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Better Health & Social Care

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

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

Jean-Pierre Girard
Lead Researcher & Editor

Volume 1: Report

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

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

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

BETTER HEALTH & SOCIAL CARE

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

Edited by Jean-Pierre Girard, LPS Productions

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

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

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

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Acknowledgments

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

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

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

Foreword

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Best co-operative regards,

José Carlos Guisado

Chairperson

Executive Summary/Highlights

Why this research?

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

How was the research carried out?

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

Key figures from the research

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

Innovation

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

Major players

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

LIST OF ABBREVIATIONS

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

Introduction

Your health is your most important asset.

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

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

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

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

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

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

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

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

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

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

PURPOSE & SCALE OF THE PROJECT

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

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

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

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

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

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

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

LIMITATIONS OF THE INFORMATION

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

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

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

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

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

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

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

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

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

Operational Definitions[13]

HEALTH COOPERATIVE

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

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

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

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

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

SOCIAL CARE COOPERATIVE

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

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

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

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

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

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

COOPERATIVE PHARMACIES

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

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

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

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

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

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

HEALTH

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

HEALTH CARE

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

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

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

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

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

MEMBERSHIP BASE: NO SIMPLE (OR PERMANENT) MATTER

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

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

HEALTH CARE: WHAT DOES IT MEAN?

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

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

FUNDING BASE: ANOTHER COMPLEX ISSUE!

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

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

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

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

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

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

HEALTH INSURANCE: A NARROW RANGE OF OPTIONS

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

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

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

So the mutual might be active in several ways:

