assets: 951,876 EUR

Revenues: 2,147,294 EUR

Production costs: -

Result of the exercise: 45,521 EUR

In 2016, the turnover amounted to 2,100,000 EUR. 86 percent of the turnover came from the activities of members and 14 percent from non-members (services to other entities). The economic return is lowering costs and therefore offering cost-effective services. The cooperative is able to offer rates better than the average market price.

Impact analysis

The evolution of the Italian health system (NHS) has been characterized by reforms that have changed its structure from a national to a decentralized system operating at a regional level. The national government defines healthcare basket benefits in order to guarantee a homogeneous service standard among regional systems, but the effects of the basket benefit are not as expected because there are many differences between regional systems, especially between northern and southern Regions. The system is public, but due to the reduction in public health expenditure, many regional systems cannot always meet all the needs of the population, which at the same time is increasing due to higher life expectancy. The healthcare cost per citizen is also rising as a consequence of the ageing population, due to the increasing impact of chronic illness. Both factors place strain on the public system, which has been forced to cut back on services and subsidies, especially in the aftermath of the financial crisis and the subsequent austerity policies. In this context, citizens have started resorting more to private doctors, specialists, and medical structures. This has generated a substantial growth of the market for private healthcare, which cooperatives are filling, trying to co-produce and co-programme new strategies to improve the national health system and not entering directly in the private market. Through the collaboration between local administrations, local health authorities, citizens, and cooperatives operating in the health system it is possible to interpret the evolving needs of the population and efficiently provide new services. It is possible for example to integrate the NHS with social cooperatives operating in the system and address the out-of-pocket to the mutualistic systems in which the aggregate demand can be more sustainable.

In the case studies presented above it is possible to underline some common characteristics shared by the cooperatives. In particular, all of them aim to fill the gaps in the coverage of the NHS in their own sector of activity and thus contribute to satisfying some of the essential needs of the population in the areas where they operate. Some of these organizations (e.g. Medici 2000 and CEF) operate in lines of business that allow them to pursue a more market-oriented strategy. Thus, by the nature of their core activities, these cooperatives have a higher chance to survive and fulfil their mission even if local administrations or the national government do not directly intervene to create conditions favourable for the realization of their projects. Moreover, market oriented cooperatives are able to take advantage of institutional weaknesses when they result in private initiative. By contrast, other organizations offering healthcare services (e.g. S.P.E.S. Trento and Agape) need to develop important relationships with local authorities and municipalities, partly because the services that they offer are particularly useful to people experiencing economic or social hardship. The *countercyclical* nature of the mission of this kind of cooperative is thus likely to benefit more from a cooperative institutional environment than from the opportunities afforded by markets. In the cases of the latter kind of organizations, it is possible to observe that regional differences in Italy are still important: in fact, as long as territories remain heterogeneous in terms of wealth and effectiveness of the healthcare system, it will be more difficult for cooperatives to contribute to covering the needs of the population.

Chapter 6: Spain: Fundación Espriu, best practice of solidarity and shared management¹⁷⁰

Introduction

The National Health System in Spain was established in 1986, and the last major reform was enacted in 2011 with the promulgation of General Law 33/2011 on Public Health. The National Health System is a decentralized system, i.e. its main responsibilities related to the delivery of health services and primary jurisdiction are in the hands of 17 regional governments. Furthermore, the regional governments' financing scheme promotes regional autonomy in both expenditure and revenue raising. The strategic areas, such as pharmaceuticals' legislation and the equitable functioning of health services across the country, among others, are the responsibility of the national Ministry of Health and Social Policy (MSPS).

Law 33/2011 extended universal healthcare coverage to the entire population of Spain. However, in 2012, the national government decided to return to the previous scheme, leaving some categories of individuals outside the coverage of the public health system. These categories include: foreigners without a residency permit, Spaniards without a labour contract who have left Spain for more than 90 days (even if they left to seek work or training because they had exhausted benefits in the Spanish unemployment system), professionals without direct health coverage, people with no link to social security (no labour contract) and even the descendants of insured persons older than 26 whose income exceeds a certain limit (though such limit was not specified by the regulation). The provision of services is free of charge at the point of delivery, with the exception of pharmaceuticals prescribed to people aged under 65, which entail a 40 percent co-payment with some exceptions.

According to the IDIS Foundation (2017), total Spanish healthcare expenditure in 2014 accounted for 9.1 percent of GDP, which represents a slight increase with respect to the latest figures published by the OECD for 2013. This growth was primarily due to the increase in private healthcare expenditure, whose weight in total health spending grew from 29.1 percent to 30.2 percent. Government health expenditure reduced its weight in total healthcare expenditure from 70.9 percent to 69.8 percent in 2014.

In evolutionary terms, private healthcare expenditure has continued its growing trend, reaching 28,558 million EUR in 2014, representing 2.7 percent of GDP. Government healthcare expenditure, on the other hand, has continued its downward trend in terms of GDP (6.3 percent), although it has grown slightly in absolute terms.

There is a percentage of government healthcare expenditure which is earmarked for the financing of private provision through public-private arrangements (in 2014, it stood at 11.8 percent). In terms of GDP, the public-private arrangements were estimated in 2014 at 0.75 percent (0.57 percent

¹⁷⁰ Millán Díaz-Foncea and Carmen Marcuello, University of Zaragoza.

corresponded to regions, 0.15 percent to official mutual societies, and 0.03 percent to the social security system).

Furthermore, the insurance industry continues to record significant increases. In 2016 there were 9.7 million policyholders, an increase of 4.9 percent over the previous year. Compared with neighbouring countries, Spain is positioned at an intermediate level in expenditure on private insurance in relation to GDP (0.5 percent), ranking ahead of countries such as Germany or Italy, but behind France, Switzerland or the Netherlands. At market level, the health insurance sector presents a high degree of concentration, with five leading companies representing 72 percent of the health premium market, which increases to 83 percent if the ten major insurance companies are considered.

Based on statistics published by the Spanish Ministry for Health, Social Services and Equality, three significant issues concerned the health system in Spain in 2017. It is noteworthy that the available statistics only provide information until 2013 and, for a few variables, only until 2014. This is important because the situation observed from the available data points towards a major negative change in the public health system.

Firstly, a significant disinvestment occurred in the public health system in the 2010–2014 period. This disinvestment can be seen in the level of total expenditure, the number of available hospital beds and the total number of medical personnel in hospitals. Secondly, a highly relevant issue is the health coverage situation. In the end, the concept of universal coverage has been pushed aside to return to the idea of insured persons. The third important issue is the situation of waiting lists,¹⁷¹ both for surgical procedures and for speciality consultations, and the care provided by accident and emergency services. The Ministry for Health regularly publishes a national report on waiting lists and the autonomous communities also publish such reports. The situation is so complex that there are specialities with a delay of six months before the first visit and surgical specialities with an average delay of over seven months. This situation is leading to an increase in the number of private medical insurance policies taken out. Hospital accident and emergency services are also largely saturated in the autonomous communities.

Consequently, we can confirm that the public health system has been severely eroded. The situations in the various regions, however, differ significantly.

Regarding the role of cooperatives and mutual insurance societies in the health system there are very different situations. First, it should be pointed out that the origin of cooperatives and mutual insurance societies in the Spanish health system is the model based on the *igualatorio* system (medical insurance groups, known in Spain as “*iguales*”). Throughout the nineteenth century and part of the twentieth, this system was the origin of mutual insurance societies, health cooperatives and what were known as “sickness funds”. However, in the twenty-first century the situation has changed and, currently, the existing health cooperatives have been reduced to three groups: the *Cooperativa Sanitaria de Galicia* (COSAGA), the CES Clinicas in Madrid and the entities formed by the Espriu Foundation (COSAGA, 2017b). Second, pharmaceutical cooperatives in Spain have mostly developed as

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https://www.msssi.gob.es/estadEstudios/estadisticas/inforRecopilaciones/docs/LISTAS_PUBLICACION_DIC15.pdf

distribution companies with a huge impact on the sector: their market share in 2015 was 71.2 percent. These cooperatives are owned by the pharmacies themselves. Third, mutual provident societies are grouped into the Spanish Confederation of Mutual Provident Societies, created in 1947. They amounted to 371 in 2015, with 1,376 employees, more than 2.5 million members and a revenue of 3,326 million EUR from premiums.

Espriu Foundation

History and background

The Espriu Foundation is the point of convergence of the four institutions that Dr Josep Espriu founded. Its aim is to help increase social value and human capital in the health sector through cooperativism by bringing together medical personnel and users around the same table on an equal footing and creating a multi-stakeholder organization that allows for medical care that is socially satisfactory to both professionals and patients.

This is what Dr Espriu termed “comprehensive health cooperativism”, which, according to the Espriu Foundation’s articles of association, is “an instrument of participation and responsabilisation of health professionals and users of health services and facilities, in the co-management of organisations which cooperatively pursue health policy objectives in all forms of preventive, curative, primary, family, community, specialised, hospital, recovery and predictive medicine and any other forms resulting from ongoing progress in medicine in general and in social medicine in particular”.

The Espriu Foundation is divided into two sections: the Barcelona network and the country network. The Barcelona network groups together *Autogestió Sanitària*, a medical service cooperative and the owner of the insurance company *Assistència Sanitària*, and SCIAS, a cooperative of users. The country network comprises Lavinia, a medical services cooperative, and the insurance company ASISA. The establishment and development of these four organizations, influenced by the social and economic context and by existing legal restrictions, are fundamental for understanding the principles and the activities of the Espriu Foundation. Consequently, embedded in the current health sector and linked to cooperativism in this specific area, the situation of the Espriu Foundation as an independent organization will be compared throughout the case study with the situation and development of the four entities forming the foundation, and which it furnishes with principles and international projection.

The history of the Espriu Foundation and the organizations within it began in the mid-1950s (a prodigious decade for Spanish cooperativism, since that is when the Mondragón corporative scheme came into being) when Dr Espriu discovered the recently established scheme of medical insurance groups in Bilbao and decided to transfer it to Barcelona and then to the rest of Spain. This was the start of the development process of a cooperativist model specifically linked to healthcare, which was well known internationally, but not in Spain.

As explained in the previous section, in the 1950s Spain did not have an extended, universal and free health system. In fact, doctors were independent liberal professionals who were responsible for healthcare in a specific region and who charged for the services that they provided to their patients.

Especially in rural areas, it was extremely expensive for an average family to pay for a medical process, above all for a severe illness, and this not only posed a serious problem for public health, it also encouraged harmful behaviours in patients (mostly because they delayed visiting the doctor until it was unavoidable, which worsened their health problem) and placed doctors in vulnerable situations.

This is the context of competition and need in which the medical insurance groups model arose as a solution to dignify healthcare and maintain the standard of living of the people involved in providing it. One of the main examples in this sector is the *Igualatorio de Médicos de Bilbao*, which also transferred the scheme from the countryside to the urban area. This *igualala* was defined as a type of private medical insurance whereby residents paid an amount established in agreement with a doctor to the latter every month via the *igualala* and received medical care in return. Thus, doctors could be certain of the monthly payments that they would receive without depending on the progress of their patient's health.

After experiencing this model, Dr Espriu took it upon himself to disseminate it, first in Barcelona and then through the rest of Spain, thus launching what would be known as comprehensive health cooperativism. Dr Espriu was helped in this endeavour by other individuals and similar collectives, mainly the medical associations, which played a key role in the first stages of this model becoming widespread. Consequently, various organizations were established to improve doctors' working conditions and patients' health situations. Dr Espriu also added an important innovation to the way cooperatives managed healthcare: the figure of the patient as a health creditor to whom medical care is due and who has to participate actively in the healthcare organization. All this formed a special and complex organizational architecture, which has been successively modified by developments in tradition and legislation when they came into being.

Specifically, Dr Espriu fostered the creation of two insurance firms (public limited companies) and then of three cooperative companies (for consumers and users, services, and work), all linked to the health sector. It would undoubtedly be complicated for these organizations to be established today. However, in the 1960s, the need to ensure work for doctors and to receive satisfactory care at acceptable prices led to an unprecedented organizational architecture to deal with the stakeholders: doctors and patients.

In 1989, 42 years after these organizations had been established, the Espriu Foundation was created as a body gathering all the organizations promoted by Dr Josep Espriu with the aim of reflecting on, devising, and promoting comprehensive health cooperativism. The Espriu Foundation arose as a solution to the difficulties experienced by the Espriu Foundation organizations in forming a second-level cooperative that would make it possible to complete the organizational architecture of the cooperative framework in the health sector. This was Dr Espriu's original idea: to create a comprehensive cooperative that could group healthcare-related cooperatives and insurance firms (public limited companies) governed by cooperative principles based on the example of other cooperative groups, such as Mondragón in the Basque Country, Migros in Switzerland and Lega-Coop in Italy.

