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ADVANCE UNEDITED VERSION*

REVIEW OF NATIONAL EXPERIENCE IN PROMOTING AND SUPPORTING THE CONTRIBUTION OF CO-OPERATIVES TO SOCIAL DEVELOPMENT:

CO-OPERATIVE ENTERPRISE IN THE HEALTH AND SOCIAL CARE SECTORS - A GLOBAL REVIEW AND PROPOSALS FOR POLICY COORDINATION

Prepared by the
United Nations Department for Policy Coordination
and Sustainable Development
in collaboration with the
International Co-operative Alliance

Geneva and New York, May 1996

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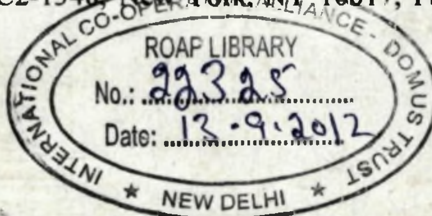

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Explanatory Note

Co-operatives are business enterprises, although they are not for-profit enterprises. A global review of the engagement of co-operatively organized business enterprises in the health and social care sectors of necessity includes some reference to individual enterprises. Indeed one of the purposes of the review is to identify enterprises engaged in this sector as a means to encourage collaboration between them, and the development of partnerships with them by Governments and other stakeholders. Nevertheless, mention of individual co-operative enterprises in this publication does not imply endorsement by the United Nations.

In United Nations editorial usage since 1991 no hyphen is used in the word "cooperative", whether or not applied to a type of business enterprise or association. However, in the international co-operative movement outside North America the hyphen is used, and is included in the titles of all individual co-operative organizations and enterprises. As these organizations are mentioned frequently throughout the Global Review, and substantial quotations are made from documents produced by them, the hyphen is used in the spelling of "co-operative" throughout for the sake of consistency in presentation.

Abbreviations

The following acronyms of organizations are used in this publication:

CECOP	Comité Européen des Coopératives de Production et de Travail Associé (European Committee of Worker's Co-operatives)
CGM	Consorzio Nazionale della Cooperazione di Solidarietà Sociale "Gino Matarelli" (Consorzio Gino Mattarelli) (Italy)
CHCA	Co-operative Home Care Associates (USA)
CICOPA	International Organization of Industrial, Artisanal and Service Producers' Co-operatives
COOMEVA	Cooperativa Medica del Valle y de Profesionales de Colombia
COLACOT	Confederación Latinoamericana de Cooperativas y Mutuales de Trabajadores
ICA	International Co-operative Alliance
ICMIF	International Co-operative and Mutual Insurance Federation
ICOM	Industrial Common Ownership Movement Limited (UK)
IHCO	International Health Co-operative Organization
ILO	International Labour Organization
JCCU	Japanese Consumers' Co-operative Union
HSB	Union of Housing Co-operatives (Sweden)
HIP	Health Insurance Plan of Greater New York (USA)
KDM	Koperasi Doktor Malaysia Berhad (Malaysian Doctor's Co-operative)
KOSIHAT	Pertubuhan Koperasi Kesihatan Malaysia Berhad (Malaysian Co-operative Health Insurance and Service Delivery System)
MCIS	Malaysian Co-operative Insurance Society
NATCCO	National Confederation of Co-operatives (Philippines)
NTUC	National Trade Union Council (Singapore)
PROMEPART	Cooperative de Servicios de Proteccion Medico Particular Ltda. (Chile)
SEWA	Self Employed Women's Association (India)
SCIAS	Sociedad Cooperativa de Instalaciones Asistenciales Sanitarias (Spain)
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNIMED	Brazilian National Confederation of Health-care Co-operatives (Unimed do Brasil)
UNSC	United Seniors' Health Cooperative (USA)
WHO	World Health Organization
WSM	Wereldsolidarieteit (Belgium)

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Preface

Since the first year of its existence the United Nations has been concerned to establish a mutually beneficial partnership with the international co-operative movement. In its first session, in 1945-46, the General Assembly granted the International Co-operative Alliance (ICA) the highest category of consultative status with the Economic and Social Council of the United Nations. Subsequently, the United Nations and the ICA have collaborated on many issues of common concern. Since 1950 the General Assembly has adopted 10 resolutions calling for the continued support of the co-operative movement throughout the world by Member States and by the United Nations system itself. The Economic and Social Council has adopted 11 resolutions on the same theme. Both the Assembly and the Council have referred to the significance of co-operatives in other resolutions, dealing with agriculture and with entrepreneurial development. By the end of 1995 ICA represented and served a total of 760,000,000 individual members of co-operative business enterprises world-wide.

In its resolution 47/90 of 16 December 1992 the General Assembly requested the Secretary-General "... to maintain and increase the support provided by the United Nations to the programmes and objectives of the international cooperative movement ...". In its latest resolution on the issue of co-operatives, 49/155 of 23 December 1994, the General Assembly requested the Secretary-General "... to continue to provide support to the programmes and objectives of the international co-operative movement".

The General Assembly, in both its resolutions 47/90 and 49/155 referred to the "broad significance" of cooperatives "in contributing to the solution of major economic and social problems". In the latter resolution it also recognized that:

> "Co-operatives in their various forms are becoming an indispensable factor in the economic and social development of all countries, promoting the fullest possible participation in the development process of all population groups, including women, youth, disabled persons and the elderly."

Both resolutions encouraged Governments "to consider fully the potential of co-operatives for contributing to the solution of economic, social and environmental problems in formulating national development strategies."

In 1987 an Interregional Consultation on Developmental Social Welfare Policies and Programmes, held in Vienna, adopted the "Guiding Principles for Developmental Social Welfare Policies and Programmes in the Near Future". These were subsequently endorsed by the General Assembly in its resolutions 42/125, 44/65 and 46/90. The Guiding Principles noted that:

> "A basic principle and objective of social welfare policy is to provide the widest possible participation of all individuals and groups, and greater emphasis needs to be placed on translating this principle into practice. This may be achieved through new partnerships in the field of social welfare policy, providing opportunities for a greater involvement of beneficiaries, individually and collectively, in decisions concerning their needs and in the implementation of programmes, including community-based programmes." (para. 11)

"Health needs, especially of the most vulnerable, can be met most effectively when integrated with social welfare activities involving not only medical and para-medical practitioners, but also community workers and health workers suitably trained in prevention and promotion techniques. ... Health costs may be contained by placing less emphasis on institutional treatment and more emphasis on ambulatory health care and by using simple medical techniques in a community context, suitably co-ordinated with other welfare activities." (para. 30)

"Social welfare is the concern not only of Governments but also of numerous other sponsors. Non-governmental and voluntary organizations, trade unions, co-operatives and community and social action groups are major sponsors of social welfare programmes that must be recognized, supported and consulted. ... (para. 38)

"There are advantages to such a diversity of sponsors and approaches including the potential for a more precise identification of needs, innovation in strategies, generating broader participation and the involvement of more resources. This may result in a need for better co-ordination of diverse activities and programmes and for a clearer delineation of areas of responsibility and function to achieve optimal effect. ... (para.39)

Among the Guiding Principles themselves was the following:

"Within the framework of national laws there is a need to strengthen the role and contribution of non-governmental and voluntary organizations, private entities and people themselves in enhancing social services, well-being and development." (49(h)).

In its resolution 44/58 of 8 December 1989 the General Assembly noted that co-operatives were called upon to contribute to the implementation of the Guiding Principles, and requested the Secretary-General to follow closely national experience in promoting co-operatives and to encourage all forms of international co-operation, in collaboration with interested governments, governmental and non-governmental organizations "as an important part of the social development strategy". It also invited the regional commission and the specialized agencies concerned to make further efforts with a view to promoting the cooperative movement as an important instrument of economic and social development "...thus contribution to the implementation of the Guiding Principles..".

The Copenhagen Declaration on Social Development adopted at the World Summit for Social Development in March 1995 committed signatories to increase significantly and utilize more efficiently the resources allocated to social development. To this end they would, among other things "utilize and develop fully the potential and contribution of co-operatives for the attainment of social development goals" (Commitment 9,(h)).

The programme of the United Nations Secretariat undertaken in response to these requests of the General Assembly has been the responsibility primarily of the Department for Policy Coordination and Sustainable Development. It includes liaison between the United Nations and the international co-operative movement, and specifically ICA, representation of the United Nations on the Committee for the Promotion and Advancement of Co-operatives (COPAC); and preparation every two years of a report on the status and role of cooperatives in changing economic and social conditions, made by the Secretary-General of the United Nations to the General Assembly.

One of its functions is to identify areas where there appears to be a significant potential for a further mutually beneficial collaboration between the United Nations system and the international co-operative movement, and

then to promote contacts between the movement and those elements of the United Nations system likely to be concerned. It is in the context of this function that the Department has prepared this paper, in close collaboration with ICA.

The purpose in preparing this global review is to clarify prerequisites for further development of the health and social care component of the international co-operative movement, largely by use of its own resources, but with the possible support of relevant agencies of national, regional and local governments and of the relevant specialized agencies and bodies of the United Nations system.

It should be emphasized that this paper is not based on any comprehensive evaluation of individual health or social care co-operatives. Rather it is based upon insights arising from consideration of the rather limited literature available, identification of what appear to be common problems, and evaluation of certain solutions already tried or under consideration. However, it also draws upon the wider experience accumulated by the United Nations of the promotion of partnerships between intergovernmental and governmental organizations and the international co-operative movement.

Because this may be the first comprehensive review of the matter, and because information is highly dispersed and not likely to be accessible to many readers, it was thought appropriate to include a considerable amount of information descriptive of the actual situation and the processes whereby this has developed. This is set out in Chapters II, III and IV. While every effort was made to undertake a comprehensive review of all known health co-operatives, this was not done for social care co-operatives, in respect to which information is intended to be illustrative only.

The United Nations Secretariat wishes to acknowledge the very substantial support provided in the form of information and specialist comment by many organizations and individuals during the preparation of this global review. Its preparation was possible only with the close collaboration of ICA under the direction of the Director-General, Mr. Bruce Thordarson. Through its UN/Development Liaison Officer, Ms. MariaElena Chavez, and its Documentation Officer, Ms. Alina Pawlowska, ICA provided information from the data bases maintained at its headquarters and at its regional offices; invited a representative of the Secretary-General to participate in the International Forum on Co-operative Health and Social Care which it organized at Manchester, United Kingdom in September 1995; circulated a first draft of the global review to other participants at this Forum, to members of the Steering Group responsible for preparing the establishment of the International Co-operative Health Organization, to be one of ICA's specialized organizations, as well as to other member organizations and specialists; and channelled comments and information received from them to the Secretariat; requested information from all relevant co-operative organizations world wide via the INTERNET and channelled responses to the Secretariat. The organizer of the International Forum, Dr. Arsenio Invernizzi, commented on and made suggestions for revision the first draft.

Mr. Hans Dahlberg, Chief Executive Officer of the International Co-operative and Mutual Insurance Federation (ICMIF), a specialized organization of ICA, made comprehensive comments on the first draft, which he circulated also to those members of ICMIF's Insurance Intelligence Group responsible for development of information and research in health and social care. ICMIF also provided the report of its 1995 Conference, held at Manchester, United Kingdom, as well as papers presented at a seminar held at the Conference on "social welfare provision - a fitting opportunity in an opening market?"