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

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

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

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

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

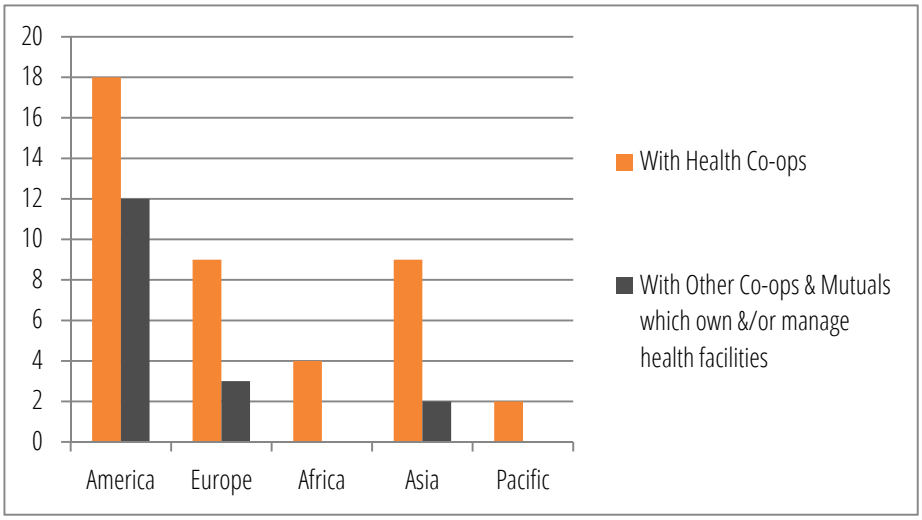
1. HEALTH CO-OPS

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

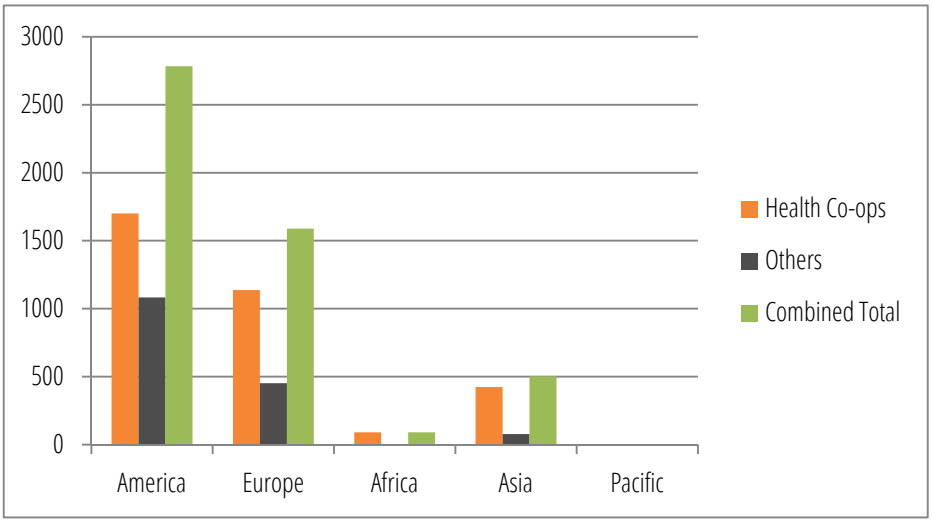
Geographical base

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

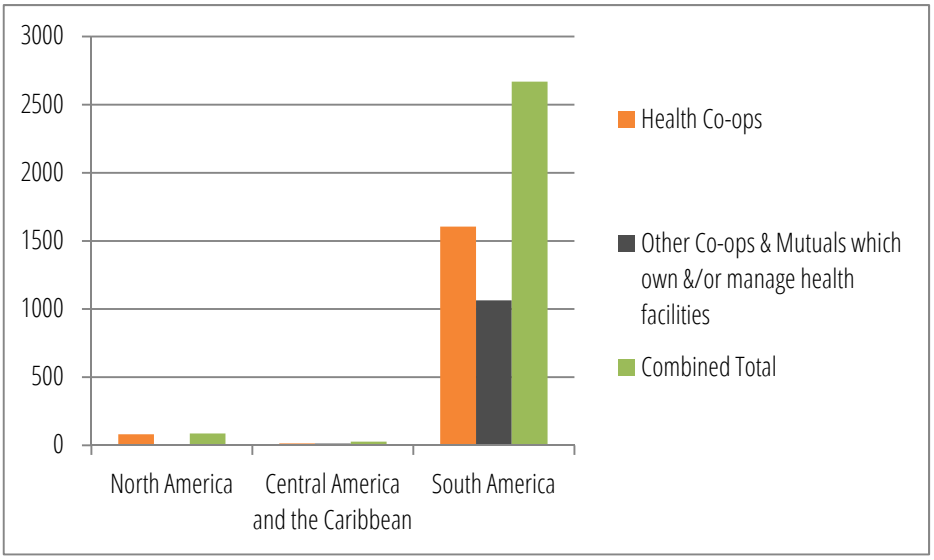
Graphic 1: Number of Countries with Health Co-ops, or with Other Co-ops & Mutuals which own &/or manage health facilities



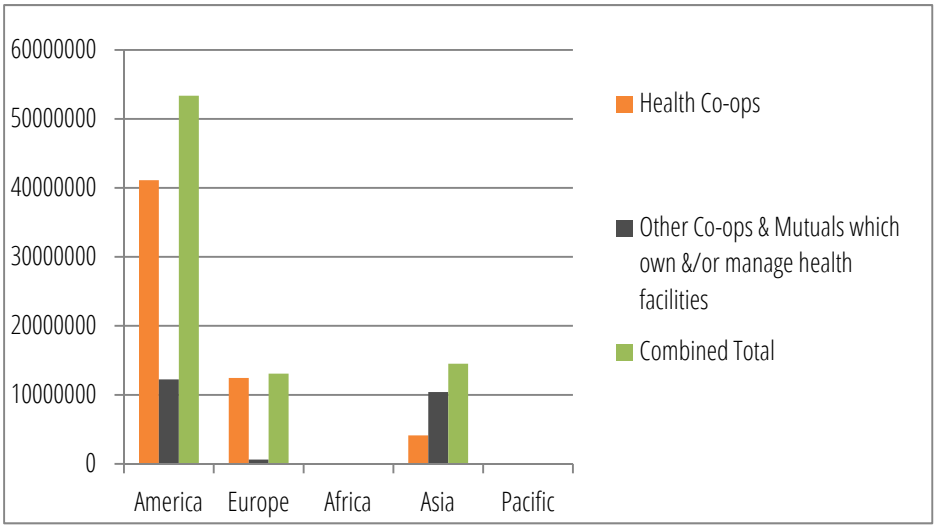
Graphic 2: Health Co-ops, Other Co-ops & Mutuals which own &/or manage health facilities, & Combined Total by Region



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



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



What about Russia & China?