Given that this proved difficult, the Espriu Foundation channeled the ideological and philosophical core of the activity performed by its entities acting as the guardian of the project's philosophy. It supervised the promotion and expansion of the comprehensive health cooperativism concept, which was pivotal for its expansion plans. Consequently, the Espriu Foundation is an independent entity with no functional dependence on the other organizations forming it, which would be the case of a comprehensive cooperative. Currently, the Espriu Foundation continues the endeavour to promote collaboration among group entities.

In 1982, SCIAS joined the *Autogestió Sanitària* and Lavinia cooperatives to establish a fund for developing health cooperativism (Hernández, 2012). For that purpose, small entities were established that led to the beginning of what would later become the Espriu Foundation. These included:

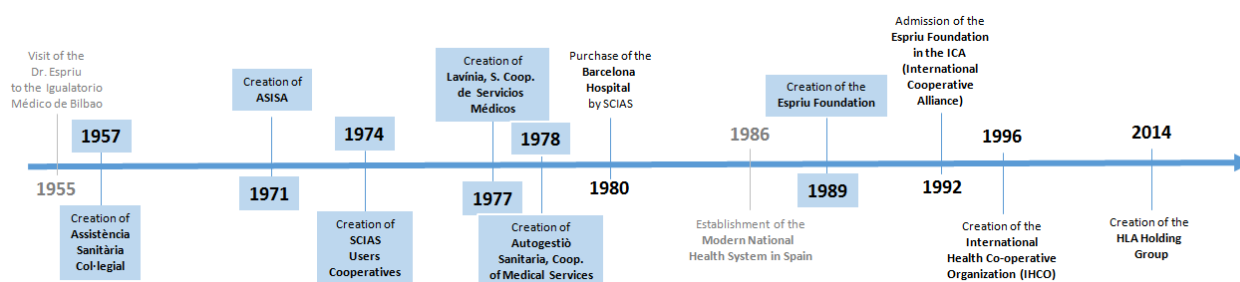
- Elaia, S. Coop. (1962), which offered the additional service of publishing books, gazettes and documents for all the entities.
- Spaces such as the Office for the Study and Promotion of Health Cooperativism (1983), which, with no structure of their own, were dedicated to organising conferences and study meetings for the collective, establishing a periodic forum for the directors of the entities to define common objectives or take decisions jointly.
- Sinera, S. Coop. (1985), which, with the inter-cooperation of all the entities, enabled the institutionalisation of the general practitioners' work as part of the healthcare offered by the group's entities, although it did not exist for very long.

Besides these more specific organizations, conceived for disseminating tasks and support for the comprehensive health cooperativism, there are the organizations created around the Espriu Foundation, which give meaning to comprehensive health cooperativism and the foundation itself. The following sections focus on them.

Life cycle

Although the Espriu Foundation was officially established in 1989, in regard to its life cycle one must start with Dr Espriu's 1957 visit to the *Igualatorio de Bilbao* (still operating with the name *Igualatorio Médico Quirúrgico, IMG Group*) to learn about the free-choice surgical care system, funded by families or individuals through the payment of a modest monthly fee, that had been set up in the area.

Figure 8. Life cycle of the entities of the Espriu Foundation



Source: Own elaboration.

It was on the basis of this example that the insurance company called *Assistència Sanitària Colegial* (ASC) was created in Barcelona. It provided health insurance and grouped many of the doctors linked to the Medical Association of Barcelona. The services that the company offered depended on the skills of the associated doctors, who offered their own consultation (the medical profession was independent). They addressed the demand for medical services in Barcelona and its province.

During this period, ASC's activity expanded to incorporate more doctors as shareholders of the company and to increase the number of insurees. It was Dr Espriu himself who undertook the coordination of the ASC medical collective, in which there was broad consensus about the need to enlarge the reach of its activities to the rest of the country. The main problem was that there were no other provincial medical insurance groups to cooperate with (only 17 of the 50 provinces had one). Consequently, doctors in the regions were approached to establish medical insurance groups in every province. The evangelisation work performed by Dr Espriu was extremely important at this stage.

As Hernández (2012) explained, this dissemination increased after acquisition of a small hospital in Badalona in 1971 (it was the first medical facility acquired, since previously facilities had been rented from other entities), which served as a legal basis for the creation of a country network called *Asistencia Sanitaria Interprovincial S.A. (ASISA)*. Other medical insurance groups and doctors from other provinces gradually joined the network, convinced by Dr Espriu. ASISA overcame legal and organizational obstacles in the various regions (provincial medical associations did not always collaborate actively in this process), forming the basis of the ASISA group. The financial resources provided by the many doctors who were members of the association and by the ASC helped in this endeavour, especially because the ASC was sufficiently established to provide significant payouts.

The legislative amendments enacted in the mid-1970s enabled the organizational structure to approach the cooperative model with the establishment of the work and medical services cooperatives *Autogestió Sanitària* (in Barcelona) and Lavinia (statewide), which grouped the shareholder doctors of the insurance companies, who then became cooperative members, and the cooperative owners of the insurance companies. Hitherto, ASC had undertaken all the administrative tasks necessary to extend the model throughout Spain free of charge. However, once the parallel organizational structures were established in Barcelona and the rest of Spain, Dr Espriu and the other ASC doctors transferred all the ASISA shares (which they owned) to their doctor colleagues in the ASISA-Lavinia structure.

In this same period, the 1970s, the SCIAS users cooperative was established with the social objective of building and managing, democratically and cooperatively, its own hospital facilities (Hernández, 2012). This closed the circle around health cooperativism, institutionalised the patient/user issue and dignified the users' ability to self-organise and manage the facilities where doctors would meet them. The funds for this project were provided by the member consumers with monthly insurance premiums paid for several years, which were set aside for the future acquisition. This became reality in 1980 with the purchase of the future Barcelona Hospital (which did not start operating until 1989).

SCIAS also made it possible to contemplate establishing a real second-level cooperative group for healthcare in the Barcelona area. However, this desire never came to fruition. The aim of creating a closer collaboration has been present throughout the development of the entities in both Barcelona and the rest of Spain, and formed the basis for the creation of the Espriu Foundation.

Besides the organizational and legal structure, until 1990 the economic development of the entities linked to the Espriu Foundation showed constant growth in the number of patients seen and services supplied, since the public social security system had not previously been universal. They treated 70 percent of the labour force in the secondary (industry) and tertiary (services) sectors.

From 1990, the strategy of the organizations linked to the foundation turned into “maintenance”, or, in other words, avoiding the loss of market share, as was occurring in the sector because market niches such as healthcare for the self-employed were disappearing. The Spanish healthcare market changed drastically and this affected the development of entities offering private healthcare services. This occurred with SCIAS’ plan to create a network of regional or provincial hospitals in Barcelona, which then had to be limited to the management of the Barcelona Hospital alone, since no more healthcare facilities were needed by *Assistència Sanitària*, due to the lack of business opportunities for its insurance products, demand for which was related to SCIAS’ supply of facilities.

Nevertheless, in view of these changes, the cooperative organization of work or services proffered by the foundation’s entities grouped together professional doctors for whom the activity of the cooperatives and insurance companies was the only or main source of income. Consequently, in contrast to other organizations in the mutual sector, in which the organization’s owners are the users/patients, the organizations in the Espriu Foundation, stemming from the situation of medical insurance groups, in which the doctors are the owners/workers of the organization, were in a better position as they were forced to seek new employment opportunities and new market niches to continue to perform their activity and earn income.

Since then, the organizations participating in the Espriu Foundation had to seek new market niches and make investments to increase the quality of their services in order to differentiate them from the services offered by the general social security system. This has occurred in the case of the Barcelona Hospital and the health facilities managed by the Lavinia-ASISA tandem. Since the 2000s, medical technology has decreased the need for hospital stays after surgical procedures, which has led to a change in the hospital concept. This has not involved a decrease in the annual average stay, since, although there are fewer hospital stays, they have become longer because people have greater needs.

Since then, the strategy of the Espriu Foundation entities has been that of maintaining some financial stability and market share, mainly with a view to increasing competition in the market. The latter primarily affects ASISA, which is in a controlled market (it is the mutual insurance societies for civil servants that establish prices and conditions), but also ASC and SCIAS, which had to maintain the highest level of quality to offset the cost, after paying through taxes, of the service offered by the public health system.

One of the priority objectives, which was consolidated with the establishment of the Espriu Foundation, has been the international outreach of health cooperativism. The foundation promoted

the creation of the International Health Cooperative Organisation (IHCO), the healthcare branch of the International Cooperative Alliance. The strengthening of internationalisation since 2000 has also promoted the development of the healthcare service, especially in the case of ASISA, which has overcome national barriers to expand principally into South America, Europe and Africa.

In addition, this period has been characterised by a market decrease. This has required an effort to improve the provision of owned facilities by increasing not only their number but also their quality and computerisation. This has been achieved by leveraging the advantages afforded by the cooperative structure, as non-profit distribution is allowed and the pursuit of more quality for the owners (doctors and patients) is encouraged. In the case of the Lavinia-ASISA Group, this reinvestment capacity has led to the purchase of health facilities throughout Spain, which grouped into the HLA Hospital Group in 2014.

Core business model

The Espriu Foundation focuses on promoting and developing comprehensive health cooperation. It has pursued this goal through activities such as the publication of specialised journals (mainly the *Revista Compartir*, which currently has a circulation of 30,000 copies in three languages, plus a digital version), the organisation of events (conferences, seminars and discussion forums), advisory services, collaboration with organizations linked to the social economy and to health cooperativism, and the implementation of research and communication campaigns on related topics.

Although these activities were previously performed by the organizations, the foundation took over their management to become the reference entity in the dissemination of comprehensive health cooperativism by performing actions that have been fostered in the foundation's various stages. These actions include literary awards, grouping the already existing periodic publications, and promoting studies of shared social medicine (Hernández, 2012).

The foundation's dissemination of comprehensive health cooperativism is primarily technical, and the activities are performed by personnel and by the trustees of the entities forming the Espriu Foundation. All the foundation's entities understand the need to disseminate this concept, which is still innovative in the Spanish context and has a long way to go before it becomes general practice internationally as well. In fact, comprehensive health cooperativism produces a set of conditions that make it possible to organise healthcare that respects the dignity of current or potential patients and also of medical professionals, without being restricted to the most economically disadvantaged classes. Given the current situation of the public social security system, this amounts to a revolution in the healthcare service (Hernández, 2012). These conditions, which form the values presented in the strategic plans of the four entities constituting the Espriu Foundation, can be summarised in the following points:

- a) Conditions linked to medical and human requirements¹⁷²
 - Free choice of doctor

¹⁷² Hernández (2012) included a fourth condition: "Private room during hospital treatment". This is now obsolete due to advances in hospital treatment, which favours outpatient care where possible.

- Payment for medical treatment¹⁷³
- Accompaniment during hospital treatment¹⁷⁴

b) Conditions related to economic and organisational requirements

- Principles of mutual aid within the community of members
- No economic gain¹⁷⁵
- Participative and self-managed structure

In Dr Espriu's ideology, these principles should pervade the entire structure regardless of whether they are cooperatives for work, services, users or commercial companies associated with comprehensive health cooperativism, which is one of the main functions of the Espriu Foundation. They should also adapt to social, medical and technological changes as they occur.

The main activity of all the organisations represented on the foundation's Board of Trustees concerns healthcare and insurance. Specifically, ASISA and ASC obtain their clients from individual or collective free-choice insurance. The latter is especially representative in the case of ASISA, a company that explicitly collaborates with the public health system by means of agreements with the mutual insurance societies for civil servants and state-employed personnel (MUFACE, ISFAS and MGJ).

Another of the key activities performed by the foundation's entities is the provision of services through healthcare facilities. The Lavinia-ASISA Hospital Group owns the second most extensive network of non-public hospitals in Spain. The Barcelona Hospital, owned by SCIAS, is one of the most important facilities in Catalonia as far as the number of beds is concerned. This policy of acquiring facilities has made it possible to decrease costs and to obtain revenues from transferring and renting them, and also to acquire first-hand knowledge of the market prices established in the sector, which resulted in a significant advantage when negotiating with third parties (Monzón et al., 2010). These activities are complemented by the private management of public centres, although this activity is in decline.

Healthcare cooperativism is seen as an alternative that complements the public social security system, except in the case of the mutual insurance societies for state civil servants, in which it actually supplements the provision. From a macroeconomic point of view, the impact of the organizations in the Espriu Foundation involves a positive externality (shorter waiting lists, lower costs, and so on) as they provide services to a specific population group that collaborates in maintaining the public system, but which does not demand services from the public system, thus freeing up resources that can benefit all.

¹⁷³ Although patients pay a fixed periodic fee, the cooperative distributes payment based on a scale agreed collectively by the doctors, which has the consequence that the doctors do not receive a salary but instead are self-employed.

¹⁷⁴ In both cases, this situation is based on respect for the patient's privacy.