Most of those co-operative enterprises active in the health and social care sectors, including co-operative insurance enterprises, as well as co-operative research institutions and university departments of co-operative studies,

whose activities are referred to in the review, provided annual reports and other published materials and specially prepared comments and information, as well as, in some cases, comments on a first draft. Substantial comments were made, and information provided, by Professors Roger Spear and Johanan Stryjan, Chairman and one of the Vice-Chairmen of ICA's Committee on Co-operative Research respectively; Dr. Yehudah Paz, Director and Principal of the International Institute (Histadrut), Israel; Mr. Iain Williamson, Chief Information Officer, Co-operative Union Ltd., United Kingdom; Mr. Peter Walker, Chief Executive, the United Kingdom Co-operative Council; Mr. K. Blomqvist of the Swedish co-operative insurance enterprise Folksam on behalf of ICMIF; Mme. Jeanine Devuyst of the Association of European Co-operative and Mutual Insurers (ACME); M. Didier Wafflard of the Belgian co-operative insurance enterprise P & V Assurances; and Dr. Manuel Canaveira de Campos, President of the Institute António Sérgio do Sector Cooperativo in the Presidency of the Council of Ministers, Portugal.

Mr. Shoji Kato, Chairman of the Medical Co-op Committee of the Japanese Consumers' Co-operative Union (JCCU), commented extensively on an early draft. Dr. E. Castilho, President of the Brazilian National Confederation of Health - care Co-operatives (Unimed) provided comprehensive material on this organization and the development of health co-operatives in Latin America. Christine Kushner of the University of North Carolina provided preliminary versions of a number of research papers on the development of health co-operatives in the United States. Dr. José Espriu, founder and President of the Espriu Foundation, Barcelona, provided information on the concept of integrated health co-operation and the development of health co-operatives in Spain. Professor Johnston Birchall of Brunel University in the United Kingdom, editor of the Journal of Co-operative Studies, prepared especially for this the Global Review a note on the history of co-operative involvement in health and social care in the United Kingdom. Professors Yvan Comeau and Jean-Pierre Girard of the Chaire de coopération Guy-Bernier at the Université du Québec à Montréal kindly provided advance copies of a study on health co-operatives in eleven countries which was published later in 1996 by the University. The Co-operative Branch of the International Labour Organization (ILO) supplied information on its interregional programme on the promotion of social services through social economy.

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I. TYPOLOGY OF CO-OPERATIVE ENTERPRISES BASED ON THE NATURE OF THEIR ENGAGEMENT IN THE HEALTH AND SOCIAL CARE SECTOR

A. Basis of the taxanomic system

The business activities of almost all co-operative enterprises have an impact upon the health and well-being of their members and employees and their dependents. In many cases they have an impact also on non-member users and other persons in the communities in which they operate, and, often, even if only indirectly, on persons elsewhere in national society.

Some co-operatives are engaged in the health and social care sector itself, providing health and other relevant insurance, and health and social care services to their user-members or other users; others have an impact through, for example, the nutritional quality of the foodstuffs they produce, process or retail; many do so through their concern for the occupational health of their worker-members and employees; while many of these, as well as other co-operative enterprises, provide health insurance coverage to their members or employees.

Many co-operatives engaged in the health sector itself extend the services they provide to their members or other affiliated users from curative to both preventive and rehabilitative programmes, and from there into associated areas of medical social work, and provision of social care services. These may be of a preventive nature, concerned with the promotion of healthy living and individual well-being within families and communities. They seek to identify conditions which may have consequences for social well-being and health. Others may be within the rehabilitative area.

These areas of concern generally extend to situations of social integration in the sense of the assimilation or acculturation of individuals, families and communities who are in some sense different and for this reason disadvantaged and marginalized within the host community. This leads into the larger area of the contribution of co-operative enterprises to the avoidance, alleviation or overcoming of poverty and all its associated and resultant conditions. The review will not extend into these broader areas, although reference will be made to them to the extent that they form the context of the narrow focus.

While the focus of the present paper is that part of the co-operatively organized sector of the market which is directly concerned with provision of health and social care services, it is thought useful to consider this activity within the broader context of the impact of the entire co-operative movement or sector upon health and social well-being. By this means the actual and potential alliances and operational relationships between different types of co-operative enterprise in respect to their total contribution to health and social care may be better explored, and a strategy proposed which will attempt to make greater use of the very large possibilities for mutual support within the wider co-operative movement.

Given the diversity of types of co-operative enterprise involved, it was thought necessary, before moving to an evaluation of progress made, and an identification of the areas of possible further development, to clarify the nature of the relationship between the activities of the co-operative movement and health and social well-being. This will be done by means of a typology of co-operative enterprises based on the nature of their impact upon the health and social well-being of the communities in which they operate.

Design of a typology based upon characteristics which are functionally relevant to the goal of achieving health and well-being for all members, their dependents and their communities serves to ensure a better understanding of the contribution of each part of the co-operatively organized sector, and hence the nature of their actual and potential relationships and the most effective means of combining their efforts. It also reduces confusion, given that there are many distinct types of co-operative enterprise among those having direct and indirect, intentional and unintentional impact upon health and well-being, and particularly given that each of these may have been given different names in different countries and periods of their development.

A typology which encompasses all types of co-operatives, that is the entire co-operatively organized sector of a national society, but which leads to a focus on health and social care co-operatives, can be established on the basis of responses to the following questions:

(a) do the activities of the co-operative enterprise have an impact upon health and social well-being within the national society in which it operates ?

(b) is it the primary or sole purpose of the co-operative to have this impact?

(c) is impact achieved directly, that is by the provision of health and/or social care services? or by provision of health and related insurance products? or by both activities?

(d) does the co-operative provide only health services, or does it combine these with social care services, or does it provide social care services only? or does it provide only health and related insurance products, or these in combination with other types of insurance?

(e) is the co-operative owned by its users, that is those whose health and social well-being is affected?

(f) if the activities of the co-operative enterprise do not include provision of health and social care services or insurance, but have an impact upon health, what type of activity has such an impact? Is this the sole or primary activity of the co-operative?

(g) if the activities of the co-operative have no direct impact upon health or well-being, do they nevertheless include in their business goals the provision of support for the operations of co-operatives directly involved (such as financial services)?

An initial brief listing of the principal types of co-operative whose activities contribute to an improvement in health and social well-being is set out below. A summary of the taxonomic system is presented in Figure 1. The characteristics of each type and subtype are examined in more detail thereafter.

B. Summary list of types of co-operative engaged in health and social care

Co-operative enterprises owned by users

- **user-owned health co-operatives**, operated as fully independent primary level enterprises, and owned and directly controlled by their members independently of any other of their affiliations with co-operative enterprises, for the purposes of obtaining effective and affordable

health insurance, or health services, or both for themselves and their dependants;

- **user-owned health co-operatives,** operated as fully independent primary level enterprises and owned and directly controlled by their members, but affiliated either through simultaneous membership or organizational linkages with broad co-operative movement;

- **user-owned health co-operatives,** operated as autonomous primary enterprises but sponsored by a broader co-operative or trade union organization with which there are operational linkages and common membership;

- **user-owned health co-operatives,** operated as autonomous primary enterprises but sponsored by provider-owned health (medical) co-operative organizations with which there is no common membership but close operational linkages;

- **user-owned comprehensive systems of health and social care insurance and service delivery** operated as specialist subsidiaries of co-operative organizations;

- **health insurance and services provided by user-owned co-operative enterprises in other sectors** to members, employees and their dependents, as a benefit of membership or employment, by means of a specialized department or subsidiary enterprise (but not by means of an autonomous health co-operative enterprise);

- **primary level jointly-owned (user- and provider-owned) "multi-stakeholder", or "interested parties" health co-operatives;**

- **all co-operatives** which provide high standards of occupational health to worker-members and employees, promote improved occupational health by enterprise members and safety in the home for individual members, and seek to reduce environmental hazards to health in the communities where they operate;

- **user-owned social care co-operatives** operated as fully independent primary level enterprises and owned and directly controlled by their members;

- **jointly-owned (user- and provider-owned) or "multi-stakeholder" or "interested parties" social care co-operatives** operated as fully independent primary level enterprises and owned jointly by users, providers and other interested parties;

- **provider-owned social care primary co-operatives** established, owned and controlled by groups of professional social care providers as a means to enjoy satisfactory working conditions, protect their economic and professional interests, and satisfy their concerns to make available affordable and appropriate social care services to sections of the population otherwise inadequately served. Usually membership includes also other individual and institutional "interested parties", such as representatives of organizations of persons needing social care, trade unions and local government authorities;

- **social care services provided by user-owned health co-operative enterprises** as an extension of their preventive and rehabilitative community-based services;

- **social care services provided by user-owned co-operative enterprises in other sectors** to members, employees and their dependents, as a benefit

of membership or employment, by means of a specialized department or subsidiary enterprise (but not by means of an autonomous social care co-operative enterprise);

- **co-operative insurance enterprises**, in some cases owned and controlled directly by individual policy-holders, but more usually indirectly through individual membership in other co-operative enterprises and organizations which are the owners, and providing health insurance, as well as accident, disability and life insurance relevant to prevention and rehabilitation;

- **primary level user-owned co-operative pharmacies**, established by consumers as a special form of retail co-operative, but with additional health promotion, prevention and education functions;

- **pharmacy departments** within stores and supermarkets operated by consumer-owned retail co-operatives;

- **secondary level co-operative networks owned by user-owned co-operative pharmacies** in order to undertake bulk purchases, common service and marketing functions;

- **food processing, manufacturing and distribution co-operatives** owned by retail co-operatives and ensuring the supply of nutritionally appropriate and safe foods to enterprises;

- **retail co-operatives** providing unadulterated and nutritionally correct foods at affordable prices, as well as consumer education services to members, other customers and the communities in which they operate;

- **housing and community development co-operatives** providing utilities, sanitation, consumer protection advice, preventive health and health education, rehabilitation and social care;

- **environmental management, sanitation and cleaning co-operatives** contributing to health through an improved built environment;

- **financial co-operatives (savings and credit co-operatives ("credit unions") and co-operative banks)** assisting individuals with financial management, thereby reducing stress and helping them meet costs of shelter, nutrition, health and social care;

- **financial co-operatives (savings and credit co-operatives ("credit unions")** and **co-operative banks)** supplying affordable capital to health and social care sectors co-operative enterprises;

- **co-operative research and development organizations** engaged in policy development and improvement in operational efficiency in the health and social care sectors;

- **co-operative media enterprises**, and media facilities operated by other co-operatives, diffusing information on health, nutrition and social care;

- **co-operative education enterprises** providing professional, managerial and administrative training in the health and social care sectors;

Co-operative enterprises owned by individual providers

- **primary level provider-owned health co-operatives**, established, owned and controlled by groups of health professionals, but in some cases dentists, nurses or medical technicians, usually doctors, as a means to

enjoy satisfactory working conditions, protect their economic and professional interests, and satisfy their concerns to make available affordable and appropriate health services to sections of the population otherwise inadequately served;

- **health insurance and services provided by provider-owned co-operative enterprises in other sectors** to members, employees and their dependents, as a benefit of membership or employment, but means of a specialized department or subsidiary enterprise (but not by means of an autonomous health co-operative enterprise);