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

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

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

Business Model

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

Health & Social Care

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

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

Public Recognition

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

Innovation: People First in Italy's co-ops

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

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

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

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

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

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

Innovation: Mobile Health Teams in Guatemala

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

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

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

Innovation: Personal Health Record Platform

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

4. SOCIAL CARE CO-OPS

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

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

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

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

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

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

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

5. PHARMACY CO-OPS

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

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

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

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

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

Innovation: Passion & belief in natural health!

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

6. MUTUALS & CO-OPS PROVIDING HEALTH PLANS

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

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

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

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

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

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

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

Innovation: Financial access to care

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

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

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

Mali

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

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

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

Democratic Republic of Congo

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

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

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

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

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

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

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

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

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

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

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

Table 3: Social Care Cooperatives Around the World

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

Tables 1-3: Sources

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

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

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

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

Major Players

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

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

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

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

Health co-ops in low-income countries

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

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

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

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

Coffee & cocoa production cooperatives taking action in health

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

Savings & credit cooperatives taking action in health

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

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

Mutipurpose cooperatives & health care

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

Alternative medicine & cooperatives

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

Mutuals & Health Care among Native People

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

Dentist Co-ops & Innovative Management

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

Insurance Co-ops & Health Education

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

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

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

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

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

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

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

Observations & Development Considerations

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

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

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

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

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

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

POOR & RICH

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

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

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

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

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

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

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

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

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

UNIVERSAL HEALTH COVERAGE

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

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

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

HEALTH SYSTEMS

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

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

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

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

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

DEMOGRAPHIC BOOM

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

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

AGING POPULATION

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

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

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

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

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

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

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

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

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

READINESS TO CONSIDER ALTERNATIVE PATHS OF HEALTH CARE

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

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

PROXIMITY ORGANIZATIONS: WORKING TOGETHER!

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

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

BE INNOVATIVE!

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

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

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

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

"Man.

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

Next Steps

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

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

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

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

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

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

Annex 1: Methodological Framework

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

A. THE PROCESS

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

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

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

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

The strategy for collecting the data was simple.

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

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

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

B. THE CONTENT

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

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

Population data:

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

Expenditure data:

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

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

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

BACKGROUND INFORMATION ON NATIONAL HEALTH FUNDING

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

CO-OPS & MUTUALS

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

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

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

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

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

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

THE LEGAL DIMENSION

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

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

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

CASE STUDIES

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

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

PICTURES

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

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

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

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

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

Beveridge

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

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

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

Bismarck

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

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

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

National Health Insurance Model

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

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

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

Out-of-Pocket Model

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Currently there are three main types of social insurance scheme:

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

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

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

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

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

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

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

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

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

Annex 5: Other Health Co-ops in the World

Palestine

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

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

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

Iran

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

Sri Lanka

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

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

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

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

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

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

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

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

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

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

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

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

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

Annex 7: The Project Team

RESEARCH MEMBERS

Jean-Pierre Girard

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

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

Maria Elena Chávez-Hertig

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

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

Li Zhao

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

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

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

Willy Tadjudje

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

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

Candice Mazzoleni

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

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

Laëtitia Lethielleux

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

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

Mélissa Boudes

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

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Maryline Thénot

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

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

Don McNair

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

STEERING COMMITTEE MEMBERS

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

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

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

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

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Notes

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

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

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

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

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

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

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

[11] WHO 2014a.

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

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

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

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

[16] UN 1997:7.

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

[18] UN 1997:34-35.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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[196] Like the conference which took place in Saskatoon, Saskatchewan, Canada in October 2008. See Leviten-Reid 2009 in Annex 9, Key References.
[197] In its early years, ICA published country data on cooperatives (it later focused on membership data) and then began collecting data from non-members again. The World Council of Credit Unions (WOCCU) collects world credit union statistics. The International Cooperative and Mutual Insurance Federation (ICMIF) collects data as does the Committee for the Promotion and Advancement of Cooperatives (COPAC). The UN and ILO also engage in initiatives to collect national cooperative statistical data collection on a worldwide scale.
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[209] It is worth mentioning that "Government financing has transformed from direct subsidies of government-run providers to subsidies for households to enroll in social health insurance. This financing change, often called 'moving from subsidizing the supply side to subsidizing the demand side', has been most dramatic in rural areas, where as recently as 2001 government subsidies were almost exclusively in the form of supply-side budgetary support of healthcare providers" (Eggleston, 2012: 5).
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