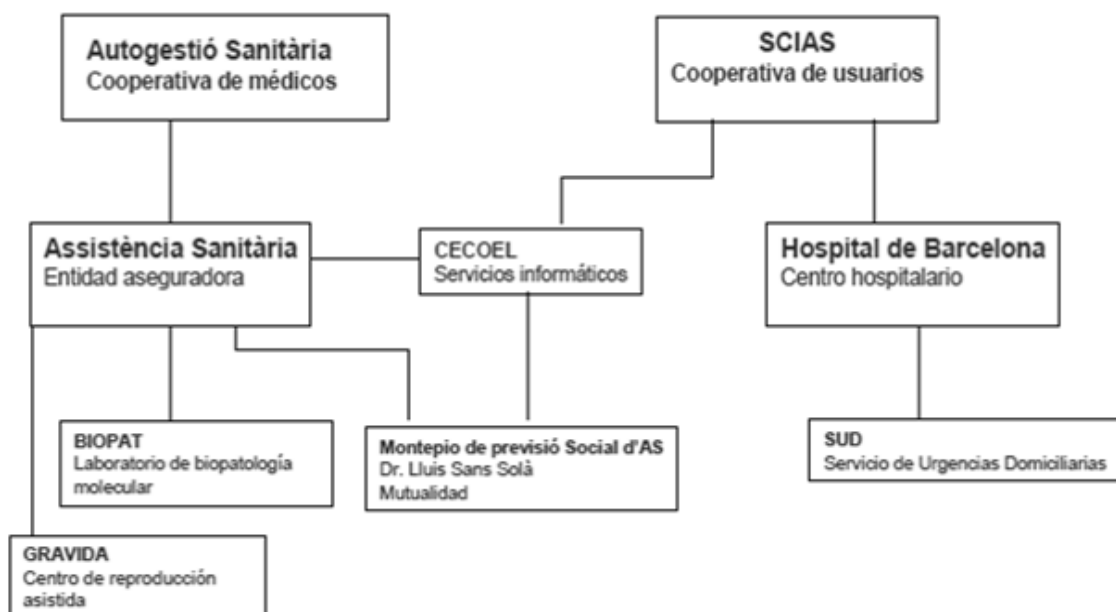
¹⁷⁵ This condition implies that the entities do not distribute profits or dividends; they reinvest them in the activity itself. However, a sound and competitive management is needed for the entities to be sustainable. Moreover, member doctors of the cooperative practice their profession like any other doctor, for a salary.

The business model followed by each of the entities participating in the Espriu Foundation is described below. Given the specificities of the models, the foundation's Barcelona section and country section are presented separately.

The Barcelona section

This section considers three main entities (ASC, SCIAS and *Autogestió Sanitària*) and a series of organizations that provide services to them.

Figure 9. Organizational structure of the Barcelona section of the Espriu Foundation



Source: Sustainability Report of Assistència Sanitària (2015)

Assistència Sanitària Colegial (ASC)

According to a ministerial order issued in 1955, a cooperative could only provide insurance for its own associates, but not for the public in general. Consequently, Dr Espriu, imitating the Bilbao case, proposed the establishment of *Assistència Sanitària Colegial S.A.* as an alternative to the creation of a cooperative in 1957.

Consequently, ASC became a public-limited company, but its capital was 100 percent paid up by shareholders with specific characteristics: medical graduates or health-sector-related graduates who were members of associations qualified to exercise the profession (Hernández, 2012). To encourage participation, the possibility to delegate one's vote was limited, as was the distribution of profits, which had to be reinvested.

The aim was to ensure that the health problems of its insurees were addressed following a doctor–patient dialogue model based on equality and seeking the benefit of both collectives. Its services now include a long list of medical and healthcare treatments designed to cover all the insurees'

requirements. Its scope of action is especially limited to the province of Barcelona where it manages 36 hospitals and runs private clinics and a network of 19 branches.

During its development, ASC has implemented several activities shared with the other organizations in the Barcelona network (see Figure 9). They include the following:

- GRAVIDA: assisted reproduction centre (2010).
- BIOPAT: laboratory of molecular biopathology (1995) for the study of diseases (ASISA also has a shareholding in it).
- MONTEPIO DE PREVISIÓ SOCIAL D'AS "DR. LUIS SANS SOLÀ" (1966): an exclusive and obligatory mutual insurance society for the doctors that are shareholders of ASC to deal with any requirement that may arise and with their retirement.
- CECOEL (SCIAS also has a shareholding in it): internal information management service.

The fostering of health cooperativism has enabled *Assistència Sanitària* to be a leader organization in its field in Catalonia for over 20 years, with a loyalty rate of its insurees that is double the average in the sector and with an excellent satisfaction level among both its doctors and users (ASC press dossier, 2015).

Autogestió Sanitària S. Coop.

Given the difficulties in turning ASC into a cooperative, which was the aim of Dr Espriu and the other shareholders, a structure was created in 1978 that owned the insurance company and managed to achieve the objective of having a cooperative organisation to promote medical participation. All the shares of the shareholders of the public-limited company ASC were transferred to *Autogestió Sanitària S. Coop.*, whose only activity is to manage this property.

Autogestió Sanitària S. Coop. was established as a workers' cooperative, grouping members working in their private surgeries. The surgeries were under the responsibility of each doctor, as there were no shared facilities. The cooperative's shares could not be transferred to third parties without being offered first to the cooperative. Consequently, ownership of the insurance company was retained over the years by the cooperative despite any changes arising in its capital (Hernández, 2012).

Sociedad Cooperativa de Instalaciones Asistenciales Sanitarias (SCIAS)

SCIAS was created in 1974 by the people insured by *Assistència Sanitària Colegial*, whom Dr Espriu encouraged to group together in their own cooperative so that their voice could be heard in the healthcare sector and they could be included in the organisational structure of health cooperativism. Around 85 percent of the insurees also became members of the users cooperatives at that time, a percentage that has remained stable to date.

The main activity of SCIAS is the management of the facility where the Barcelona Hospital is located, which was acquired in 1980 and opened in 1989 to set up a suitable framework for the providing of quality healthcare and personalised, human treatment to patients, thus keeping the spirit of health cooperativism and management in the hands of the users receiving the healthcare. In 1988, the

management of the company SUD (*Servicio de Urgencias Domiciliarias*, Homecare Emergency Service) was added to the Barcelona provincial districts (ASC press dossier, 2015).

Currently, SCIAS is a multi-stakeholder organization, although its legal form is that of a consumers cooperative. In SCIAS there are user members and worker members. Both have the same rights and social duties with a weighted participation in the governing body that is more than proportional in the case of the number representing worker members. These worker members include not only general practitioners and specialised doctors (radiology, ICU, emergency, and so on) but also nursing staff, nursing auxiliaries (such as the healthcare staff in the Barcelona Hospital), personnel working in catering, laundry and other additional services, which means that almost 90 percent of the workers is a member.

The twofold direction of client-provider established between ASC and SCIAS is worth highlighting, since the consumer members of SCIAS are clients of the insurer ASC, but at the same time ASC is a client of SCIAS when it needs the services of the Barcelona Hospital, which is owned by SCIAS. Barcelona Hospital therefore has two clients: the insurance company, the main source of income, and users that are co-owners and are admitted to the hospital, representing approximately 95 percent of the hospital users.

The presence of SCIAS means that in a healthcare environment, which would appear to be controlled by medical professionals, there is a dialogue with patients and they participate so that both collectives can co-manage equally. SCIAS represents the legal confirmation of Dr Espriu's idea of including potential patients in health-related decisions. This is a truly innovative and revolutionary focus (both at that time and in the present day).

The country section

This section includes two entities: ASISA and Lavinia, owned by ASISA, and a series of other entities and facilities forming the group. These two organisations, founding members of the Espriu Foundation, are described below.

Asistencia Sanitaria Interprovincial de Seguros, S.A. (ASISA)

At the beginning of the 1970s, one of the major challenges of healthcare was covering all of Spain and adapting it to provinces with very diverse health situations. There was no State-provided healthcare network and not every province had medical insurance groups. It was also vitally important to provide doctors and patients with suitable services in the whole country. This was especially important in Madrid, at the time the capital of a very centralised State.

In 1971, ASISA was established with this objective as an interprovincial medical insurance group. The hard work of its founder, Dr Espriu, established ASISA branches in provinces that had no medical insurance groups. By 1973, its network already had 19 provincial and one interprovincial medical insurance groups. Legal restrictions at that time prevented cooperatives from offering insurance services directly to non-members, which led to the creation of a public-limited company in which associated doctors were capitalist shareholders with equal shares and the same rights and obligations.

ASISA's aim was to continue promoting the doctor-patient relationship based on a commitment to medical quality. As a result, ASISA has two lines of activity: a healthcare insurance service (over 2 million people to date) for its affiliated members (users/patients); and the construction, purchase and management of medical facilities and their technological improvement to provide member doctors with suitable instruments for their medical practice, limiting the distribution of profits so that they can be reinvested in improving the production process.

The synergies between both service lines have led ASISA to offer a wide range of medical and healthcare services, including basic medical services, specialised medicine and additional services (see Figure 11). Its availability of facilities positions it as the largest non-public hospital network in Spain (Monzón et al., 2010), grouped in the Lavinia-ASISA Hospital Group (HLA Group). ASISA is also present in many other countries, including Brazil, Guinea, Italy, Morocco, Mexico and Oman.

Figure 11. Geographical distribution of the Lavinia-ASISA health facilities



Source: Activity Report of ASISA, 2015

With these resources and aims, ASISA collaborates with the public health system, and it was one of the first entities to sign agreements with the mutual insurance societies for civil servants in 1976, a collaboration that is still ongoing today. This sector represents ASISA's most important client share, as it is responsible for collaborating with the mutual insurance societies for civil servants of all the Espriu Foundation's entities, including those that provide healthcare to civil servants in Barcelona and Catalonia. In 2015, ASISA was chosen by over 35 percent of the State's civil servants to be their health insurance company (ASISA Activities report, 2016).

This collaboration with the government has also occurred in two other areas of activity. Firstly, in complementing the public health system through a special agreement to provide healthcare services in areas that are difficult to reach or lack provision for diagnostic tests or surgery (shortening waiting lists and increasing the number of services available in the area). Secondly, in managing state-subsidised private clinics, although this form of collaboration is currently declining due to political

and economic difficulties (only one hospital is currently managed by ASISA, the Torrejón University Hospital in Madrid, out of the three managed until some years ago. The remaining two hospitals are located in the autonomous community of Valencia).

ASISA was established with the aim of being the point of reference for the quality healthcare model fostered by the sector in which it operates (technological innovation is increasing in the health sector). Its organisational structure enables the ongoing reinvestment of profits to improve healthcare and to promote constant innovation, so that the most advanced diagnosis techniques and treatments can be incorporated into all the centres. ASISA has consolidated its position as a company committed to innovation, ongoing improvement of its processes and, in short, as a technologically advanced organisation.

Lavinia, S. Coop.

Lavinia is a medical services cooperative established in 1977 to manage the property of *Asistencia Sanitaria Interprovincial de Seguros, S.A.* (ASISA) and to facilitate the participation of doctor members in the healthcare activities that it provides, a situation similar to the one that occurred one year later (1978) in Barcelona with the cooperative *Autogestió Sanitaria*. Dr Espriu's influence on the creation of the organization can be grasped from its name, which stems from the way Salvador Espriu, the doctor's brother and a well-known poet, referred to Barcelona in his poems.

When Lavinia was created, doctors that were shareholders of ASISA until 1977 became members of Lavinia, S. Coop., and their shares became the responsibility of this cooperative. Therefore, Lavinia is the organisation through which doctors can take part in the activity of the entire holding. The connection between both entities is so close that they even share the same structures. It was decided at the general meeting of Lavinia S. Coop. that the cooperative's governing body would govern ASISA by default (Lavinia's chairperson is ASISA's chairperson, etc.) and the Lavinia-ASISA Group is referred to as an "organisational unit".

The cooperative also makes arrangements to offer discounts on specific services for its associates (discounts on legal services, travel agents, and so on). This restriction to a specific series of activities and the close ties with ASISA can be seen in the cooperative's limited number of employees (two in 2015) mainly for administrative and management tasks.

Figure 10: Organizational structure of Lavinia, S. Coop.

Lavinia Sociedad Cooperativa

Asisa, Asistencia Sanitaria Interprovincial de Seguros, S.A.U.

Empresas del Grupo

Asisa Vida Seguros, S.A.U.

HLA Lavinia Salud, S.L.U.

Inmo Asisa, S.L.U.

Policlinic Lleida, S.L.

Clinica Ntra. Sra. del Rosario Albacete Grupo HLA, S.L.U.

Clinica Vistahermosa, S.A.U.

Traumatología Vistahermosa, S.L.

Oftalmología Vistahermosa, S.L.

Unidad Reproducción Asistida, S.L.

Hospital&Health Products, S.L.

Policlinico San Carlos, S.L.U.

Clinica Terapéutica Mediterráneo, S.A.U.

Hospital de la Inmaculada Concepción, S.A.U.

Clinica Los Naranjos Grupo HLA, S.L.U.