- **social care services provided by provider-owned co-operative enterprises in other sectors** to members, employees and their dependents, as a benefit of membership or employment, by means of a specialized department or subsidiary enterprise (but not by means of an autonomous social care co-operative enterprise);

- **worker-owned labour-contracting co-operatives in health and social care sectors** providing, for example, building maintenance, catering, cleaning, security, or parking supervision services, or acting as employment agencies for members (i.e. providing labour directly within sector facilities, as a complement to their own labour force);

- **worker-owned primary level health and social care sector supply co-operatives**, whose members constitute the work-force and which either manufacture special inputs (medical equipment, special furniture, etcetc) or supply services (ambulance drivers, accountants, lawyers, facility architects and equipment designers, etcetc); (i.e. providing goods and services created by application of labour outside sector facilities);

- **secondary level co-operative networks** owned by primary level **worker-owned health and social care sector** support co-operatives;

Co-operative enterprises owned by non-co-operative enterprise

- **secondary health services delivery co-operatives** owned by groups of non-co-operative enterprises;

- **secondary level provider-owned health co-operative networks** owned by independent self-employed health providers (doctors' or dentists' solo- and group-practices);

- **secondary health insurance purchasing co-operatives** owned by non-co-operative enterprises;

- **secondary level co-operative networks owned by independent for-profit pharmacies**, set up in order to undertake bulk purchasing, common service and marketing functions;

- **enterprise user-owned secondary level health sector support co-operatives**, owned by facilities such as hospitals and clinics (in public, co-operative, private for-profit and private not-for-profit sectors) for the purpose of making bulk purchases and providing common services such as financial and personnel management, specialist medical services, temporary staff administration, legal services and insurance;

- **agricultural and fisheries purchasing and marketing co-operatives** owned by independent producers, and **primary producer co-operatives in agriculture and fisheries** processing and marketing nutritionally appropriate and safe foods;

The types of co-operative are listed above in three groups: those owned by consumers (users, clients or beneficiaries); those owned by workers (providers or producers); and these owned by enterprises, including for-profit firms. In the remainder of the chapter, however, these types are organized into groups according to the extent to which their business goals are concerned with health and social care.

C. Co-operative enterprises whose business goals are solely concerned with health and social care

This type includes co-operative enterprises whose original and current sole or primary function is to provide either health or social care services, or both, to users. A basic distinction is made between co-operatives primarily providing health services, but which in some cases also provide social care services, and those co-operatives providing social care services (none of which also provide health services).

[1.1] Co-operative enterprises providing health services to individuals (health co-operatives)

A distinction is made between a first group of health co-operatives, which are user-owned,
a second group which are owned jointly by users and providers of health services, and a third group owned by providers only.

The terminology used in respect to co-operatives of this type varies between countries and organizations, and over time. There is some tendency in English-language usuage to refer to user-owned co-operatives as "health co-operatives" and to those which are provider-owned as "medical co-operatives". This would imply that the intermediate group would be termed "joint health/medical co-operatives". User-owned preference for "health" and provider-owned preference for "medical" may have developed at a time when user-owned enterprises were engaged in health maintenance, in contrast to provider-owned enterprises, which were concerned very largely with curative, and to some extent rehabilitative services, which might be termed "medical". However, there has been a trend toward the latter type adding a substantial preventive component, including concern for broad programmes of "healthy living", implying that medical interventions are only one among several valid approaches to achievement of health. Consequently, the broader term "health co-operative" appears to be appropriate even in the case of provider-owned co-operatives engaged in the health sector.

The Brazilian provider-owned health co-operative system, Unimed, refers to itself in English translation as the National Confederation of Health-care Co-operatives. User-owned co-operatives have had a similar emphasis upon broad preventive approaches for an even longer period, so that the term "health co-operative" has always been particularly appropriate for them. It should be noted, however, that for purposes of translation into English, the Japanese consumer co-operative movement prefers to use the term "medical co-op" or "medical-health" co-operatives for user-owned enterprises. In view of this convergence of emphases, use of the term "health co-operative" appears to be the most appropriate as a general description of this type of co-operative enterprise, and will be adopted in this review.

Use of the term "health co-operative" to include both user-owned and provider-owned enterprises has been acknowledged very recently by the co-operative movement itself. The Draft Rules of the International Health Co-operative Organization, adopted in January 1996 by a Steering Committee responsible for setting up this specialized body of ICA, describe the

Organization as "a forum for consumer and producer health co-operatives". These are described as "co-operative organizations which ... have as their main or partial objective the provision of health care to their members or the provision of self-employment for health professionals".

However, some variety in English-language terminology still exists. In some countries the term which has been used is "health care co-operative" (or "dental care co-operative"). In Saksatchewan, Canada, individual user-owned health co-operatives are referred to as "community health service associations", but the secondary organization in Saskatchewan which brings together five such associations has the name "Federation of Health Co-operatives". In British Columbia a similar user-owned health co-operative is termed a "health services society". In India and Sri Lanka such co-operatives are often termed "hospital co-operatives". In Sweden a proposed model for a community-based but user-owned health co-operative was termed a "Medikoop" (in Swedish).

In the United States a number of user-owned health co-operatives describe themselves as "group health co-operatives" or "group health associations". Others term themselves "community health centres". Because they combine service delivery with a health insurance system (or "plan") some are termed "group health plans" or "family health plans", "metropolitan health plans" or "community health plans", or "health insurance plans". A few are termed "family health plan co-operative". Generically, they are designated "health maintenance organizations (HMOs)", with the qualification that they are co-operatively organized, as distinct from other types of HMO, which may be not-for-profit (but not co-operatively organized) or for-profit enterprises. However, only a few term themselves "co-operative health maintenance organization", or "group health co-operative health maintenance organization". Some user-owned health co-operatives have names which give no indication of their co-operative character - for example, "Health Partners". In the United States the term "health cooperative" has been applied also to a secondary purchasing, supply and service network owned by independent hospitals.

Provider-owned co-operatives refer to themselves variously as "co-operative health clinics", "hospital and health services co-operative", or "general practitioners'/doctors'/specialists', co-operative".

Social care co-operatives frequently designate themselves on the basis of function - e.g. child-care co-operatives, nursery co-operatives, pre-school co-operatives, co-operative creches, home care co-operatives, co-operative residences/residential co-operatives, nursing home co-operatives, disabled persons special workplace co-operative, sheltered work-placé co-operatives, rehabilitation co-operatives. In Italy a distinction is made between "social care" co-operatives and "social employment" co-operatives, the latter being the equivalent of sheltered workshop co-operatives. A small proportion of "social care" co-operatives in fact specialize in health service delivery.

Some variety in terminology exists also in French and Spanish. In French a comprehensive review of both user- and provider-owned co-operatives in eleven countries terms them "coopératives de santé". A system of distinct but affiliated provider-owned and user-owned co-operatives in Spain has been termed in French "le complexe coopératif de soins de santé". Social co-operatives are termed simply "coopératives sociales", or "coopérative d'initiative sociale"

In Spain a specific provider-owned health co-operative has been designated "autogestio sanitaria". A hospital co-operative has been designated "Sociedad Cooperativa de Instalaciones Asistenciales Sanitarias". In discussion of the topic, although not as a designation of an actual co-operative enterprise in the health sector, the term "cooperativa de salud" has been used. The entire area of co-operative engagement in the health sector

is termed "cooperativismo sanitario". When referring to the movement which has brought into close association provider-owned and user-owned enterprises, the term "cooperativismo sanitario integral" has been used.

In some countries, particularly those formerly socialist countries where health and social security systems were closely associated with enterprise-based eligibility, the term "medical co-operative" is the term in English translation used by the organizations themselves to refer to the health services department of a co-operative enterprise or larger co-operative organizations.

[1.1.1] User-owned health co-operatives

[1.1.1.1] User-owned health co-operatives operated as fully independent primary enterprises not affiliated with any other co-operative enterprise or organization

This basic type of user-owned health co-operative is a fully autonomous enterprise operating at the primary level. It is owned and directly controlled by its members who, in establishing or maintaining their co-operative, do so independently of any other affiliation they may have simultaneously with another co-operative enterprise or organization. Its *original primary business goals (and usually its only goals) are to maintain* the health status of members and their dependents, if this is already satisfactory, or to improve that status, if not yet satisfactory. The co-operative is an organizational means whereby the group of individuals who are its members empower themselves in respect to both environmental processes relevant to their health, and to other institutions engaged in the health sector. Members, who are the owners as well as the actual or potential users or clients of the enterprise, may represent themselves alone or, additionally, members of their families, households or other dependents within a wider support system.

This type of health co-operative combines health insurance and service delivery functions: they manage their own autonomous health insurance fund (or "plan", in the United States), and they deliver directly at least part of the total of services they require in order to maintain their health, or to recover it when ill.

In the United States this type of health co-operative is considered to be one sub-type (that which is co-operatively organized) of enterprises termed "health maintenance organizations" (HMOs), some of which are not-for-profit, other for-profit enterprises.

Principal variants of this basic type can be identified in terms of organizational structure and operational processes, both of which are closely related to phases in their development over time. It seems possible to distil from the actual experience of this type of health co-operative what might be described as a "normal" developmental trajectory, as part of which both function and organization change. Naturally there are numerous variants of this trajectory and each existing user-owned health co-operative has had its own unique experience and hence character.

The following are the principal developmental phases defined in terms of activities and organization structure:

[phase A] Use of collective self-help activities without external resources; actions on the natural and built environment as preventive measures; pooling of indigenous experience and knowledge, including particularly that held by specialists (for example, indigenous physicians and midwives); pooling of internal labour in order to provide curative or

rehabilitative care, including collection and processing of indigenous drugs, special foods and other materials; and pooling of resources, financial and in kind, as an insurance against conditions of individual ill-health and/or disability. **[type 1.1.1.1/A]**

[phase B] Use of combined resource (member shares, fixed pre-payments), predominantly financial, but in difficult conditions also in kind, in order to constitute a mutual assistance fund for health insurance from which to purchase as required external professional care, equipment and medicines, including physician and nursing services and access to clinics and hospitals. External purchasing may involve initially ad hoc fee-for-service arrangements, then, usually as a later development, agreement on pre-paid contracts. Subsequently, there may develop group participation in health insurance programmes operated by external private enterprises or public agencies **[type 1.1.1.1/B]**.

[phase C] Use of combined resources (member shares, member loans, fixed pre-payments) to establish the co-operative's own facilities (usually by stages: first clinics, then hospitals, perhaps first leased, then owned although mortgaged, then freely held), to employ own professional, para-professional and support personnel, and to develop increasingly comprehensive health insurance programmes **[type 1.1.1.1/C]**.

[phase D] Diversification and extension of services by means of own staff and facilities, or by establishing operational links with specialist facilities and institutions **[type 1.1.1.1/D]**.

[1.1.1.2] **User-owned health co-operatives operated as fully independent primary enterprises but affiliated either through simultaneous membership or organizational linkages with a broad co-operative organization**

This type of health co-operative is established by persons who are already members of a co-operative enterprise or organization (for example, a consumer-owned retail co-operative or an agricultural co-operative organization). They are operationally autonomous enterprises and may develop their own secondary and tertiary organizations. Because of the coincidence of membership, however, some form of affiliation at all levels usually develops within the context of the broader co-operative organization.