Ntra. Sra. del Perpetuo Socorro Sanatorio Médico-Quirúrgico de Lérida, S.A.U.

Corlleida, S.L.U.

Centre Oftalmologic Avançat de Ponent, S.L.

Hospital Mondoa, S.A.U.

Oftalmología Mondoa, S.L.U.

Hospital El Ángel, S.A.U.

Clinica Belén Grupo HLA, S.L.U.

Clinica Virgen de La Vega, S.A.U.

Clinica Santa Isabel, S.A.

Clinica Médico-Quirúrgica Montpellier, S.A.U.

Laboratorio Clínica Montpellier, S.L.U.

Hospital Jerez Puerta del Sur, S.A.U.

Oftalvist-CIO Jerez, S.L.

Oftalvist La Vega, S.L.

Alcuneza, S.A.

Hospital Moncloa Internacional, S.L.U.

Sociedad Guineana de Salud, S.A.

Resona, S.A.U.

Asisa Dental, S.A.U.

Instituto Andaluz Implantológico, S.A.U.

Centros e Instalaciones Asistenciales de Asisa, S.A.U.

Centro médico de Alicante

Centro médico de Elche

Centro médico de Alcoy

Centro médico de Barcelona

Densitómetro de Cáceres

Centro médico de Córdoba

Centro médico de Jaén

Centro médico de Madrid

RAD

Centro médico de Soria

Centro médico de Tarragona

Densitómetro de Valencia

Centro médico de Ceuta

Shikari Tecnología, S.L.U.

Inversora de Asistencia Médica, S.A.U.

Asisa, Servicios Integrales de Salud, S.A.U.

Asuman Servicios y Mantenimiento, S.A.

Instrumental Clínico y Distribución Material Didáctico Sanitario, S.A.U.

Tecnología de la Información Care Health Consulting, S.L.

Asisa Internacional Salud, S.L.U.

Empresas asociadas y multigrupo

Sociedad

Centro Inmunológico Cl. Vistahermosa, S.L.

Analiza Sociedad de Análisis Clínicos, S.L.

Centre D'Análisis Biologiques, S.L.

Biopat Biopatología Molecular, S.L.

Transmural Biotech, S.L.

Centro Médico Bidasoa, S.L.

Sanatorio Médico Quirúrgico Cristo Rey, S.A.

Torrejón Salud, S.A.

ADE Italia, S.R.L.

Unidad de Reproducción Hispano Mexicana, S.R.L. de C.V.

Nucleopet, S.L.

Asyas, Promociones Sanitarias, S.A.

Saham Asissanté, S.A.

Mutualidad de la que Asisa es socio protector

Sociedad

Mutualidad de Previsión Social de Asisa Dr. Atilano Cerezo

Source: Activity report of ASISA, 2015.

Institutional/governance structure

The Espriu Foundation is a body that gathers all the organisations that Dr Espriu helped to establish. It is a point of convergence that upholds the principles, carries forward the spirit, and fosters the promotion of comprehensive healthcare cooperativism shared by the four entities in the group. The foundation forms the hub of the work performed by the group Lavinia-ASISA and by the conglomeration Autogestió-SCIAS, although the foundation has no functional leadership over these entities (Figure 12).

Figure 12. Organizational structure of the Espriu Foundation's Board



Source: Own elaboration

The board of the Espriu Foundation comprises 14 people, including an honorary chairman, a chairwoman, two deputy chairmen and one secretary. There are three trustees representing each of the four entities (Autogestió Sanitària, Lavinia, ASISA and SCIAS), which in turn are members of the governing bodies of these entities. This helps to balance representation across the four entities and link their strategic decisions with the work of the Espriu Foundation. In addition to these representatives, there is also an elective trustee, who does not directly represent any entity, and the honorary chairperson.

The entities participating on the board remain in constant contact through periodic meetings held by the foundation. Consequently, these organisations can share best practices and easily transfer knowledge and information.

The Espriu Foundation's internationalisation efforts and related practices concerning how medicine and health cooperativism work allow for a constant, fluid exchange of perceptions and knowledge.

In the entities linked to the public network (the Lavinia-ASISA Group), the governing body of Lavinia is formed by nine members (eight men and one woman), all member doctors of the entity and

chosen democratically by the 10,000 members. This governing pattern is replicated for ASISA and the HLA Group, with several external advisers on the management committee who provide technical know-how for decision-making (legal and accounting aspects, and so on).

In the Barcelona network, the two organisations (SCIAS and Autogestió Sanitària) maintain a strategic alliance through the group committee in which high-ranking members of the governing bodies of each entity participate based on a co-management decision-making model. Nevertheless, this group committee does not have legal personality, so that joint agreements have to be ratified by each entity's governing body. This means that doctors and patients, represented in each entity, can work closely together, aware of the other party's strategic needs and focus. Furthermore, because there are commercial cross flows (as explained above, the clients of one company are the owners of the other), the interests of both stakeholders can converge and the service objectives can be met¹⁷⁶.

SCIAS is especially noteworthy in the Barcelona network as it is an explicitly multi-stakeholder organisation. Its governing body comprises 15 members chosen by the general meeting every five years and, to maintain the level of participation of all the collectives, there are 12 members of the governing body chosen from among the consumer members and three from among the work members. This gives the latter a greater representation percentage per member (it is a much smaller collective than the first).

Prominence is given to both inter-meeting and meeting participation processes through the participation area. In the former, joint meetings are held with spokespeople and secretaries from all the groups to share their work, unify criteria and convey first-hand information to members interested in the proper functioning of SCIAS. In the latter, members participate in internal cooperative groups (seven in the city of Barcelona and 14 in the provincial districts of Barcelona) so that all members feel represented.

External relations

Historically, the two main entities with which the Espriu Foundation has collaborated are regional medical associations and the public social security system.

Despite the Barcelona Medical Association's initial fostering of Dr Espriu's venture when comprehensive healthcare cooperativism first arose, these medical associations have now turned their backs on implementing a cooperativist model in healthcare. According to Hernández (2012), the medical associations mainly lacked confidence in ASISA due to its expansion through the public system and because of the concern for competition, as ASISA too grouped medical professionals together. On a regional and country level, these institutions often vetoed the possibility of creating new cooperatives. And the reason for this is that the trade-union instinct and cooperativism prove to be extraordinarily antagonistic in health cooperativism experiences (Hernández, 2012).

The organisations in the Espriu Foundation have always aimed to collaborate with the public health system in a way that either supplements (in the case of the mutual insurance societies for civil

¹⁷⁶ A more in-depth explanation of the Barcelona co-management system can be found in Martí (2010) and at <http://www.fundacionespriu.coop/medicos-y-usuarios-que-reman-juntos/>

servants) or complements it, when the entities' healthcare services help to shorten public health waiting lists or provide a service in a region with few medical services. In their healthcare services work, the entities form part of several public emergency healthcare systems, such as the National Transplant Organisation¹⁷⁷, on a state level, or the Ictus Code Network¹⁷⁸, on a regional level (in this case in Madrid). In any event, private healthcare provided through the health insurers participating in the foundation creates positive externalities for the public health system by reducing demand for health services and by providing resources that are paid for twice by the insurees of ASISA and ASC who do not use the public system.

On an institutional level, in order to provide visibility and expand the presence of cooperativism in civil society, the Espriu Foundation participates as an institutional representative of the health entities forming it in the following fora and organisations:

In the field of social economy, the foundation collaborates with the main existing Spanish platforms:

- CEPES (*Confederación Española de Empresas de Economía Social*, Spanish Confederation of Social Economy Enterprises), in which it is a member of the board of directors.
- CIRIEC (*Centro Internacional de Investigación e Información sobre la Economía Pública, Social y Cooperativa*, International Research and Information Centre of Public, Social and Cooperative Economy)
- AECOOP (*Asociación de Estudios Cooperativos*, Association of Cooperative Studies)
- AEF (*Asociación Española de Fundaciones*, Spanish Association of Foundations)
- CCF (*Coordinadora Catalana de Fundaciones*, Catalan Coordinator of Foundations)

Internationally, the foundation collaborates with the ICA (International Cooperative Alliance), and it has been a member of its global board and governance committee; the IHCO (International Health Cooperative Organisation), the health branch of the ICA, over which it has presided for more than 15 years and of which it currently holds the vice-presidency. It is also a member of the board of the Alliance for Health Promotion, linked to the World Health Organisation (WHO).

These collaborations allow the entities forming the foundation to establish their own collaboration relationships with entities in other countries and to go on and receive visits from other health cooperative groups. These visits have enabled groups of doctors from several countries to learn the features of the organisations in the Espriu Foundation so that they can transfer them to a similar system in their own regions. The health cooperativism for which the Espriu Foundation is a benchmark is especially applicable in countries that do not have a national health service, where the levels of health coverage are not complete and the roles of the agents are not yet defined.

The organisations maintain their own relationships with all kinds of entities. Especially noteworthy is the case of the Lavinia-ASISA Group, which maintains alliances with Spanish and international

¹⁷⁷ ONT (Organización Nacional de Transplantes, National Transplant Organisation): <http://www.ont.es>

¹⁷⁸ Red Madrileña de Código Ictus (Madrid Ictus Code Network): http://www.madrid.org/cs/Satellite?cid=1354348454609&language=es&pagename=PortalSalud%2FPage%2FPTSA_pintarContenidoFinal&vest=1354348454609

universities (Harvard, Michigan and Chile), several sports sponsorships and cultural patronage and collaboration with over 30 NGOs and associations (ASISA Activities report, 2016).

Economic data

The main data on the Espriu Foundation and all the organisations forming it are presented in the following table.

Table 45. Main Basic Numbers of the Espriu Foundation, 2015

Concepts	Numbers
Cooperative Members	182,850
Medical Doctors	38,766
Employees	45,388
User members	2,264,966
Turnover (EUR)	1,684,783,791
Assets (EUR)	742,139,070

Source: The Espriu Foundation

Based on the information provided by the Espriu Foundation and the reports published by the organisations forming it (*Autogestió Sanitària* and SCIAS, Lavinia and ASISA), the group involves a very large number of people with various roles within the organisation. In 2015, the total number of cooperativist members was 182,850, including 38,766 doctors and 45,388 employees. In regard to economic data, in 2015 turnover exceeded 1,684 million EUR, and the group's total assets amounted to 742,139,070 EUR.

Policy environment

The organisation has the legal form of a foundation. In Spain, foundations are defined by Law 50/2002 as “organisations established to be non-profit, whose assets are willingly and permanently set aside by their creators for general interest purposes”. Consequently, the Espriu Foundation use its assets exclusively for the dissemination of comprehensive health cooperativism, as decided by the four entities forming it (*Autogestió Sanitària* and SCIAS, and Lavinia and ASISA), which have delegated the activity of promoting and defending health cooperativism to the foundation.

These are the entities that annually provide the funds that the foundation needs to perform its activities and no public funding is received for that purpose. Neither do the foundation's entities depend on public subsidies for their activity as they perform it fully in the market. Although in some cases (mainly ASISA) the market has been defined because the provision of services is mostly requested by the public sector, they have also been provided in a competitive environment as well. ASISA has managed to attain a relatively balanced portfolio of private clients and users from the administrative mutual system (MUFACE and others).

The establishment of a foundation that represents the Spanish health cooperativism has resulted from legal, cultural and organisational developments and from the current situation. This aspect has been a constant since Dr Espriu established health cooperativism, and has made it difficult to transfer the cooperative system as Dr Espriu envisaged it to the current organisational and legal situation. His dream of forming a cooperative group and a second-level cooperative to integrate organisations linked to health cooperativism has been realised by the Espriu Foundation, which groups these entities.

However, the current economic, fiscal and social environment does not help in planning a possible second-level cooperative with the necessary guarantees. The development of medical technologies and healthcare, the complexity of the insurance sector, and competition in the market make it enormously difficult to progress any further.

Finally, the contrast between the Barcelona structure and the country structure suggests that a context could be developed to group together ASISA consumers and users, as occurred with *Assistència Sanitària* in SCIAS, as a second stage. However, because of the characteristics of the Spanish health sector, in which the majority of users/patients receive the services from the public system, and because of the fact that ASISA's clients are insured collectives it will be extremely difficult to implement this next step if the economic and social context does not change. Nevertheless, this type of development, in which patients/users take precedence by participating in cooperatives that manage the facilities, might be useful to implement private healthcare models in public hospitals.

Impact analysis

The assessment of the impact of the Espriu Foundation involves different levels of commitment and scope. First of all, we need to take into account the model that Dr Espriu established concerning the free-choice relationship between doctor and patient. Some 60 years later, in a completely different context from the one in which Dr Espriu first proposed this model, it is still thriving. The evidence of this is the fact that there are 182,000 members: 166,000 users and 16,000 doctors, whose work is constantly growing.

The second issue is the growth model developed throughout the project's life. This model has maintained the foundational ideas, and ASISA is currently the third company in turnover volume after ADESLAS and close to SANITAS. The main characteristics of this growth model are the absence of profit, the offer of the best services to the insureds and the creation of quality employment for the doctors, mainly for those that have decided to be cooperativists. In the words of the trustees, "we have created cooperativism to continue to grow in a reasonable way. The growth has been much slower than in other profitable private companies. This growth has been concentrated in certain areas, above all to create quality employment and to ensure sustainability".

The third issue is connected to both the organisational model and its implementation. Decisions within the organisation are based on a democratic decision-making process with a clear conviction and understanding that it is valuable for the functioning of the organization. Sometimes this has slowed down the decision-making process, but it has ensured a sustainable growth and operational model.

The fourth issue stems from the aim of collaborating with other health organisations in the sector, and especially with the public system. The Espriu Foundation is a benchmark organisation for its dedication in supporting public healthcare. In the current situation, with an overwhelmed public health system, the role of health cooperatives is essential to support the development of a basic universal coverage model.

The fifth issue stems from the cooperative nature of the organisation and the fostering of the doctor-patient relationship. These comprehensive health cooperativism conditions have turned the foundation into an international leader due to both its size and track record. This is complemented by its international outreach, in which the following two aspects can be discerned: support for national and international dissemination of the cooperative model and direct commitment to the specific development of social-health cooperativism. The presence of the Espriu Foundation in the bodies of the International Cooperative Alliance (ICA) is an example of its commitment to the cooperative model internationally. Another example are its extremely close relationships with Latin American countries, for example Colombia, Brazil and Argentina, but also with Australia and Japan, in developing the social-health cooperative model.

This international focus also manifests itself in the collaboration agreements between ASISA and Lavinia and other organisations, such as Save the Children. The organisation encourages the cooperatives' doctors to work as volunteers for different ONGs. This has led to collaborations with local organisations in health and education projects in Chile, Palestine, Nepal and other countries.

REFERENCES

- Acuña, C. H. & Chudnovsky, M. (2002). El sistema de salud en Argentina. Centro de Estudios para el Derarrollo Institucional – Fundación Gobierno y Sociedad. Universidad de San Andrés. Documento 60. Available at: <http://www.ccgsm.gob.ar/areas/salud/dircap/mat/matbiblio/salud.pdf> [Accessed: February 2018]
- Adam, S. *Mutualités*. Dictionnaire d'économie sociale. Centre d'économie sociale, Université de Liège. Available at: http://www.ces.ulg.ac.be/fr_FR/services/cles/dictionnaire/m-n/mutualites [Accessed: February 2018]
- Agência Nacional de Saúde Suplementar - ANS (2009). Caderno de Informação da Saúde Suplementar : beneficiários, operadoras e planos. Ano 1, Dados eletrônicos. Rio de Janeiro. Available at: http://www.ans.gov.br/images/stories/Materiais_para_pesquisa/Perfil_setor/Caderno_informacao_saude_suplementar/2009_mes06_caderno_informacao.pdf [Accessed: February 2018]
- Agência Nacional de Saúde Suplementar - ANS (2012). Sistema de Informações de Beneficiários/ANS/MS - 12/2016 e População - IBGE/DATASUS. Available at: <http://www.ans.gov.br/perfil-do-setor/dados-gerais> [Accessed: February 2018]
- Aiken, M. (2010). Taking the Long View: Conceptualising the Challenges Facing UK Third Sector Organizations in the Social and Welfare Field. In: A. Evers & A. Zimmer (Eds.), *Turbulent Environments: the impact of commercialization on organizational legitimacy and the quality of services*. Berlin: Nomos, pp. 295-316.
- AIOP Giovani (2016). L'evoluzione dei modelli sanitari internazioni a confronto. Per costruire il servizio sanitario nazionale del futuro. Available at: <http://www.aiop.it/LinkClick.aspx?fileticket=poAPR08fRIU%3d&portalid=4> [Accessed: February 2018]
- Akamine, O. (1997). *UNIMED 30 Anos*. São Paulo: Cartaz Editorial.
- Albuquerque, A. (2012). *UNIMED, 45 anos: uma história de paixão pelo cooperativismo médico*. São Paulo: Unimed do Brasil.
- Alemayehu, B. & Warner, K. E. (2004). The Lifetime Distribution of Health Care Costs. *Health Services Research*, 39: 627–642.
- Allen, P. (2009). Restructuring the NHS Again: Supply Side Reform in Recent English Health Care Policy. *Financial Accountability & Management*, 25(4), 373–389.

- Alliance Nationale des Mutualités Chrétiennes (2016). Rapport Annuel 2015. Available at: https://www.mc.be/media/rapport-annuel-2015-mc_tcm49-31718.pdf [Accessed: February 2018]
- Allin, S. & Rudoler, D. (2014). The Canadian health care system, 2014. *International profiles of health care systems*, 21-31. Available at: http://www.commonwealthfund.org/~media/files/publications/fund-report/2015/jan/1802_mossialos_intl_profiles_2014_v7.pdf [Accessed: February 2018]
- Anderson, I., Crengle, S., Leialoha Kamaka M., Chen T. Palafox, N. & Jackson Pulver L. (2006). Indigenous Health 1 - Indigenous health in Australia, New Zealand, and the Pacific. *Lancet*. 367. 1775-85.
- Andorlini, C. & Marocchi, G. *La cooperazione sociale in ambito sanitario*. Quaderni di Idee in rete. Available at: <http://www.ideeinrete.coop/aggiunte/quaderni/quaderno04.pdf> [Accessed: February 2018]
- Anell, A., Glenngard, A. H. & Merkur S. (2012). Sweden: Health system review. *Health Systems in Transition*, 14(5):1-159. European Observatory on Health Systems and Policies. Available at: http://www.euro.who.int/data/assets/pdf_file/0008/164096/e96455.pdf?ua=1 [Accessed: February 2018]
- Angus, D. E. & Manga, P. (1990). Coop-Consumer Sponsored Health Care Delivery Effectiveness. Canadian Cooperative Association.
- Annemans, L., Boeckxstaens, P., Borgermans, L., De Smedt, D., Duchesnes, C., Heyrman, J. & Vanmeerbeeck, M. (2009). Voordelen, nadelen en haalbaarheid van het invoeren van 'Pay for Quality' programma's in België. *KCE Reports*. 118: 1-177. Available at: <https://kce.fgov.be/sites/default/files/atoms/files/d20091027350.pdf> [Accessed: February 2018]
- Armeni, P., Fenech, L., Furnari, A., Longo, F., Petracca, F. & Ricci, A. (2016). Rapporto OASI 2016. Osservatorio sulle Aziende e sul Sistema Sanitario Italiano. Centro di Ricerche sulla Gestione dell'Assistenza Sanitaria e Sociale. Università Commerciale Luigi Bocconi. Available at: http://www.cergas.unibocconi.it/wps/wcm/connect/Cdr/Centro_CERGASit/Home/Area+download+Rapporto+OASI+e+Mecosan/ [Accessed: February 2018]
- ASISA (2016). Activities report 2016. Available at: <https://www.asisa.es/informacion/actividades> [Accessed: February 2018]
- Baggott, R. (2004). *Health and Health Care in Britain*. Basingstoke: Palgrave Macmillan.
- Bahia, L. (2001). Planos privados de saúde: luzes e sombras no debate setorial dos anos 90. *Ciênc. Saúde Coletiva*, 6(2), São Paulo.
- Barkley, M. (1995). Handbook for developing a co-operative community health centre. Canadian Cooperative Association, British Columbia Region.

- Belló, M. & Becerril-Montekio, V. M. (2011). Sistema de salud de Argentina. *Salud Pública de México*, vol. 53, núm. 2, 2011, pp. S96-S108. Instituto Nacional de Salud Pública Cuernavaca, México.
- Berlinguer, G., Teixeira, S. M. F. & Campos, G. W. S. (1988). Reforma sanitária-Itália e Brasil. São Paulo: Cebes/Hucitec.
- Beveridge, S. W. (1942). Social Insurance and Allied Services. London: His Majesty's Stationery Office.
- Bridgen, P. (2007). Voluntary Failure, the Middle Classes, and the Nationalisation of the British Voluntary Hospitals, 1900-1946. In B. Harris & P. Bridgen (Eds.), *Charity and Mutual Aid in Europe and North America Since 1800*. New York: Routledge.
- Bruque Cámara, S., Hernández Ortiz, M. J., Moyano Fuentes, J. & Vargas Sánchez, A. (2002). ¿Son más competitivas las sociedades cooperativas? : un análisis en el sector de la distribución farmacéutica. Centro Investigación Información Economía Pública Social y Cooperativa – CIRIEC. N. 42, pp. 131-157. ISSN 0213-8093.
- Bruque Cámara, S., Hernández, M. J. H., Sánchez, A. V., Fuentes, J. M. (2002). Caracterización competitiva del sector de distribución farmacéutica: especial referencia al subsector cooperativo. *REVESCO: revista de estudios cooperativos*, (76), 27-50.
- Canalejo, N. P. (1991). Macrocooperativas y cooperativismo sanitario. *REVESCO: revista de estudios cooperativos*, (59), 219-222.
- Castelló, J. E. (1995). Presentación de la Fundación Espriu. Presented at *La Participación de los Socios en el Cooperativismo Sanitario: VIII jornadas de Sanidad y Cooperativismo*, 30 y 31 de marzo de 1990 (pp. 11-18), Barcelona. Fundación Espriu.
- Castilla, F. C. (1996). La intercooperación en la asistencia sanitaria: el largo camino hacia el cooperativismo sanitario integral. *REVESCO: revista de estudios cooperativos*, (62), 157-162.
- Castles, F. G., Leibfried, S., Lewis, J., Obinger, H. & Pierson, C. (2010). *The Oxford Handbook of the Welfare State*. Oxford; New York: Oxford University Press.
- Castro, H. C. O., Machado, L. Z., Walter, M. I. M., Ranincheski, S. M., Schmidt, B. V., Marinho, D. N. C. & Campos, T. A. (2008) A Satisfação dos Usuários com o Sistema Único de Saúde (SUS). *Sociedade em Debate*, 14(2): 113-134, jul.-dez.
- Cheney, G., Santa Cruz, I., Peredo, A. M. & Nazareno, E. (2014). Worker cooperatives as an organizational alternative: Challenges, achievements and promise in business governance and ownership. *Organization*, 21(5), 591-603.

- Chevreur, K., Berg Brigham, K., Durand-Zaleski, I. & Hernández-Quevedo, C. (2015). France: Health system review. *Health Systems in Transition*, 17(3): 1–218. European Observatory on Health Systems and Policies. Available at: http://www.euro.who.int/_data/assets/pdf_file/0011/297938/France-HiT.pdf?ua=1 [Accessed: February 2018]
- Conaty, P. (2014). Social co-operatives: a democratic co-production agenda for care services in the UK. Manchester: Co-operatives UK. <http://www.cooperatives-wales.coop/wp-content/uploads/2014/07/CUK-Social-Co-operatives-Report-final.pdf> [Accessed: February 2018]
- Confederación Española de Mutualidades (2016). Memoria de actividades 2015. Available at: <https://www.cneps.es/memorias> [Accessed: February 2018]
- Consorzio per la Ricerca Applicata in Sanità – CREA Sanità (2016). *12° Rapporto sanità, la Sanità tra equilibri istituzionali e sociali*. Edited by: Spadonaro, F. Università di Roma Tor Vergata. Available at: <http://www.creasanita.it/images/rapportosanita/12/EXS.pdf> [Accessed: February 2018]
- Corens, D. (2007). Belgium: Health system review. *Health Systems in Transition*, 9(2): 1-172. European Observatory on Health Systems and Policies. Available at: http://www.euro.who.int/_data/assets/pdf_file/0007/96442/E90059.pdf [Accessed: February 2018]
- Craddock, T. & Vayid, N. (2004). *Health care co-operatives in Canada*. Co-operatives Secretariat. Government of Canada. Available at: http://www5.agr.gc.ca/resources/prod/coop/doc/healthcare_coopsincan2004_e.pdf [Accessed: February 2018]
- Cylus J., Richardson E., Findley L., Longley M., O'Neill C. & Steel D. (2015). United Kingdom: Health system review. *Health Systems in Transition*, 17(5): 1–125. European Observatory on Health Systems and Policies. Available at: http://www.euro.who.int/_data/assets/pdf_file/0006/302001/UK-HiT.pdf [Accessed: February 2018]
- Datafolha (2014). Opinião dos brasileiros sobre o atendimento na área de saúde. Available at: <http://portal.cfm.org.br/images/PDF/apresentao-integra-datafolha203.pdf> [Accessed: February 2017]
- Decancq, K. (2017). Measuring multidimensional inequality in the OECD member countries with a distribution-sensitive Better Life Index. *Social Indicators Research*, 131(3), 1057-1086.
- Decreto 2065/1974, de 30 de mayo, por el que se aprueba el texto refundido de la Ley General de la Seguridad Social. Available at: <http://www.seg-social.es/prdi00/groups/public/documents/normativa/097312.pdf> [Accessed: February 2018]