[1.1.1.3] **User-owned health co-operatives operated as autonomous primary enterprises but sponsored by broad co-operative or trade union organizations with which there are operational linkages and common membership**

This sub-type of health co-operative is established not by means of the initiatives of some of the individuals who become members, as is the case for sub-types 1.1.1.1 and 1.1.1.2, but rather by a tertiary level organization as a means to provide existing membership with a service. In this sub-type the organizational means chosen is that of an autonomous primary health co-operative, rather than as a subsidiary of, or department within, the apex organization itself, as is the case in type 1.1.1.5.

[1.1.1.4] **User-owned health co-operatives operated as autonomous primary enterprises but sponsored by provider-owned health co-operative organizations with which there is no common membership but close operational linkages**

This sub-type of health co-operative is established by a provider-owned co-operative organization in the form of an autonomous enterprise but with functions which are similar to those of an organizational affiliate.

Membership of the user-owned affiliate is different from that of the sponsoring provider-owned organization.

[1.1.1.5] **User-owned comprehensive systems of health and social care insurance and service delivery operated as specialist subsidiaries of co-operative organizations**

In some cases co-operative organizations representing enterprises at national level have established their own subsidiary organization specifically in order to provide comprehensive health and social care insurance and service delivery to all members and employees, and their dependents, in all component organizations and enterprises. In some instances this is undertaken in close collaboration with trade unions. The subsidiary organization operates its own facilities in all areas where members require services.

This arrangement is similar to that of some co-operative insurance enterprises, except that service delivery is integrated with insurance functions. It differs from types 1.1.1.2 and 1.1.1.3 in that the facilities it operates are not autonomous health co-operatives but branches of a national level subsidiary of the co-operative apex organization.

User-owned comprehensive systems of health and social care insurance and service delivery operated as mutual, not co-operative, organizations

Although not included as a type within the classification system adopted for the purpose of this review, a brief reference is included [Chapter II, section J) because of the broad similarities with some co-operative approaches and the implications thereof for policy development in respect to co-operatives in health and social care, and relationships between co-operatives and other stakeholders.

[1.1.2.] **Jointly owned (user- and provider- owned) health co-operatives**

A new health co-operative can originate by means of the joint action of prospective users and prospective providers, and can be constituted as a jointly-owned enterprise from the outset. This can be seen as constituting one sub-type **[1.1.2.1]**.

A second type of situation arises primarily as a phase in the development of existing health co-operatives, whether of one or other of the main types: user-owned or provider-owned. In the former case, members of a user-owned health co-operative bring into full membership the professionals who have been staff employees hitherto **[1.1.2.2.1]**. In the latter case, the situation described in respect to the first sub-type of provider-owned health (medical) co-operatives [1.1.3.1], in which there is usually a strong concern by the health professionals who are the provider-owners to secure the participation of users, is carried a step forward by bringing users into full membership **[1.1.2.2.2]**.

This sub-type usually begins at developmental phase C, as the initiators, who are usually health professionals, already operate a co-operatively organized practice based on a clinic or hospital facility which they lease, buy or construct for this purpose. This type of health co-operative may be termed also a "multi-stakeholder" or "interested parties" co-operative.

[1.1.3] **Provider-owned health co-operatives**

In this type of health co-operative, the members and owners are the persons who function as the providers of health services: they are usually

physicians, but in some cases dentists, nurses or community health workers. They are in fact the providers of the services supplied by the health co-operative to its users, customers or clients, however these are determined. They are worker-owned service provision co-operative enterprises. This main type of health co-operative originates in the efforts of health professionals, some of whom already have some experience of co-operative forms of organization.

[1.1.3.1] Primary level provider-owned health co-operatives

In this principal sub-type the members and owners are health professionals (usually doctors, but sometimes dentists or health technicians). Their primary goals are to improve their own professional status and financial security while at the same time improving the health services provided to the communities from which their clients are drawn. They consider that the best means to achieve these goals is to combine to establish a primary health co-operative, which functions as a co-operatively organized type of group practice. By this means they may benefit from economies of scale, diversity of experience and hence increased comprehensiveness of services offered.

In many cases, the underlying concept is altruistic, and the co-operative is perceived not only as an enterprise but also as a philanthropic undertaking, although the need for economic viability is acknowledged. Possibly for this reason such co-operatives have rarely combined to form networks in the form of secondary co-operatives. Provider-owned health co-operatives of this type generally favour significant client and community participation. This may reflect some personal association with popular organizations such as trade unions, farmers' organizations or consumers' organizations. There is likely to be some emphasis upon preventive health services. Hence, there is some tendency toward to transformation of the co-operative into a joint provider/user enterprise.

[1.1.3.2] Secondary health co-operative networks owned by independent health providers

This second principal sub-type of provider-owned co-operative in the health sector is a network established by a group of health professionals, usually physicians or dentists. The co-operative is made up of both self-employed individual physicians engaged in a "solo practice", or non-cooperatively organized independent and for-profit "group practices" usually operating a clinic. The co-operative may be administered by a small core of administrative and managerial staff.

This is a type of secondary level purchasing, supply, common service and marketing co-operative. Members seek by this means to better achieve their professional and financial goals. Benefits from activities include economies of scale: bulk purchasing of materials, equipment and services and access to common services; as well as diversification and specialization within the same facility: this has benefits both in professional satisfaction and in enhancement of income generation.

Establishment of such provider-owned health co-operatives is likely to occur when there are opportunities for medical entrepreneurship provided by new national social security systems which offer health insurance for the first time to sections of society, and when the environment for individual and group practice is threatened by the entry of large-scale private for-profit health care enterprises, which may include multinationals. There are considerable differences in size of membership, number and quality of staff and facilities, and scale of operations. This can be an expression of phase of development, but not necessarily so. This second type of provider-owned

health co-operative begins its development at phase D, in which it progresses rapidly by means of the development of regional and national business groupings engaged in standardization of services. A phase E might be distinguished when the co-operative establishes specialist common service subsidiaries, and a phase F when it promotes the development of linked user-owned health co-operatives within an integrated national system (already reached by Unimed de Brazil, and under consideration in Malaysia).

Usually the relationship of these co-operatives to their population of their service areas becomes active only when individuals in the community become unwell and become patients or clients. In order to assure a pool of prospective users, various schemes for "user-association" (in the United States "enrollee status"), both individual or group, are developed. Privileged user association can be obtained by depositing a full or partial pre-payment fee (individually, or through an enterprise health insurance scheme, or through a public health insurance programme). However, this associate status is not the same as membership in a user-owned or mixed co-operative, as the "members" do not participate in the direction or management of the provider-owned co-operative enterprise. In some cases, however, the provider-owned enterprise promotes the establishment of a functionally associated user-owned health co-operative.

[1.2] Co-operative enterprises providing social care services to individuals (social care co-operatives)

This type includes only those co-operatives whose original and current primary or 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 co-operatives, whose members may be made up of the persons in need of social care themselves, and those co-operatives, whose membership may also consist entirely or largely of persons in the same or similar condition, but whose business goals are different. For example, a co-operative 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 co-operative. Not included would be a co-operative 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 co-operative in order to secure employment and income, for example an agricultural production co-operative, small manufacturing enterprise or a computer software production and servicing co-operative. The distinction holds even if the purpose of the employment or income generation is to enable the members to pay for the social care they require.

A distinction is made between a first group of social care co-operatives, which are user-owned (or beneficiary-owned), a second group which are owned jointly by users and providers of social care services, and a third group owned by social care providers only.

[1.2.1] User- or beneficiary-owned social care co-operatives (co-operatives owned by the users, clients or beneficiaries of the social care services it provides or by individuals or institutions responsible for them)

This basic type of social care co-operative is a primary user- or beneficiary-owned co-operative enterprise set up by a group of individuals. Its original and primary or sole current business goal is to maintain the social well-being of members and/or their dependants, if this is already satisfactory (in societal environments containing both processes supportive of, but also inimical to social well-being) or to improve the degree of social

well-being, if not yet satisfactory, by means of the provision of some type of care. However, concern with maintaining existing satisfactory social well-being is probably much less common than concern to resolve problems, malfunctions, dysfunctions. This is in contrast to the situation with health co-operatives, where concern with the maintenance of health among members who are healthy, may be an element of the objectives of members of equal significance to dealing with ill-health.

In contrast to user-owned health co-operatives, most of which provide both insurance and service delivery, social care co-operatives 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).

Principal variants can be identified in terms of the characteristics of the users or beneficiaries, the nature to a significant degree of the disadvantage which may be resolved, ameliorated or avoided by means of social care **services**. **The** following **are** the principal groups, defined in terms of type of disadvantage:

- persons suffering from the physical conditions and the socio-cultural discrimination associated with **age**, including **infants, children and young persons** and **elderly persons**;
- persons suffering from the physical conditions and the socio-cultural 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).

In some cases membership is homogeneous (i.e. all members are elderly persons, young women who have experienced domestic violence, persons with disabilities (in some cases of similar type), etcetera). An example would be that of a group of persons retired from the same enterprise, public agency or institution, or resident in the same community, set up a co-operative which functions as a social and cultural association, but also as an organizational means whereby members may provide to each other assistance in everyday living, counsel in the face of legal or financial problems, etcetera.

In other cases membership is heterogeneous (i.e. members include a variety of types of individual suffering from disadvantage or dysfunction - young persons who have suffered from substance abuse and elderly persons, persons with and without disabilities, or with disabilities of different types, etcetera). An example would be that of a group of young persons, adults and elderly persons, usually resident in the same community or sub-region, establish a co-operative whose functions may include organization of social and cultural activities, but which acts also as an organizational vehicle whereby reciprocal assistance is provided by young and adult members to the elderly (for example in the form of help in everyday living) in return for assistance (in the form of counselling or training) provided by the elderly to the young, and perhaps also to adult members.

To a much greater extent than is the case with health co-operatives, the user-owners are likely to include not only the individuals who will directly benefit from the activities of the co-operative: i.e. the persons who require the services provided by or through the co-operative, and who are the direct beneficiaries: they are likely also to comprise individuals acting on behalf

of their dependants, or persons for whom they have responsibility: (as is the case with children, persons with certain disabilities, persons deprived of full civil rights, such as persons on probation).

Child care, day care and nursery co-operatives, are examples of this latter type of co-operative. They are owned by the parents or guardians of the children for whom the co-operative provides the service. This consists of a programme of care and education based on play activities appropriate to their age which promotes the social, physical, intellectual and emotional development and well-being of each child. The parent-members are the owners of the co-operative and control its business goals and practices through the normal co-operative structures, an elected and volunteer board of directors. This board hires qualified staff, who are then responsible for the professional development and operation of the programme. A special feature of this type of co-operative is the fact that a significant proportion of the labour required is provided voluntarily by parents. Indeed most such co-operatives require parental participation of some kind as a condition of membership.

Parents feel it appropriate to the purposes of the programme that they participate. In many cases they learn from the professional staff, and apply their improved understanding of child development and parental functions to family life outside the programme. Mothers and fathers alike are supported in their role as parents and are encouraged to participate in this way in their child's early experiences. In the process, they learn more about their own child, child development and parenting. Parents and early childhood educators develop a special kind of partnership as they work together to provide a quality programme for the children.