- DeNavas-Walt, C., Proctor, B. D. & Smith, J. C. (2011). Income, Poverty, and Health Insurance Coverage in the United States: 2010. U.S. Census Bureau. Available at: <https://www.census.gov/prod/2011pubs/p60-239.pdf> [Accessed: February 2017]
- Department of Health (2008). High Quality Care for All - NHS Next Stage Review Final Report. London: The Stationery Office. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228836/7432.pdf [Accessed: February 2017]
- Duarte, C. M. R. (2001). UNIMED: história e características da cooperativa de trabalho médico no Brasil. *Cad. Saúde Pública*, Rio de Janeiro, 17(4): 999-1008.
- Egdell, V. & Dutton, M. (2016). Third Sector Independence: Relations with the State in an Age of Austerity. *Voluntary Sector Review*, 8(1), (25-40).
- Ellerman, D. (1990). *The Democratic Worker-Owned Firm*. London: Unwin-Hyman Academic.
- Ellerman, D. (2017). Worker Cooperatives as Based on First Principles. *Journal of Entrepreneurial and Organizational Diversity*, Volume 5, Issue 1 (2016) 20-32.
- Estrin, S., Jones, D. C. & Svejnar, J. (1987). The productivity effects of worker participation: Producer cooperatives in Western economies. *Journal of Comparative Economics*, 11(1), 40-61.
- Fédération des maison médicales (2016). Fiche d'information 2016. Available at: <http://www.maisonmedicale.org/-Statistiques-des-maisons-medicales-.html> [Accessed: February 2018]
- FEDERFARMA (2015). *La farmacia italiana 2015*. Available at: https://www.federfarma.it/Documenti/farmacia_italiana2015.aspx [Accessed: February 2018]
- Ferrè F., De Belvis A. G., Valerio L., Longhi S., Lazzari A., Fattore G., Ricciardi W. & Maresso A. (2014). *Italy: Health system Review. Health systems in transition*, Vol. 16 N. 4. European Observatory on Health Systems and Policies. Available at: http://www.euro.who.int/_data/assets/pdf_file/0003/263253/HiT-Italy.pdf [Accessed: February 2018]
- Ferrera, M., Fargion, V. & Jessoula, M. (2012). *Alle Radici del Welfare all'Italiana. Origini e Futuro di un Modello Sociale Squilibrato*. Collana Storica della Banca D'Italia. Venice: Marsilio Editori.
- Forget, E. (2002). National Identity and the Challenge of Health Reform in Canada. *Review of Social Economy*, 60(3):359-75.
- France, G., Taroni, F., Donatini, A. (2005). The Italian health-care system. *Health economics*, Volume 14, Issue S1, September 2005, pages S187-S202.

- Fraser, D. (2002). *The Evolution of the British Welfare State*. Basingstoke: Palgrave Macmillan.
- Frey, C. B. & Osborne, M. (2013). The future of employment. *How susceptible are jobs to computerisation*.
- Gidron, B., Kramer, R. M., & Salomon, L. M. (1992). *Government and the Third Sector: Emerging Relationships in the Welfare State*. San Francisco: Jossey - Bass Publishers.
- Girard, J. P. (2014). *Better Health and Social Care. How are Co-ops & Mutuals Boosting Innovation & Access Worldwide? Volume 1: Report*. International Summit of Cooperatives, 6-9 October 2014. LPS Productions. Available on the internet at: http://www.fundacionespriu.coop/wp-content/uploads/Report_LPS_Vol1.pdf [Accessed: February 2018]
- Girard, J. P. (2014). *Better Health and Social Care. How are Co-ops & Mutuals Boosting Innovation & Access Worldwide? Vol 2: National Cases*. International Summit of Cooperatives, 6-9 October 2014. LPS Productions. Available on the internet at: http://www.fundacionespriu.coop/wp-content/uploads/Report_LPS_Vol2.pdf [Accessed: February 2018]
- Girard, J. P. & Garon, I. (2000). *Les coopératives dans le domaine sociosanitaire au Québec: portrait de la situation*. Cahier de recherche, Chaire de coopération Guy-Bernier (UQAM) and Direction des coopératives, ministère de l'Industrie et du Commerce, gouvernement du Québec, 43 p.
- Glover, L. (2016). The Australian Health Care System, 2015. In: E. Mossialos, M. Wenzl, R. Osborn & D. Sarnak (Eds.), *2015 International Profiles of Health Care Systems*. The Commonwealth Fund. Available at: http://www.commonwealthfund.org/~media/files/publications/fund-report/2016/jan/1857_mossialos_intl_profiles_2015_v7.pdf [Accessed: February 2018]
- Gouveia, G. C., Souza, W. V., Luna, C. F., Souza-júnior, P. R. B. & Szwarcwald, C. L. (2009). Satisfação dos usuários do sistema de saúde brasileiro: fatores associados e diferenças regionais. *Rev Bras Epidemiologia*, 12(3): 281-96.
- Gragnotati, M., Lindelow, M. & Couttolenc, B. (2013). *Twenty years of health system reform in Brazil: an assessment of the Sistema Único de Saúde*. International Bank for Reconstruction and Development. The World Bank: Washington.
- Greer, S. L. (2016). Devolution and Health in the UK: Policy and Its Lessons Since 1998. *British Medical Bulletin*, 118(1), 16–24.
- Greer, S. L., Wilson, I., & Donnelly, P. D. (2016). The Wages of Continuity: Health Policy Under the SNP. *Scottish Affairs*, 25(1), 28–44.
- Grijpstra, D., Broek, S., Buiskool, B.J. & Plooi, M. (2011). *The role of mutual societies in the 21st century*. Policy Department A: Economic and Scientific Policy, Directorate General for Internal Policies,

European Parliament. Available at:
<http://www.europarl.europa.eu/document/activities/cont/201108/20110829ATT25422/20110829ATT25422EN.pdf> [Accessed: February 2018]

- Guisado, J. C. (2014). Pasado, presente y futuro de la Fundación Espriu. *Compartir: revista de cooperativismo sanitario*, (95), 33-35.
- Hall, K., Miller, R., & Millar, R. (2012). Jumped or Pushed: What Motivates NHS Staff to Set Up a Social Enterprise? *Social Enterprise Journal*, 8(1), 49–62.
- Hall, K., Miller, R., & Millar, R. (2016). Public, Private or Neither? Analysing the Publicness of Health Care Social Enterprises. *Public Management Review*, 18(4), 539–557.
- Hammond Ketilson, L. & Quennell, M. (1990). *Community-based Models of health care: A Bibliography*. Centre for the Study of Cooperatives. University of Saskatchewan.
- Hammond, V., MacPherson, I., & Sherman, M. (2008). *Forging Alternatives: Starting an Integrative Health Co-operative in Victoria*. Victoria: Victoria Health Co-operative.
- Harris, J. (1990). Society and the State in Twentieth-century Britain. In F. M. L. Thompson (Ed.), *The Cambridge Social History of Britain 1750-1950*. Vol. 3, pp. 63–118. Cambridge: Cambridge University Press.
- Hassenteufel, P. & Palier, B. (2007). Towards Neo-Bismarckian Health Care States? Comparing Health Insurance Reforms in Bismarckian Welfare Systems. *Social Policy & Administration*, 41: 574–596.
- Healy, J., Sharman, E. & Lokuge, B. (2006). Australia: Health system review. *Health Systems in Transition* 2006; 8(5): 1–158. European Observatory on Health Systems and Policies. Available at: http://www.euro.who.int/_data/assets/pdf_file/0007/96433/E89731.pdf [Accessed: February 2018]
- Health Co-op Saitama (2013). Iryo Seikyo Saitama: Gappei 20nen no Ayumi (20 Years of Health Co-op Saitama since a Merger).
- Henry J. Kaiser Family Foundation (2017). *Health Insurance Coverage of the Total Population*. Available at: <https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> [Accessed: February 2017]
- Hernández Bevavente, S. (2012). *Josep Espriu i Castelló. La vocació de la medicina cooperativa*. Barcelona: Cossetània Edicions.
- Himeji Medical Co-op (2016). Tsujo Sodaikai Giansho (Annual Report for AGM).

- Institut National d'Assurance Maladie-invalidité (2014). Répertoire des union nationales de mutualités. Available at: <http://www.inami.fgov.be/fr/Pages/default.aspx> [Accessed: February 2018]
- Instituto Brasileiro de Geografia e Estatística – IBGE. *Pesquisa nacional de saúde 2013, acesso e utilização dos serviços de saúde, acidentes e violências*. Rio de Janeiro: IBGE. Available at: <https://biblioteca.ibge.gov.br/visualizacao/livros/liv94074.pdf> [Accessed: February 2018]
- Instituto para el Desarrollo e Integración de la Sanidad – IDIS (2017). *Sanidad Privada, Aportando Valor. Análisis de la Situación 2017*. Madrid: IDIS. Available at: https://www.fundacionidis.com/wp-content/informes/informe_analisis_situac_idis2017_web2.pdf [Accessed: February 2018]
- Instituto de Pesquisas Econômicas Aplicadas - IPEA (2011). *Sistema de Indicadores de Percepção Social (SIPS) - Saúde*. Available at: http://www.ipea.gov.br/portal/images/stories/PDFs/SIPS/110207_sipssaude.pdf [Accessed: February 2018]
- Ishida, M. (2017). *Nokyo Koseijigyo no Rekishi to Kon-nichiteki Kadai* (History and contemporary tasks of agricultural co-op's health care business). A paper presented to the Symposium on Jan. 28.
- Izawa, S. (2015). *Saku Sogo Byoin no Chiiki Zukuri* (Community building in Saku Central Hospital in Byoin). No.74, Vol.7.
- Jaafar S., Mohd Noh K., Muttalib K. A., Othman N. H. & Healy J. (2013). Malaysia: health system review. *Health systems in transition*, Vol.3 No. 1 2013. Asia Pacific Observatory on Health Systems and Policies. Available at: http://iris.wpro.who.int/bitstream/handle/10665.1/5283/9789290615842_eng.pdf [Accessed: February 2018]
- Jetté, C. & Vaillancourt, Y. (2009). *L'économie sociale et les services de soutien à domicile au Québec: coproduction ou coconstruction?* Cahier de recherche du LAREPPS, No. 09-07, 20 p.
- Kanavos, P., Schurer, W. & Vogler, S. (2011). The pharmaceutical distribution chain in the European Union: structure and impact on pharmaceutical prices. European Commission, Brussels, Belgium. Available at: <http://eprints.lse.ac.uk/51051/> [Accessed: February 2018]
- Kawakami, T. (1988). *Noson Igaku kara Mediko Porisu Koso e: Toshikazu Wakatsuki no Seishin-shi* (From Rural Medicine to Medico-Polis Vision: Toshikazu Wakatsuki's, Intellectual History). Tokyo: Keiso Shobo.
- Kijima, A. (2016). *Ooi Mura kara 70nen (70 Years of Ooi Village Clinic)*. Health Co-op Saitama.
- Klein, R. (2010). *The New Politics of the NHS: From Creation to Reinvention (6th Revised edition edition)*. Oxford: Radcliffe Publishing Ltd.

- Kurimoto, A. (2003). Co-operation in Health and social Care: its role in Building Communities. *The Role of Volunteering and the Third Sector in Building Stronger Communities*, 58.
- Kurimoto, A., & Kumakura, Y. (2016). Emergence and evolution of co-operatives for elderly care in Japan. *International Review of Sociology*, 26(1), 48-68.
- Law, A., & Mooney, G. (2012). Devolution in a 'Stateless Nation': Nation-building and Social Policy in Scotland. *Social Policy & Administration*, 46(2), 161-177.
- Le Grand, J. (1991). Quasi-Markets and Social Policy. *The Economic Journal*, 101(408), 1256–1267.
- Le Grand, J., & Bartlett, W. (1993). *Quasi-Markets and Social Policy*. Basingstoke: Macmillan Press.
- Leal, R. M. (2014). Planos de saúde no Brasil: uma análise da regulação econômica. Tese apresentada ao Programa de Pós-Graduação em Políticas Públicas, Estratégias e Desenvolvimento. Instituto de Economia, Universidade Federal do Rio de Janeiro. Available at: http://abresbrasil.org.br/sites/default/files/poster_31_0.pdf [Accessed: February 2018]
- Ley 14/1986, de 25 de abril, General de Sanidad.
- Ley 30/1995, de 8 de noviembre, de Ordenación y Supervisión de los Seguros Privados.
- Ley 27/1999, de 16 de julio, de cooperativas.
- Ley 16/2003, de 28 de mayo, de cohesión y calidad del Sistema Nacional de Salud.
- Ley 33/2011, de 4 de octubre, General de Salud Pública.
- Library of Congress Federal Research Division (2007). *Country profile: Colombia*. Available at: <https://www.loc.gov/rr/frd/cs/profiles/Colombia.pdf> [Accessed: February 2018]
- Loi du 6 août 1990 relative aux mutualités et aux unions nationales de mutualités.
- Martí, G. (2010). SCIAS - Hospital de Barcelona, una experiencia cooperativa singular. *Compartir: revista de cooperativismo sanitario*, (78), 19-21.
- Martin García, M. C. (1996). A brief review of CES Clinicas, CLINICAS CES, S. Coop. Ltda. *Revista CIRIEC - España*, nº 62, pp. 123-126.
- Martínez, F. (1996). Cooperativa Farmacéutica Española (COFARES). *REVESCO: revista de estudios cooperativos*, (62), 127-138.
- Massuia, D. R., Mendes, S. J. D. V. & Cecilio, M. A. M. (2010). Pesquisa de Satisfação dos Usuários do

SUS/SP. São Paulo: Centro de Produção e Divulgação Científica-Secretaria do Estado de São Paulo.