In addition children benefit from this combination of professional and parental involvement, which implies a high ratio of adults to children. It boosts their self-esteem, creating positive attitudes towards school and learning. Moreover, participation by parents often leads to greater involvement in neighbourhood and community affairs.

Social care services may be made available to members in the form of their own labour, or in the form of external help. In the former case they constitute a co-operatively organized form of self-help group. The persons providing the latter might be non-professional, para-professional or professional, and might be paid or voluntary. Most or all of these types are found in many social care co-operatives. Care received by user-members from other user-members is a form of reciprocal mutual help only: that is each user-member is simultaneously - or at least within a relatively limited period of time - both a recipient and a provider of care.

In the case of social care co-operatives, and in contrast to the situation for health co-operatives, the requirements in terms of capital equipment and facilities is usually not great: exceptions being, for example, residential homes for the elderly, disabled persons, orphans, women victims of violence etcetera, and particularly specially adapted work-places for persons with disabilities. In this case, in addition to the normal components constituted by an elected and voluntary board of directors or trustees, members themselves undertake not only administration, but certain operational functions, such as the scheduling of care, maintenance of records of voluntary work contributed, etcetera.

As in the case of health co-operatives it is possible to define phases in the development of social care co-operatives: for example, in child-care co-operatives parent involvement may be limited to early phases of their development. Because the review of this type of enterprise was intended to be illustrative rather than comprehensive, and because of the variety of

activities involved, no schema analogous to that used to describe health co-operatives has been included: this should be a topic for future research.

[1.2.2] Joint user- or beneficiary-owned and provider-owned social care co-operatives (co-operatives owned jointly by users, clients or beneficiaries, or by individuals or institutions responsible for them as well as by providers of social care services and other "interested parties")

A widespread model of co-operative organization by persons with disabilities as a means of self-help and mutual aid are worker-owned co-operatives of disabled persons which engage in rehabilitation and social integration through employment, thereby earning income for their members. They are organized frequently with particularly supportive work environments ("sheltered workshops" or "sheltered work stations"), where the work place lay out and equipment is adapted to the special needs of the worker-members. In the United Kingdom these are termed "social employment co-operatives" or "special needs co-operatives". In Italy they are referred to as "type B, or training social co-operatives". In some cases the majority of their members consists of persons with disabilities which impair their capacity to work, but it is not necessary that they form the majority - proportions are likely to be affected by the nature and degree of disability. Other members are persons without such disabilities, of which some may be para-professional and professional providers of counselling, vocational training and rehabilitation to those members with disabilities.

[1.2.3] Provider-owned social care co-operatives (Co-operatives owned by providers of social care services as well as by other interested parties)

As in the case of user-owned social care co-operatives it is possible to make a distinction on the basis of the type of individual in need of social care services, that is the type of disadvantage or dysfunctional condition which requires care. A further but related distinction is based on whether the beneficiaries are a homogeneous or heterogeneous group in respect to their condition.

Also as in the case of user-owned social care co-operatives it is possible to make a distinction among provider-owned types of such co-operative on the basis of the extent to which beneficiaries, although not owners or primary providers, nevertheless contribute to the provision of social care services in the form of their own labour.

More significant for provider-owned social care co-operatives is the distinction which it is possible to make on the basis of the status of the providers: they can include untrained, para-professional and professional persons. Scope for engagement of untrained and para-professional persons is considerable (possibly more so than in the case of health co-operatives). A distinction is possible also on the basis of whether the providers are paid or not, and, if unpaid, whether they are volunteers or not. In some cases unpaid providers are performing some type of civil or community service (often as an alternative to military service). In many cases contributions of labour from volunteers, who may or may not be professionals, is considerable.

Moreover, while all members are providers, by definition, these members may not constitute the whole of the work-force providing social care to beneficiaries: employees of all types may be employed to supplement the work of members.

As in the case of user-owned social care co-operatives, a further distinction is possible on the basis of whether the operation is organized as a network, with or without a fixed base, or as a base facility.

Because funding is usually made on behalf of beneficiaries by external institutions, usually from the public sector, these are represented as "interested parties" in the ownership of the co-operatives, rendering it a true "multi-stakeholder" organization.

For all types of user, mixed and provider-owned social care co-operative distinctions may be made according to the sources of income: provided by individual users, or the persons responsible for them, from their own resources; provided on behalf of individual users by insurers, including state health and social security insurance; provided directly to the co-operative as a subsidy from public, private for-profit or private not-for-profit sources. All combinations of source income are possible.

[1.3] **Co-operatives retailing goods and equipment needed for individual health and social care including medicines and equipment (co-operative pharmacies)**

[1.3.1] **Primary level user-owned co-operative pharmacies**

These are a specialist form of customer-owned retail co-operative: some have developed their own wholesale subsidiaries. Both user-owned and provider-owned health co-operatives usually dispense drugs and medicines and supply medical equipment, usually at prices which reflect enhanced group purchasing power. Similarly, the health services provided to members, and in some cases employees, by co-operative enterprises in other sectors also dispense drugs and medicines and provide equipment at lower than normal retail cost. In a few cases each of these types of organization may manufacture drugs, medicines and equipment within their own facilities in order to reduce costs of external purchasing.

[1.3.2] **Secondary level co-operative networks of pharmacies**

[1.3.2.1] **Secondary co-operatives owned by user-owned co-operative pharmacies**

Primary level user-owned co-operative pharmacies set up their own secondary networks which undertake joint purchasing, common service and common marketing functions.

[1.3.2.2] **Secondary co-operatives owned by independent provider-owned pharmacies**

Independent for-profit pharmacies have established their own networks in the form of a secondary co-operative. Such purchasing, wholesale supply, common service and marketing co-operatives may extend vertically to establish their own drug, medicine and medical equipment manufacturing subsidiaries.

[1.4] **Co-operatives whose business goals are primarily to provide goods and/or services to other enterprises in the health and social care sectors (health and social care sector support co-operatives)**

[1.4.1] **Primary level health and social care sector support co-operatives**

[1.4.1.1] **Primary level labour - contracting co-operatives**

These provide only labour to health and social care sector enterprises, to complement their own labour force. Activities may include building maintenance, cleaning, catering and vehicle maintenance.

[1.4.1.2] Primary level worker-owned manufacturing or service provision co-operatives

These are worker-owned producer or service provider co-operative enterprises engaged in the manufacture of goods used in the health and social care sectors, or in the provision of services required by these sectors. In contrast to sub-type 1.4.1.1. their labour is applied within their own premises to the production of goods or the preparation of services which are then supplied to the health and social care enterprise, in some cases with associated labour.

Goods may include drugs, medical equipment or more general consumer goods modified in some way for use in clinics, hospitals, and social care institutions. Services may range from data processing to hospital planning to provision of ambulance services. The distinction between these and professional provider-owned health and social care co-operatives, which are also a form of worker-owned co-operative, lies in the fact that these supply enterprises in the sector but not the individuals user, client or patient. They are owned by their worker-members, and not by the enterprises they supply.

A distinction can be made also on the basis of whether the support co-operative provides goods and services only to co-operatively organized enterprises within the health and social care sectors (i.e. is within what might be described as the co-operatively organized component of these sectors), or whether they are provided also, or solely, to non-co-operatively organized enterprises.

[1.4.2] Secondary health and social care sector support co-operative networks

[1.4.2.1] Provider-owned secondary support health and social care co-operatives

These are co-operative networks set up by worker-owned producer or provider-owned health and social care sector support co-operatives (i.e. those of type 1.4.1.2).

[1.4.2.2] Enterprise user-owned secondary health and social care support co-operatives

These are co-operatives established by enterprises (co-operative or others) operating in these sectors: they are users of their services or consumers of their products. They are established in order to reduce costs and improve efficiency by combining common activities, such as data processing, building management, financial management, joint recruitment and human resource management, laboratory work and, particularly, group purchasing. Hospitals and clinics, as well as social care institutions, may combine for these purposes.

A distinction may be made on the basis of whether the owner-member user enterprises are themselves co-operatively organized (implying a development within the co-operatively organized component of these sectors), or whether they are non-co-operatively organized private enterprises (whether for-profit or not-for-profit), or public sector enterprises (or combinations of these, including combinations of both co-operative and non-co-operative enterprises).

[1.5] Co-operatives whose business goals are to provide health insurance or services to the labour force of the enterprises which own them

[1.5.1] Secondary enterprise-owned health service delivery co-operatives

Non-co-operative enterprises combine to form a co-operative whose function is to deliver health services to their labour forces.

[1.5.2] Secondary enterprise-owned health insurance purchasing co-operatives

Non-co-operative enterprises combine to form a co-operative whose function is to use aggregate buying power to purchase appropriate and affordable health insurance for their labour forces.

D. Co-operative enterprises whose business goals include, but are not limited to, the health and social care sectors [type 2]

As the principal focus of this review are the types of co-operative defined above as either health or social care co-operatives, this and the following elements of the taxonomy will be provided in outline only. The purpose of their inclusion in the taxonomic scheme is to allow for an appreciation of the potential which exists within a fully developed co-operatively organized health and social care sector for multiple forms of mutual support which will not only allow for an increased aggregate impact of co-operative activity on the health and social well-being of members, employees, users and the communities in which they operate, but will establish an environment within which health and social care co-operatives, defined in the narrow sense, will be better able to develop.

Thus all co-operative enterprises, are concerned with the occupational health of their worker-members and employees. All co-operatives are concerned, in respect to the community in which they operate (and by extension, wider society), about the environmental impact of their activities, including production and operational aspects, and hence about environmental influences on health.

[2.1] Co-operatives in primary production

To an increasing extent both production co-operatives as well as secondary supply and marketing co-operatives, in agriculture, fisheries and forestry, are concerned with the impact of their activities on the natural environment, and hence upon health and social well-being of the communities in which they operate, as well as more widely within national and global society. They are seeking to adjust production practices toward more sustainable relationships with the environment. As one part of this concern, they are seeking to ensure that the primary commodities they produce do not constitute a risk to health, and they are responsive to changes in consumer demands for nutritionally more appropriate foods. In many instances producer and consumer co-operatives have collaborated for this purpose. These co-operatives have taken an increasing interest in reducing the occupational hazards involved in inappropriate use of pesticides, herbicides and other chemical substances by member-workers and employees.

[2.2] Co-operatives in secondary processing and manufacturing

Processing and manufacturing co-operatives, as well as those engaged in utilities production and distribution, transportation and construction, are increasingly aware of the need to ensure that the impact of their activities on the environment and on the consumer are conducive to health. They are

introducing adjustments in business goals and practices in order to promote and strengthen a presence in the community and wider national society which i supportive of health and social well-being.

[2.3] Co-operatives in tertiary service provision other than in the health and social care sectors)

[2.3.1] retail distribution co-operatives

(a) In respect to improved nutrition, household safety and healthy living

This type of co-operative enterprise has been in the forefront of attempts to educate consumer members in respect to healthy living, as well as to respond to consumer-driven programmes to ensure that only nutritious and healthy products are offered for sale.

Retail co-operatives, particularly those larger enterprises that have expanded horizontally in many countries and which include substantial proportions of the population in their membership, often include special social care services for members, former members, their dependants, and employees and their dependants. These are specific benefits, additional to the supply of affordable and appropriate foodstuffs of high nutritional quality, often supported by information and guidance concerning nutrition, which may be of particular interest to the elderly, but also to young persons young mothers. This is a significant contribution to healthy living.