McBride, G. (2012). *Agricultural cooperatives: Their why and their how*. Springer Science & Business Media.

Miller, R., Millar, R., & Hall, K. (2012). New development: Spin-outs and social enterprise: the 'right to request' programme for health and social care services. *Public Money & Management*, 32(3), 233-236.

Minami Medical Co-op (2016). *Otagaisama no Machizukuri* (Community Building based on Mutual Help).

Ministerio de Sanidad, Servicios Sociales e Igualdad (2016). Informe Anual del Sistema Nacional de Salud 2015. Available at: <https://www.msssi.gob.es/estadEstudios/estadisticas/sisInfSanSNS/tablasEstadisticas/InfAnSNSAnosanteriores.htm> [Accessed: February 2018]

Ministerio de Sanidad, Servicios Sociales e Igualdad (2015). Estadística de Centros Sanitarios de Atención Especializada - Indicadores Hospitalarios. Evolución 2010-2014. Available at: <https://www.msssi.gob.es/estadEstudios/estadisticas/estHospiInternado/inforAnual/homeESCRI.htm> [Accessed: February 2018]

Ministerio de Sanidad, Servicios Sociales e Igualdad (2015). Sistema de Información sobre listas de espera en el Sistema Nacional de Salud Available at: https://www.msssi.gob.es/estadEstudios/estadisticas/inforRecopilaciones/docs/LISTAS_PUBLICACION_DIC15.pdf [Accessed: February 2018]

Ministero della Salute (2014). Relazione sullo stato sanitario del paese 2012-2013. Available at: <http://www.rssp.salute.gov.it/rssp2012/homeRssp2012.html> [Accessed: February 2018]

Mizutani, I. (2014). *Aratana Kokyo no Ninaite no Keisei Katei ni Kansuru Bunseki:Minami Iryo Seikatsu Kyodo Kumiai no Jissen kara* (Analysis on the Formation Process of Actors of New Public Commons: From Minami Medical Co-op's Practice). Paper presented to the Japan NPO Research Association.

Monzón Campos, J. L., Antuñano Maruri, I. & Marco Serrano, F. (2010). La Fundación Espriu y sus instituciones de cooperativismo sanitario. Caso de empresa. Available at: <https://www.eoi.es/es/savia/publicaciones/19045/la-fundacion-espriu-y-sus-instituciones-de-cooperativismo-sanitario> [Accessed: February 2018]

Naruse Y. (2012). *Iryo, Kaigo, Fukushi, Anshin no Machizukuri* (Community building based on health and elderly care, welfare and security). Kyodokumiai Keiei Kenkyu No.638.

National Bureau of Economic Research (2014). Tax Breaks for Employer-Sponsored Health Insurance. Available at: <http://www.nber.org/aginghealth/2010no1/w15766.html> [Accessed: February 2018]

- National Fédération of Socialist Mutual Health Funds (2013). *Access to health Care for All*.
- Nishimura, I. (2011). *Kyodo tte Ikamo?* (Is co-operation good?). A reportage on Minami Medical Co-op, Godo Shuppan.
- NorWest Coop Community Health (2016). Annual Report 2016. Available at: <https://norwestcoop.ca/> [Accessed: February 2018]
- Office de contrôle des mutualités et des unions nationales de mutualités (2014). Rapport annuel 2014. Available at: <http://www.ocm-cdz.be/download/publi/ra2014.pdf> [Accessed: February 2018]
- Office de contrôle des mutualités et des unions nationales de mutualités (2015). Rapport annuel 2014. Available at: <http://www.ocm-cdz.be/jaarver-f.htm> [Accessed: February 2018]
- Office Des Pharmacies Cooperatives De Belgique. Les pharmacies cooperatives belges: des origines a nous jours. Available at: <http://www.ophaco.org/images/documents/90.pdf> [Accessed: February 2018]
- Pagano, R. C. V.; Massarifilho, L. G. (2014). A sustentabilidade das cooperativas médicas na saúde suplementar. Faculdade Unimed, Mostra do Conhecimento, Núcleo de Desenvolvimento Humano (NDH). Available at: <http://www.fundacaounimed.org.br/Paginas/monografia.aspx> [Accessed: February 2018]
- Paim, J., Travassos, C., Almeida, C., Bahia, L. & Macinko, J. (2011). O sistema de saúde brasileiro: história, avanços e desafios. Saúde no Brasil.
- Paim, J., Travassos, C., Almeida, C., Bahia, L. & Macinko, J. (2011). O sistema de saúde brasileiro: história, avanços e desafios. Saúde no Brasil.
- Panayotof-Schaan, L. (2009). An overview of health co-operatives: a case-study perspective using Canadian and international examples. British Columbia Institute for Co-operative Studies. University of Victoria. BCICS occasional paper series, v. 3, issue 1.
- Pérez, J. A. (2007). La Fundación Espriu y Unimed de Brasil avanzan en gestión cooperativa. *Compartir: revista de cooperativismo sanitario*, (68), 24.
- Pérez, J. A. (2014). La Fundación Espriu, la tercera mayor cooperativa de salud del mundo. *Compartir: revista de cooperativismo sanitario*, (93), 42-43.
- Pestoff, V. A. (2008). *A democratic architecture for the welfare state*. Routledge.
- Pierce, J. L., Rubenfeld, S. A., & Morgan, S. (1991). Employee ownership: A conceptual model of process and effects. *Academy of Management review*, 16(1), 121-144.

- Porto, S. M., Ugá, M. A. D. & Moreira, R. S. (2011). Uma análise da utilização de serviços de saúde por sistema de financiamento: Brasil 1998 -2008. *Ciência & Saúde Coletiva*, 16(9): 3795-3806.
- Prince Albert Co-operative Health Centre (2012). Co-operative Health Centre Community Clinic 50th anniversary, 1962-2012. Prince Albert, Saskatchewan, S6V 0V7.
- Proposición de Ley sobre la Universalización del Derecho a la Asistencia Sanitaria Pública, septiembre 2016.
- Rago, S. (2012). *Italian mutual benefit societies: an organizational social innovation in health and healthcare system* (No. 113-2012). Associazione Italiana per la Cultura della Cooperazione e del Non Profit
- Real Decreto 1088/1989, de 8 de septiembre, por el que se extiende la cobertura de la asistencia sanitaria de la Seguridad Social a las personas sin recursos económicos suficientes.
- Real Decreto 1430/2002, de 27 de diciembre, por el que se aprueba el Reglamento de mutualidades de previsión social.
- Real Decreto-ley 16/2012, de 20 de abril, de medidas urgentes para garantizar la sostenibilidad del Sistema Nacional de Salud y mejorar la calidad y seguridad de sus prestaciones.
- Registry of co-operative societies (2016). Annual report on the cooperative societies in Singapore. Ministry of culture, community and youth. Available at: <https://www.mccy.gov.sg/~media/MCCY-corp/Publications/Annual-Reports/Co-op-ARFY15.ashx> [Accessed: February 2018]
- Rice, T., Rosenau, P., Unruh, L. Y., Barnes, A. J., & Saltman, R. B. (2013). United States of America: health system review. *Health systems in transition*, 15(3), 1-431.
- Robert-Cliche Health Solidarity Cooperative. Financial Statements as at December 31, 2016, 15 p.
- Robert-Cliche Health Solidarity Cooperative (2013). Robert-Cliche Health Cooperative Presentation Paper. Health Cooperatives Working Group, 16 p.
- Robert-Cliche Health Solidarity Cooperative (2015). Annual Report 2015, 34 p.
- Robert-Clich Health Solidarity Cooperative (2014). Rural Laboratory 2009-2014, final report: Robert-Cliche development of an unprecedented model of citizen groups based on prevention practices and Hans Kai Health Promotion, 80 p.
- Robert Wood Johnson Foundation (2007). Percentage of Nonelderly Americans Without Health Insurance Coverage, 1987-2006. CovertheUninsured.org, a project of the Robert Wood Johnson Foundation. Available at:

<https://web.archive.org/web/20071019085933/http://covertheuninsured.org/factsheets/display.php?FactSheetID=101> [Accessed: February 2018]

- Rodá, L. M. (1996). La intercooperación en la asistancia sanitaria. *REVESCO: revista de estudios cooperativos*, (62), 163-168.
- Rodrigues Costa, M. (2007). A Trajetória das Lutas pela Reforma Sanitária. *Sociedade em debate*. Pelotas. Available at: <http://revistas.ucpel.tche.br/index.php/rsd/article/download/402/356> [Accessed: February 2018]
- Rovella, A. S., & Arella, S. J. (2006). El desempeño de las cooperativas y mutuales de salud en Ila Argentina. Nuevos desafíos. Asociacion Escolar Mutualista
- Ruggeri, A., & Vieta, M. (2015). Argentina's Worker-Recuperated Enterprises, 2010-2013: A Synthesis of Recent Empirical Findings
- Ruiz, G. (2012). Quem usa o Sistema Único de Saúde? Rio de Janeiro: Portal DSS Brasil. Available at: <http://dssbr.org/site/2012/04/quem-usa-o-sistema-unico-de-saude-2/> [Accessed: February 2018]
- Rusiñol, P. (2014). Un modelo sanitario que sacude los prejuicios. *Alternativas Económicas*, nº 18. Available at: <https://alternativaseconomicas.coop/articulo/economia-social-y-colaborativa/un-modelo-sanitario-que-sacude-los-prejuicios> [Accessed: February 2018]
- Santos, I. S. (2000). Planos privados de assistência à saúde no mundo do trabalho. *Dissertação de Mestrado*. Rio de Janeiro: Escola Nacional de Saúde Pública, Fundação Oswaldo Cruz.
- Saskatchewan Federation of Labour (1964). *The First Fight for Medicare*. Regina, Saskatchewan.
- Sestelo, J. A. F., Souza, L. E. P. F. & Bahia, L. (2013). Saúde suplementar no Brasil: abordagens sobre a articulação público/privada na assistência à saúde. *Cad. Saúde Pública*, Rio de Janeiro, 29(5):851-866.
- Silva, Z. P., Ribeiro, M. C., Barata, R. B. & Almeida, M. F. (2011). Perfil sociodemográfico e padrão de utilização dos serviços de saúde do Sistema Único de Saúde (SUS), 2003- 2008. *Ciência and Saúde Coletiva*, 16(9): 3807-16.
- Tatara, K., & Okamoto, E. (2009). *Health Systems in Transition: Japan: Health System Review*. World Health Organization, European Observatory on Health Systems and Policies.
- Taylor, M. (2003). Lo Stato, il Terzo Settore e la Cultura del Contratto: l'Esperienza del Regno Unito. In U. Ascoli (Ed.), *Il welfare mix in Europa*. Rome: Carocci.
- Taylor-Gooby, P. (2002). The Silver Age of the Welfare State: Perspectives on Resilience. *Journal of Social*

- Teixeira, L. (2009). *Cooperativas médicas e planos de assistência à saúde à luz da regulação da agência nacional de saúde suplementar*. Brasília: Câmara dos Deputados.
- Thomson, S., Osborn, R., Squires, D. & Reed, S. J. (2011). *International profiles of health care systems 2011: Australia, Canada, Denmark, England, France, Germany, Iceland, Italy, Japan, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United States*. New York: the Commonwealth Fund.
- Timmins, N. (1995). *The Five giants. A Biography of the Welfare State*. London: HarperCollins.
- Torner, C. (2012). Queremos tener en toda España la misma resonancia que tenemos en cualquier otra parte del mundo: entrevista a Teresa Basurte, presidenta de SCIAS y nueva presidenta de la Fundación Espriu. *Compartir: revista de cooperativismo sanitario*, (86), 33-36.
- Torner, C. (2013). El cooperativismo sanitario es una alternativa a la crisis actual de la sanidad a escala mundial: entrevista al doctor José Carlos Guisado, presidente de la Organización Internacional de Cooperativas Sanitarias (IHCO) y CEO de la Fundación Espriu. *Compartir: revista de cooperativismo sanitario*, (89), 40-44.
- Unidad Administrativa de Organizaciones Solidarias. *Cooperativas de Salud*. Ruta Cooperativa 6. Available at: <http://www.orgsolidarias.gov.co/sites/default/files/archivos/Coop%20Salud.pdf> [Accessed: February 2018]
- Vaillancourt, Y. & Jetté, C. (2009). Les arrangements institutionnels entre l'État québécois et les entreprises d'économie sociale en aide domestique: Une analyse sociopolitique de l'économie sociale dans les services de soutien à domicile. Montréal, Québec: Les éditions vie économique.
- Vicarelli, G. (2011). Le politiche sanitarie in Ascoli, U. (a cura di). *Il welfare in Italia*. Il Mulino, Bologna, 2011, 83.
- Vieta, M. (2012). From managed employees to self-managed workers: The transformations of labour at Argentina's worker-recuperated enterprises. In *Alternative Work Organizations* (pp. 129-156). London: Palgrave Macmillan.
- Vieta, M. (2018). *From Managed Employees to Self-Managed Workers: Recovering Companies, Reviving Cooperation, and Recuperating Autogestión in Argentina*, Leiden and Chicago. Brill Academic Publishers and Haymarket Books (part of the Historical Materialism book series).
- Villela, F. (2016). Planos de saúde perdem 1,3 milhão de clientes em um ano. *Jornal Agência Brasil*. Available at: <http://agenciabrasil.ebc.com.br/geral/noticia/2016-05/planos-de-saude-perdem-13-milhao-de-clientes-em-um-ano> [Accessed: February 2018]

Wakatsuki S. (1999). *Saku Byouinshi* (History of Saku Hospital). Tokyo: Keiso Shobo.