In some cases groups of persons in similar circumstances establish their own retail co-operative - for example groups of retired government employees.

(b) In respect to distribution of medicines and medical equipment

General retail co-operatives, owned by their customers, may not only include among the goods offered for sale medicines and medical equipment, but may provide separate pharmacy services, licensed to sell prescription drugs and having qualified staff. These differ from the primary co-operative pharmacies (identified as type 1.3.1) only in that they are not an independen co-operative enterprise, but a component or subsidiary of a broader co-operative enterprise. In some cases such retail co-operatives may have their own wholesale or even manufacturing subsidiary supplying and manufacturing drugs or medical equipment.

[2.3.2] Funeral co-operatives

They are a specialized form of consumer-owned retail and service co-operative, providing to members affordable and appropriate funeral services and burial plots. They are important means to relieve emotional stress and anxiety among the elderly and their relatives is an arrangement which reduces the material and emotional costs of funeral and burial services. For many, financial costs involved in use of private for-profit service providers are b no means negligible and may serve to push survivors into poverty.

[2.3.3] Insurance co-operatives

(a) In respect to health insurance

Co-operatively organized insurance enterprises, owned by their customers or users (in this case, by policy-holders) provide a wide range of insurance products, which may include specific health insurance, or more general social security, disability and unemployment insurance. Their more general product may be relevant also in that they may reduce stress and thereby contribute tc

healthy living. In many instances such co-operative insurance products are adjusted to the special circumstances of sub-populations such as women or the elderly.

It should be borne in mind that user-owned health co-operatives, when at their earliest phase of development, function as group or mutual self-insurance co-operatives. They later develop into purchasing co-operatives whose function is to secure the most appropriate and affordable externally provided insurance. At this phase of their development their business goal is to manage member contributions as securely and effectively as possible, using them to purchase health services for their members, either by making refunds to those members who have incurred expenses individually, or, and preferably, by making agreements with health professionals and facilities to provide services to any of their members on the basis of at least a partially pre-paid schedule. In this way, they combine a health insurance with a health service purchasing function.

At subsequent development phases they combine health insurance with provision of their own health services. That is, instead of using the "insurance pool" made up of members' contributions to purchase external health services, health co-operatives set up their own facilities and hire their own employees, including professional, para-professional and other occupational groups. As the co-operative expands and diversifies it provides its own increasingly complex programmes and facilities.

At this phase, the health co-operative combines insurance with service provision functions, but these are still usually distinct. Many operate a "health (insurance) plan", whereby members make pre-paid contributions against assurance of access to free or reduced cost services. In many cases the services offered in return can be obtained only in the facilities, or through the employed or contracted professional staff, of the health co-operative, or, increasingly, of affiliated health care institutions with which the co-operative makes agreements in order to expand and diversify the range of services it can offer its members. In some cases, members are allowed the option of both using health co-operative services, and using the insurance function to pay for services obtained elsewhere.

The distinction between health co-operatives and insurance co-operatives providing health insurance products, is that the latter do not organize their own health facilities: policy-holders are free to obtain services from any provider (or at least from a list of accredited providers in some instances), usually according to schedules of acceptable costs in respect to type and quality of service provided.

In some cases health co-operatives operate without the insurance component: this is so where large-scale co-operative movements establish, as one among many types of service offered to members, the direct provision of health services within their own facilities and by their own employed professional and para-professional staff. New forms of health insurance purchasing co-operatives have become increasingly important in some countries, notably the United States. These are owned not by individuals by groups of enterprises, most in the private sector, but often including entities within the public sector, who combine to strengthen their position in the market as users of insurance products.

Probably of equal or greater significance as providers of health insurance are the co-operatively organized general insurance enterprises owned by their customers or users - in this case by the policy-holders which exist in many countries. In some these have grown to occupy a major, even predominant, position in the insurance sector. They provide the full range of individual, family and household insurance. These include old age and disability pensions and, in some cases, health insurance. More generally, by reducing many risks,

their effect is to reduce the pressures of everyday living and of personal disasters which may induce ill health directly or through the poverty they m cause. They promote greater and more effective use of health and social car services, contributing thereby, both directly and indirectly, to the health and social well being of members and their dependents.

(b) Contribution to healthy living The security offered by affordable and appropriate life insurance, both individual and enterprise, which is provided to members in the most affordable, appropriate and customer friendl form by co-operative insurance enterprises, is in itself a significant contribution to healthy living, through direct reduction in stress, and help in financial management which contributes to larger disposal incomes.

(c) Promotion of preventive health As in the case with all insurance enterprises, those which are co-operatively organized are particularly interested in reducing the incidence of ill-health. Characteristically, however, they support any improvement in health in a user-friendly manner an promote health services with a preventive component.

[2.3.4] Savings and credit co-operatives and co-operative banks

By providing affordable and accessible means of financial management, including building up reserves against emergency, and opportunities for credit, savings and credit co-operatives ("credit unions") and co-operative banks can help individuals to meet health care costs. By helping satisfy needs for improved housing, utilities including sanitation, safe water, etcetera, they help in establishing conditions for healthy living (and more basically help in secure employment, alleviation of poverty generally).

Poverty, indebtedness and stress caused by financial uncertainty are majo causes of ill-health and distress among the elderly, particularly among wome who are frequently subject to an extremely discriminatory financial status i families, other kinship-based support systems and the community. Membershi of financial co-operatives, both earlier in life and in old age, can greatly alleviate such problems, thereby helping to prevent a significant proportion of constraints on health and social well-being.

Many co-operative enterprises allocate part of their surplus to solidarit funds for the use of members in emergency, or for the support of retired members.

[2.3.5.] Housing and community development co-operatives

Provision of appropriate, affordable and secure shelter, including access to water and sanitation, fuel and energy and such community facilities as laundries, is in itself a major contributor to social well-being and to alleviation of the material and emotional factors which may cause ill-health Hence housing co-operatives, by their very functions, contribute directly to health and social well-being.

However, this type of user-owned co-operative has in many countries extended its functions from simple provision of shelter, and attention to associated infrastructure, facilities, utilities and services, to attention the special needs of its members. Many such co-operatives make special arrangements for the housing of disadvantaged sections of their membership, including persons with disabilities, elderly persons, and families with larg numbers of children. Most housing for persons with special needs is provide by general housing co-operatives, often in specially designated areas of the facilities, and according to formal or informal quotas determining proportio relative to total membership. However, some groups of persons with specia

needs have set up their own housing co-operatives, all of whose members have such needs. This has been done particularly by elderly persons, and persons with disabilities.

While some housing co-operatives were set up solely to provide housing - and some have kept to this function - many were set up originally to meet several goals, including both shelter and social care. Increasingly housing co-operatives are extending their activities also to provision of creches, nurseries, child day-care centres, community centres for young persons and the elderly, as well as to programmes designed to reduce domestic violence, delinquency and crime and substance abuse. Some housing co-operatives have developed their own home care programmes, as well as legal and financial counselling services for young persons, adult women and the elderly.

[2.3.6] Environmental management, sanitation and cleaning co-operatives

These include labour-contracting co-operatives owning mobile equipment, as well as fixed service enterprises. They undertake work-place cleaning; refuse collection and disposal and improvement in built and natural environments. They differ from those co-operatives which provide labour and/or services directly to health and social care enterprises [type 1.4.1] in that they improve environmental health either for enterprises in other sectors, or for communities in general.

E. Co-operative enterprises whose business goals do not include health and social care but which might include provision of operational support to health and social care co-operatives

Certain types of co-operative enterprise are in a position to support those co-operatives directly engaged in the health sector by providing to them goods and services, including financial services, at preferential rates.

[3.1] Financial co-operatives

Support may be given to health and social care co-operatives in the same way as to any other co-operative, in order to help them operate more effectively and thereby achieve its objectives in health and social care.

Co-operative insurance enterprises are able to contribute to the viability of health and social care co-operatives by providing them with affordable and appropriate protective coverage as enterprises, including malpractice insurance for provider-owned health co-operatives.

[3.2] Co-operative research and development institutions

These institutions, usually subsidiaries of tertiary co-operative organizations but including also subsidiaries of primary large co-operatives and university departments, may undertake research and development programmes concerning health and social care co-operatives.

[3.3] Co-operative media enterprises

Specialized media co-operatives may diffuse information on all aspects of health and social care, having a major impact on healthy living and broad preventive approaches, as well as on achieving appropriate perceptions of persons needing social care.

[3.4] Education and training co-operatives

A considerable number of co-operative business enterprises, business groups and organizations provide benefits to their members and usually also to their employees, which enable them to obtain health services. Two principal types of benefit may be identified:

(a) health insurance (sometimes as part of a package including life, employment, household, accident, legal and other insurance), which can be drawn upon to pay for service provided outside the co-operative enterprise itself, including subsidized or privileged access to certain external facilities, co-operative or not.

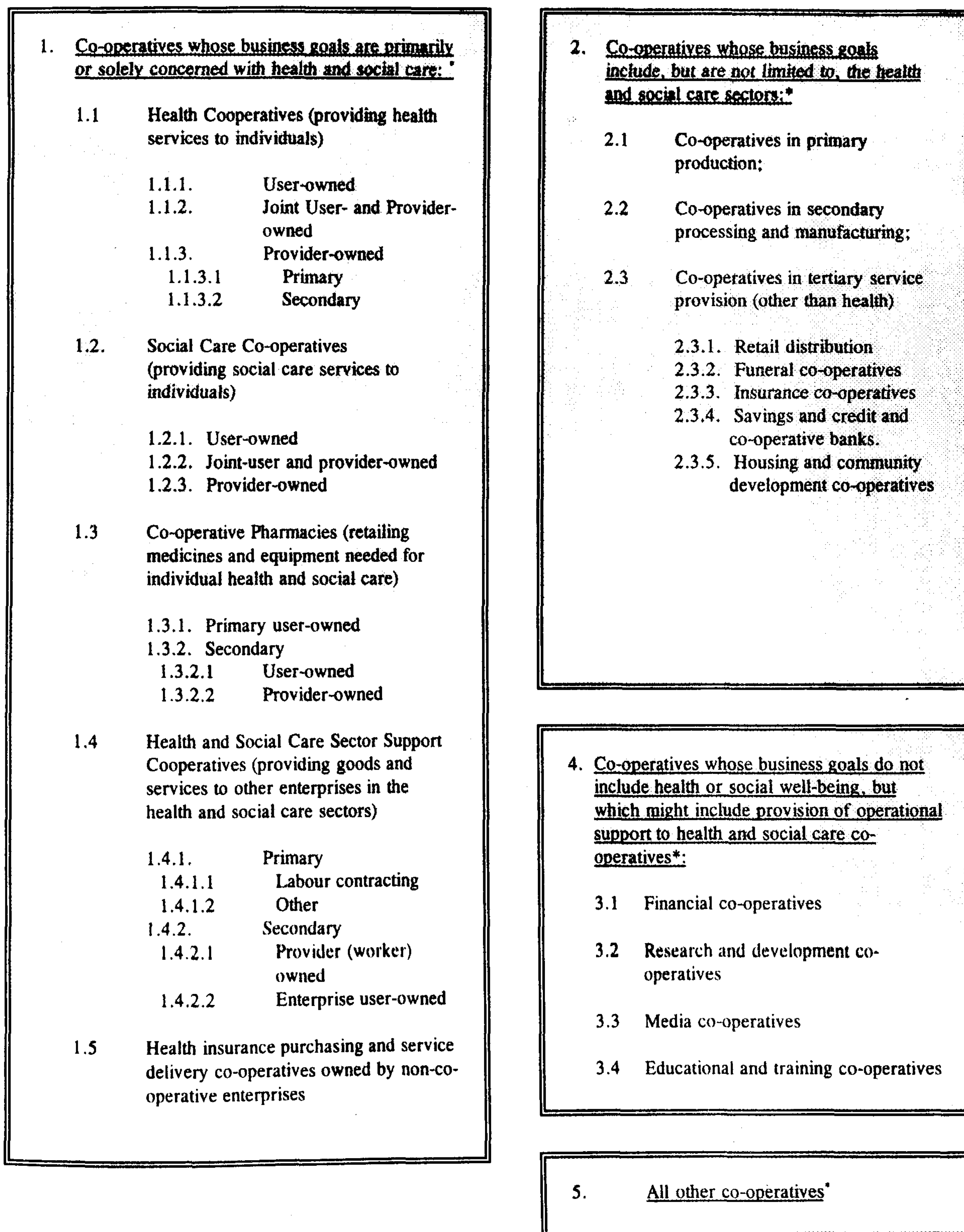
(b) health services, of varying complexity and nature, available to members (and employees) and in a facility (clinic, hospital, sanatorium) which is operated as a subsidiary of the co-operative enterprise (but not as an autonomous health co-operative).

(c) both (a) and (b).

This may be considered an additional taxonomic component, applicable to all of the types and sub-types discussed above, as well as to all remaining types of co-operative enterprise. In the case of health cooperatives themselves, provider-members and staff usually receive as a benefit of their association with the co-operative access to the facilities of the co-operative, or to those available through agreements made between the co-operative and other health providers.

Co-operative enterprises are likely to pay considerable attention to occupation health, particular in request to members in the case of worker-owned and member-operated co-operatives. Given their community-base most co-operatives try to act as model employers in respect to employees. They advise enterprise members (in the case of group purchase, common service and marketing co-operatives on their own occupational health policies and practices).

Figure 1: Types of cooperative enterprise defined according to the impact of their activities on health and well-being



1. Co-operatives whose business goals are primarily or solely concerned with health and social care: *

   1.1 Health Cooperatives (providing health services to individuals)

   - 1.1.1. User-owned
   - 1.1.2. Joint User- and Provider-owned
   - 1.1.3. Provider-owned
     - 1.1.3.1 Primary
     - 1.1.3.2 Secondary

   1.2. Social Care Co-operatives (providing social care services to individuals)

   - 1.2.1. User-owned
   - 1.2.2. Joint-user and provider-owned
   - 1.2.3. Provider-owned

   1.3 Co-operative Pharmacies (retailing medicines and equipment needed for individual health and social care)

   - 1.3.1. Primary user-owned
   - 1.3.2. Secondary
     - 1.3.2.1 User-owned
     - 1.3.2.2 Provider-owned

   1.4 Health and Social Care Sector Support Cooperatives (providing goods and services to other enterprises in the health and social care sectors)

   - 1.4.1. Primary
     - 1.4.1.1 Labour contracting
     - 1.4.1.2 Other
   - 1.4.2. Secondary
     - 1.4.2.1 Provider (worker) owned
     - 1.4.2.2 Enterprise user-owned

   1.5 Health insurance purchasing and service delivery co-operatives owned by non-co-operative enterprises

2. Co-operatives whose business goals include, but are not limited to, the health and social care sectors:*

   2.1 Co-operatives in primary production;

   2.2 Co-operatives in secondary processing and manufacturing;

   2.3 Co-operatives in tertiary service provision (other than health)

   - 2.3.1. Retail distribution
   - 2.3.2. Funeral co-operatives
   - 2.3.3. Insurance co-operatives
   - 2.3.4. Savings and credit and co-operative banks.
   - 2.3.5. Housing and community development co-operatives

4. Co-operatives whose business goals do not include health or social well-being, but which might include provision of operational support to health and social care co-operatives*:

   3.1 Financial co-operatives

   3.2 Research and development co-operatives

   3.3 Media co-operatives

   3.4 Educational and training co-operatives

5. All other co-operatives*

* Some of the co-operatives in all types provide to members, employees and their dependents health and social security insurance and/or access to the enterprise's own facilities.

II. DEVELOPMENTAL DYNAMICS AND CONTEMPORARY GLOBAL SITUATION OF USER-OWNED CO-OPERATIVE ENTERPRISES WHOSE BUSINESS GOALS ARE SOLELY CONCERNED WITH HEALTH AND SOCIAL CARE

This review is concerned with the broad engagement of all components of the co-operative movement in the questions of health and social well-being. It focuses particularly on co-operative enterprises which are directly engaged as "health" and/or "social care" co-operative enterprises, or as co-operative pharmacies, insurance co-operatives, and co-operative enterprises which have been defined as "health sector support co-operatives", but is concerned also with the very important contributions of co-operatives in primary production, processing and retail distribution, as well as housing and other service co-operatives. The developmental dynamic and current situation of co-operatives whose business goals are solely concerned with health and social care, and which are owned by their users (clients, patients), is examined in detail in this chapter. Chapter III will examine provider-owned co-operatives whose business goals are solely concerned with health and social care. Chapter IV will be concerned with the broad contributions of other components of co-operative movements mostly user-owned, to health and social well-being.

In chapters two and three, *as a prerequisite for the subsequent analyses,* diagnoses and prognoses, information is provided for each of the countries in which health and social care co-operatives are known to operate: in some cases material is substantial, in others it is still sketchy. This review is the first comprehensive treatment of the topic, and as most information is derived from written sources which are generally not accessible, from oral reports provided at a number of conferences and from information provided directly to the United Nations Secretariat by communications from the enterprises and organizations concerned, all available information relevant to an understanding of the nature of the health co-operative and the societal circumstances which have affected this development is provided in the country entries which follow. Information which will allow readers to contact relevant organizations is set out in Annex II.

A. User-owned primary health co-operatives [type 1.1.1]

User-owned health co-operatives are known to exist at present in the following countries: Bolivia, Brazil, Canada, India, Japan, Panama, Philippines, Singapore, South Africa, Sri Lanka, Sweden, United Republic of Tanzania and the United States of America. All are of type 1.1.1. but important distinctions can be made between sub-types. During the 1970s a sub-type of these co-operatives operated in Senegal. During the 1920s and 1930s such co-operatives operated in Poland and Yugoslavia. Although no longer existing information concerning these countries is included to allow comparison with currently operating enterprises of this type. Until 1995 a comprehensive system of user-owned health co-operatives existed in Israel.

1. User-owned health co-operatives operated as fully independent primary enterprises not affiliated with any other co-operative enterprise or organization [type 1.1.1.1]

In all but three of these countries, these health co-operatives were established and currently operate at the primary level as fully independent enterprises. Although in some cases the individuals who founded them, and the majority of members, may have been drawn from the co-operative management, they are not organizationally affiliated with any other contemporary co-operative enterprise or organization.

In all but one of the countries in which this type of co-operative exists they are characterized by a relatively moderate scale of operation of the

level defined in Chapter I as development phase B or, in most cases, C (i.e. in Bolivia, Canada, India, Panama, Philippines, South Africa, Sri Lanka, Sweden and the United Republic of Tanzania). These are treated together in section (a) below. Although some of these in the United States operate at this level, the majority have diversified into varied and complex enterprises, identified in the typology as characteristic of phase D. Members in most cases constitute only a minority of total users, most of whom are enroled in enterprise-based health insurance plans with which the co-operative is affiliated as service-provider. The total number of users is frequently in the hundreds of thousand, in contrast to the thousands more characteristic of the other user-owned co-operatives. For these reasons the user-owned health co-operatives in the United States are treated as a distinct sub-type in section (b) below.

(a) Relatively small-scale and organizationally simple health co-operatives at early or middle phases of development [type 1.1.1.1/B and C]

(i) Currently operating

In **Bolivia** a 1985 review reported eight health co-operatives (presumed to be user-owned) with a total of 440 members.1/ As part of its Inter-regional Programme, undertaken as a Follow-up of the World Summit for Social Development, the International labour Organization has prepared a provisional list of social services that might be organized on a mutual basis. This has been based on experience of ongoing projects undertaken by ILO in collaboration with the Belgian NGO Wereldsolidarieteit (World Solidarity: WSM), and on requests received from the governments of the countries concerned. It includes support to primary health co-operatives, organized through co-operatives and mutual groups. The programme could be undertaken in collaboration with the Confederation of Workers and the Confederación Latinoamericana de Cooperativas y Mutuales de Trabajadores (COLACOT).2/

In **Canada**, it was reported that there were 37 health co-operatives in September 1995 (presumably all were user-owned health co-operatives of the community health clinic type). There were nine in Saskatchewan, four in Manitoba and two in Alberta (a total of 15 in the Prairie Provinces); two in British Columbia; seven in Quebec and three in Ontario; and seven in Nova Scotia and three in Prince Edward Island (a total of 10 in the Maritime Provinces). In 1992 the 20 health co-operatives which responded to the annual survey of all co-operative business enterprises in Canada reported an aggregate membership of 300,000. They employed 700 persons.3/

Prior to the establishment in 1966 of a comprehensive public health system, various elements of the co-operative movement were engaged in improving the health of their members and of others in the communities in which they operated. Members of the Wheat Producers Co-operative of Manitoba contributed from their surplus (20 per cent in the financial year 1944-45) to the health programme of the Province. They also contributed to the establishment of what were described in 1950 as "group hospital co-operatives", which during the financial year 1945-1946 numbered 271 in rural districts, with a membership of 14,291 families (that is 51,471 participants). The savings and credit co-operative movement in Ontario and certain consumer-owned co-operatives in the Maritime Provinces had organized similar health services. In Vancouver, British Columbia a health co-operative was set up by members of co-operatives and credit unions. Health co-operatives appeared at local level to fill gaps perceived by groups of citizens. In Saskatchewan they appeared as a consequence of a doctor's strike in 1962. In Manitoba the Co-operative Housing Association identified a deficiency of health services in an area to the north-west of Winnipeg and recommended, in collaboration with other co-operative enterprises, establishment of a health co-operative. This was set up subsequently as the Nor'West health co-operative.4/

In February 1994 there were six community health centres in Nova Scotia but only one was a co-operative - the New Ross Health Co-operative, which was incorporated in 1987, began operation in 1990 and served a rural community of

about 2,500. It had found it could not continue to exist on community-based funding alone, and had applied to participate in a provincial government programme designed to promote community health centres (but not necessarily full health co-operatives). The Tignish Co-operative Health Centre in Prince Edward Island had in February 1994 a membership of 1,700. Staff included full and part time doctors, a public health nurse, pharmacist, dentist and two dental hygienists. Service and self-help groups operated from the co-operative, providing foot care and hearing aid clinics, as well as Alcoholics Anonymous and groups concerned with the elderly, grief coping and weight loss. It was reported in February 1994 that a second user-owned co-operative, at Wellington, Prince Edward Island, was then being established.5/

The Community Health Services Association (Regina) Limited was founded in 1962 on the initiative of the local community. In 1995 it had a membership of 4,545, which included both individuals and families, a total of 11,740 persons. Revenue in 1995 amounted to 2.3 million Canadian dollars, of which the provincial government of Saskatchewan contributed 1.98 million as payments for services rendered to persons insured by the public health system (who were members of the co-operative). Emphasis was given to health education and prevention, and particularly to family health care. A nursing service was provided for elderly members. Specialists in dermatology, optometry, minor surgery and physiotherapy, as well as counselling, laboratory and radiology services were available. All health professionals were salaried employees. The Community Health Services (Saskatoon) Association Limited had a membership of 5,500 individuals and families. The co-operatives at Regina and Saskatoon have combined with others at Lloydminster, Prince Albert and Wynyard in the Federation of Health Co-operatives of Saskatchewan.