World Health Organization (2000). *The world health report 2000: health systems: improving performance*.

World Health Organization. Available at: <http://www.who.int/en/> [Accessed: February 2018]

World Health Organization (2014). Health Statistics. World Health Organization. Available at:

http://www.who.int/about/licensing/copyright_form/en/ [Accessed: February 2018]

Zamagni, V. N. (2012). Interpreting the roles and economic importance of cooperative enterprises in a historical perspective. *Journal of Entrepreneurial and Organizational Diversity*, Volume 1, Issue 1

(2012) 21-36. Available at: <http://www.euricse.eu/wp-content/uploads/2016/06/jeodzamagniinterpretingtherolesandeconomicimportanceofcooperativeenterprisesinahistoricalperspective.pdf> [Accessed: February 2018]

6Th Global Foundation on Health Promotion. The New Leadership of Health Promotion Panel. October 17, 2016.

LINKS

<https://www.cms.gov/CCIIO/Programs-and-Initiatives/Insurance-Programs/Consumer-Operated-and-Oriented-Plan-Program.html>

<https://data.worldbank.org/indicator/SP.POP.TOTL>

www.bccm.coop

www.inami.fgov.be/fr/Pages/default.aspx

www.mc.be

www.ocm-cdz.be

www.ophaco.org

www.rais.gov.br/sitio/index.jsf

www.ic.gc.ca/eic/site/693.nsf/eng/h_00037.html

www.confecoop.coop

www.cncres.org

www.istat.it

www.bvdinfo.com/en-gb/our-products/data/national/aida

www.sncf.coop

www.bvdinfo.com/it-it/our-products/company-information/national-products/sabi

www.scb.se/en /Services/Statistics-Swedens-Business-Register/

www.uk.coop

<http://www.cremesp.org.br/>

http://www.expatica.com/fr/healthcare/french-healthcare-france-health-care-system_101166.html

http://www.fundacionespriu.coop/wp-content/uploads/Report_LPS_Vol1.pdf

<https://www.justlanded.com/english/Argentina/Argentina-Guide/Health/Healthcare>

<https://www.revista-portalesmedicos.com/revista-medica/historia-sistema-de-salud-argentino/>

<https://www.thenews.coop/97207/sector/health/argentinas-co-ops-work-state-provide-health-services/>

https://ec.europa.eu/health/sites/health/files/files/falsified_medicines/2012-06_safety-features/eusp_en.pdf

http://www.expatica.com/fr/healthcare/french-healthcare-france-health-care-system_101166.html

http://www.seg-social.es/Internet_1/Glosario/index.htm?ssUserText=M#12093

http://www.sverigeisiffror.scb.se/BE0101_12-06-2017

<https://www.privatehealth.gov.au/healthinsurance/incentivessurcharges/mls.htm>

<http://www.hspm.org/countries/england11032013/countrypage.aspx>

<https://www.mc.be/actualite/opinions/2016/pacte-mutualite.jsp>

<http://www.maisonmedicale.org/Histoire-des-maisons-medicales.html>

<http://vwgc.be/>

<https://www.gvhv-mplp.be/index.php/fr/>

<http://www.maisonmedicale.org/La-charte-des-maisons-medicales-406.html>

<http://www12.statcan.ca/census-recensement/2011/dp-pd/hlt-fst/pd-pl/Table-Tableau.cfm?LANG=Eng&T=101&SR=1&S=10&O=A>

<https://www.kidsnewtocanada.ca/care/barriers>

<https://www.ncbi.nlm.nih.gov/pubmed/25102218>

<https://www.fraserinstitute.org/studies/waiting-your-turn-wait-times-for-health-care-in-canada-2016>

http://www.cna-aiic.ca/~media/cna/files/en/the_costs_performance_canadas_health_system_e.pdf?la=en

<https://www.cma.ca/En/Lists/Medias/the-state-of-seniors-health-care-in-canada-september-2016.pdf>

http://www.cna-aiic.ca/~media/cna/files/en/fact_sheet_11_e.pdf?la=en

<https://www.thestar.com/opinion/commentary/2015/10/08/first-nations-health-crisis-is-a-canadian-problem.html>

http://www.ic.gc.ca/eic/site/693.nsf/eng/h_00037.html

<http://cdrq.coop/>

<https://www.cliniquecmi.com/>

<http://www.dossierdesante.gouv.qc.ca/>

<https://corpo.metro.ca/fr/a-propos/activites-pharmaceutiques.html>

<http://www.cegepst.qc.ca/>

<http://www.msss.gouv.qc.ca/professionnels/soins-et-services/frais-accessoires/>

<http://www.coopsanterc.com/fr/membres>

<http://www.sante.gouv.qc.ca/systeme-sante-en-bref/groupe-de-medecine-de-famille-gmf/>

<https://www.youtube.com/watch?v=FWv0pXjCMaA>

<https://www.youtube.com/watch?v=rwIugVYUjnE>

<http://www.coop-sabsa.com/partenaires/>

<http://chantier.qc.ca/?module=document&uid=867>

https://www.msssi.gob.es/estadEstudios/estadisticas/inforRecopilaciones/docs/LISTAS_PUBLICACION_DIC15.pdf

<http://www.fundacionespriu.coop/medicos-y-usuarios-que-remam-juntos/>

<http://www.ont.es/Paginas/Home.aspx>

http://www.madrid.org/cs/Satellite?cid=1354348454609&language=es&pagename=PortalSalud%2FPage%2FPTSA_pintarContenidoFinal&vest=1354348454609

<http://www.cosaga.com/comunicacion/revista-cosaga/>

<http://www.cosaga.com/cosaga/quienes-somos/>

ANNEX 1: DATA COLLECTED AND ESTIMATES FOR THE FIFTEEN COUNTRIES INVESTIGATED

As highlighted, several challenges emerged during the data collection process.

No data were found for Argentina, Malaysia, and the USA.

Available data proved to be particularly lacking as concerns users, which made it necessary to compute preliminary, and in some cases partial, estimates based on a three-step procedure.

First, we computed the average number of users per worker in the health, pharmaceutical and insurance sectors. To this end, we relied on the data available from countries that provide this information.

Second, to fill gaps for countries lacking this, we estimated the number of users (in the health, pharmaceutical and insurance sectors) by multiplying the number of employees in the sector by the ration defined at the previous point.

Finally, for each country, the total number of users was obtained by adding the estimations computed at sectorial levels. Note that final data may include double counting in some instances.

This procedure made it possible to estimate the number of users for all countries except for the United Kingdom.

ANNEX 2: NUMBER OF COOPERATIVES, TURNOVER, EMPLOYEES AND USERS IN THE STUDIED COUNTRIES

Country	Cooperative type	Year	Number of organisations	Turnover	Currency	Employees	Members	Users	Data source	Notes
Australia	Insurance	2016	19	8,127,053,112	AUD	6,331*	3,044,161*	3,044,161	Business Council of Co-operatives and Mutuals	*Data for this variable was not available for all organizations. The numbers presented in the table a count of the available data. No estimate was possible to fill in the missing entries.
	Health and social care activities	2016	156	1,116,476,024	AUD	9,322*	3,509*	600,000(e)		
	Pharmaceutical	-	-	-	-	-	-	-		
Belgium	Insurance		71	n.a.	-	14,202**	11,114,281	1,111,4281	NAMI-RIZIV, Alliance nationale des Mutualités chrétiennes, Office de contrôle de mutualités et des unions nationales de mutualités, Ophaco Belgium.	**Full time employees. Data available for: The National Alliance of Christian Mutualities (NACM), The National Union of Neutral Mutualities (NUNM), The National Union of Socialist Mutualities (NUSM), The National Union of Liberal Mutualities (NULM), The National Union of the Free and Professional Mutualities (NUFPM). *** Data Available for Maisons Medicales as Community Health Centre (CHC)
	Health and social care activities***	2014	107	1,700,000	EUR	2,000	1,200	220,000		
		2015								
		2016								
	Pharmaceutical		607 city pharmacies	1,000,000,000	EUR	3,500	13	1,800,000		
Brazil	Insurance		770	n.a.	-	45,301	n.a.		RAIS.MTb	
	Health and social care activities	2015	853	n.a.	-	47,797	n.a.	24,000,000		
	Pharmaceutical		310	n.a.	-	2,925	n.a.			

Canada	Insurance		1	****	-	****	****		Policy Coordination and Regulatory Affairs - Innovation, Science and Economic Development Canada	**** the data provider cannot release data since there is only 1 coop
	Health and social care activities	2013	129	62,603,070	CAD	1,132	148,463	381,767(e)		
	Pharmaceutical		-	-	-	-	-			
Colombia	Insurance		43	3,770,109	million COP	4,081*****	n.a.		Confecoop	*****Data for this variable was not available for all organizations. The numbers presented in the table a count of the available data. No estimate was possible to fill in the missing entries.
	Health and social care activities	2013						3,000,000		
		2015	88	2,449,089	million COP	2,357	52,647			
	Pharmaceutical		21	3,653,396	million COP	10,945	12,750	5,629,014(e)		
France	Insurance		n.a.	n.a.	-	n.a.	n.a.		French Observatory for Social and Solidarity Economy, CNCRESS	
	Health and social care activities	2014	1,576	n.a.	-	36,344	n.a.	12,257,014(e)		
	Pharmaceutical		256	n.a.	-	n.a.	n.a.			
Italy	Insurance		4	168,584,754	EUR	2,404	n.a.	2,387,941(e)	Istat and Aida	
	Health and social care activities	2014	6,731	9,039,480,510	EUR	230,764	n.a.	3,000,000		
	Pharmaceutical		21	27,136,914	EUR	229	n.a.	117,775(e)		

Japan	Insurance		1	305,349	million JPY	5,516	5462800	5,462,800	Zenkyoren, National Koseiren, HeW Co-op Japan
	Health and social care activities (Koseiren)	2014	34	748,622	million JPY	49,016	n.a.	3,833,610(e)	
	Health and social care activities (HeWCoop)	2015	110	305,349	million JPY	37,437	2,928,000	2,928,000	
Singapore	Insurance		1	3,104,195,000	SGD	1,371	n.a.	1,361,842(e)	Singapore National Co- operative Federation
	Health and social care activities	2015	3	114,152,427	SGD	900	n.a.	303,525(e)	
	Pharmaceutical		-	-	-	-	-	-	
Spain	Insurance		371	3,326,000,000	EUR	1,376	n.a.	2,550,000	SABI - Bureau Ban Dijk
	Health and social care activities	2016	88	8,489,149,000	EUR	47,555	182,883	2,264,966	
	Pharmaceutical		48	2,633,656,000	EUR	3,075	321 (29 org)	1,581,473(e)	
Sweden	Insurance		40	149,000,000,000	SEK	13,500		11,600,000	Business Register at Statistics Sweden
	Health and social care activities	2015	258	411,344,000 (106 org.s)	SEK	5,867 (197 org.s)		1,978,646(e)	
	Pharmaceutical		-	-	-	-	-	-	

UK *****	Insurance		n.a.	n.a.	-	n.a.	n.a.	n.a.	Co-operatives UK	***** data refer to co- operative and they do not include mutuals
	Health and social care activities	2012	26	54,299,721	GBP	n.a.	n.a.	n.a.		
	Pharmaceutical	2014	n.a.	n.a.	-	n.a.	n.a.	n.a.		
	Not classified		2	632,112	GBP	n.a.	n.a.	n.a.		