In Quebec the experience of community-based and user-participatory health organizations has been different in some respects from other provinces. The Provincial Government had from the 1960s introduced a network of local centres for the provision of community services (Centres locaux des services communautaires). By 1990 there were over 160 such centres, each run by a community board and with salaried - not fee-for-service - staff. Although this network has developed within the public sector, it has close organizational links to the community, having integrated in many instances previously existing community clinics.

Recently in Quebec a user-owned health co-operative was formed by a community with the dual objective of establishing a practice which could be filled by doctors and dentists in search of employment and satisfying the need for a community-based health service. This experiment (Coop Vision les grès) was undertaken by the small community of Sainte-Etienne des grès, with 1,100 residents in the Mauricie region. Support was provided by the Mouvement des caisses Desjardins (the province-wide savings and credit co-operative). Government approval has been seen by specialists as most significant as it was the first time that official recognition had been forthcoming for this type of cooperative.6/

In British Columbia the CU&C Health Services Society provides group dental, extended health and weekly indemnity plans, available to members and their families only, and operates one medical and two dental clinics, open to the general public as well as to members and their families.7/

In **India**, a health co-operative movement had existed in the 1920s and 1930s. Prior to the Second World War there were a few health co-operatives in Bengal, Madras, the Punjab. In the Punjab and in the United Provinces, "Better-living co-operative societies" provided some of the functions of health co-operatives.8/

In Bengal the Yugoslav type of health co-operatives was adopted, after a study visit made in 1930 (at the suggestion of Rabindranath Tagore) by the Superintendant of the Village Welfare Department, as a model for the establishment of similar co-operatives in the Birbhum district north-west of Calcutta. The first three user-owned, community-based, health co-operatives began to operate in 1932 - there were 12 by 1938, and had formed there own

Union. Preventive health activities, and mother and child care were given priority. The cooperatives employed doctors on fixed salaries.

In 1914 the first co-operatively organized village anti-malaria society was established: by 1940 there were 1,089 with 21,728 members. They undertook such preventive measures as cutting vegetation, clearing ponds, filling cesspools, promoting household hygiene, distributing quinine. Preventive and control measures against cholera were also undertaken. The pre-existing Anti-Malaria League was converted into the Central Co-operative Anti-Malaria Society, which acted as support and promotion organization for the local co-operatives. As an extension of the environmental control activities, support was given to improvement in horticulture and agriculture. 9/

However, there does not appear to have been much continuity between the pre-Second World War and post-War movement. The first of the user-owned health co-operatives operating in 1995 was established in 1960. By mid-1995 they were located primarily in the western and southern States of Maharashtra, Goa, Karnataka and Kerala. There were 15 in Maharashtra (not including rural hospitals and dispensaries established by sugar co-operatives in this State) and 87 in Kerala.10/

Detailed information is available for only two of these. The Shushrusha Citizens' Co-operative Hospital Limited in Bombay, Maharashtra, was the first co-operative hospital to be established in India. The concept of a health co-operative was first suggested in 1960, the co-operative began operations in 1964 and the foundation stone of its hospital was laid in 1966. A user-owned health co-operative, it was created by members of the local community as a means to provide high quality health care at reasonable cost, as well as to promote health consciousness more widely in the entire community. Having overcome two major initial difficulties: finding persons willing to invest a one thousand rupees membership fee and finding doctors to provide very low cost services, the co-operative had in March 1995 a membership of 7,624. A panel of 70 consultant doctors provided basic preventive, but also advanced curative and rehabilitative care, to members and their dependants, but also to non-members. The former obtained a discount of 20 per cent relative to prices charged to non-members: those members aged 70 and older received a discount of 50 per cent. Members included a wide range of professionals, who contributed their varied expertise to the co-operative. Services were provided free to non-member low-income households in the community, in part through campaigns for eye and skin disease prevention, early diagnosis and treatment and in part through a free immunisation centre. The co-operative operated a nurses training school. A Maternity and Child Health unit of the co-operative operated in the suburban town of Vikhroli.11/

In the State of Kerala the main objective of the 87 health co-operative units (25 hospitals and 62 clinics as of mid-1995) has been to provide family and child health care. Eight hospitals specialized in traditional Indian medicine based on the Yajur Veda and homeopathy: some manufactured homeopathic drugs. The establishment of co-operative hospitals had been strongly supported by the State Government. The largest such co-operative, the Indira Gandhi Co-operative Hospital founded in 1971 in Cochin, provided health services to the work forces of major private and governmental enterprises and to the predominantly lower income communities where it was located. It had 3,000 "shareholders" in 1992.12/

In his report to the International Co-operative Health and Social Care Forum held at Manchester, United Kingdom, on 18 September 1995, the Dean of the Shushrusha co-operative hospital noted that in India provision of health services by the private sector was still predominantly concentrated in the major urban areas, but was spreading to "semi-urban and affluent rural areas".

In **Panama** in November 1990, after almost two years of weekly meetings, a group of doctors and clients resident in the predominantly rural province of Veraguas joined together to establish the COOPASI user-owned health co-operative. They did so in a context which comprised a single overcrowded

public hospital serving a province whose population was 400,000, and unaffordable private services. The co-operative's members included both middle income (doctors, teachers, nurses) as well as lower income (rural workers, peasants) households: in October 1992 they numbered 300. In return for monthly pre-payments members were able to benefit from emergency hospitalization service during their first year and full hospital services thereafter. A panel of general practitioners and specialist physicians provided services at agreed fees paid by the co-operative in the only private hospital in the province. In addition, doctors who were members of the co-operative gave a 30 per cent discount to other members for services provided in their own practices. A health education programme, and an education programme for members in co-operative organization and management were operated.

In 1992 the co-operative reported that it had plans to establish a 24 - hour pharmacy. It was also intended to improve housing for members and provide better environmental sanitation in the urban centre in which the co-operative operated. It was planned also to negotiate an agreement with one of the largest co-operatives in Panama, the Co-operative of Educators of Veraguas, whereby hospital benefits would be provided to that co-operative's 5,000 members. Purchase of the private hospital currently used by members was under consideration.13/

In the **Philippines**, the National Confederation of Co-operatives, Inc. (NATCCO) was in the process of forming a user-owned health co-operative. It was being helped by doctors at the Capital Medical Centre in Quezon City. Members of other co-operatives and of non-governmental organizations were being invited to join. 14/

In **South Africa** it is known that at least one user-owned health co-operative operates in collaboration with the National Consumer Co-operative Union in Marshalltown (Phila Health Care Co-operatives), and that another (possibly several) health co-operative, also probably user-owned, operates in East London (Dunkan Health Co-operatives). 15/

In **Sri Lanka** user-owned health co-operatives have developed within the context of a substantial co-operative movement in which consumer, credit and savings and agricultural marketing co-operatives have been well developed for over five decades. In September 1995 it was reported that there were 10 in operation. The first co-operative hospital was established as a user-owned co-operative dispensary at Moolai in the Jaffna region in 1932 by pensioners. A doctor and two dispensers provided free services to members. In 1962 the co-operative became a fully equipped hospital with a surgery, having received a gift of equipment from Japan. Subsidized and free services were provided to members with support from the Government. By 1970 membership had increased to 3,000 and staff to five doctors, ten dispensers and 42 nurses.

Other co-operative hospitals have been established: at Kurunegala in 1951, Galle, Gampaha and Kotahena (Colombo) in 1962 and more recently at Matara. These were established primarily to provide services to members of co-operatives operating within local communities, most of whom are members of co-operatives, and there is close collaboration between them and other co-operatives. For example, the Galle District Co-operative Hospital recently decided to extend associated membership to members of all other co-operatives in the District. Fees would be paid by the welfare section of their co-operatives and recovered in whole or in part over time from individual members. The President of the Galle District Co-operative Hospital is also Chairman of the local Co-operative Thrift and Credit Society (the oldest in Sri Lanka). The President of the National Co-operative Federation of Sri Lanka is a member of the Board of Management of the Gampaha Co-operative Hospital.

All provide services to middle and lower income households. Public health services are well developed, and the health co-operatives are supported financially by the Government. They are intended by co-operators in the areas concerned as a supplement to public services which are considered to be not as

effective as they could be, while private health services are too expensive. Most co-operatives reduce fees by 50 per cent for members, while providing services to non-members at full rates. Membership of each of the autonomous health co-operatives varies between about 1,500 and 3,000; beds number between 50 and 100; most doctors work in government hospitals and provide their services as part-time consultants: only the Galle Health Co-operative employs a significant number of doctors full-time. A number of multi-purpose co-operatives have also established their own hospitals: the Nuwara-Eliya, Anuradhapura and Ratnapura societies. Their facilities were much smaller than those of health co-operatives themselves.16/

In **Sweden** discussions on the future of health care, which have become more frequent during the 1990s, have included co-operative health care as a possible solution. The Co-operative Institute, with the support of the co-operative Folksam Insurance Group and HSB: Riksforbund, the Union of Housing Co-operatives, completed a report in May 1991 in which it presented a model for consumer-owned co-operative health care centres: "Medikoop". This followed an initial report in October 1990 and a study visit to health co-operatives in Canada during the period November 1990 - February 1991. The model was intended as one option for consideration by local government authorities (county councils and municipalities) in their discussion of new forms of organizing health care.

Health co-operatives would provide the services traditionally provided by local health centres on behalf of local government authorities within a designated geographical area. However, they would extend these activities to preventive health care for members, and they would co-ordinate such services with programmes of care for the elderly, school health services and the occupational health services provided by enterprises. Folksam and HSB considered co-operative health care not as an alternative to the public sector, but rather as a complement to it and an alternative to private for-profit programmes and facilities, to whom local government authorities were increasingly contracting out programmes and services. Co-operatives of this type were termed "interested parties partnerships", involving both consumers and producers as well as local government authorities and other institutions providing funds. Although most of the initiatives appears to have been taken by potential users, potential providers were also involved, and in theory at least these may be defined as falling within type 1.2.1/1. In fact most of those actually in operation are either user- or producer-owned, and not jointly-owned.

The interest of HSB reflected the fact that already in the early 1990s it was providing services to local authorities. The programmes of housing for elderly persons included in its member-housing co-operatives had been diversified in order to include home help and service apartments: from this it was a short step to provision of primary health care to elderly members. Many elderly members of housing co-operatives were interested in its organization in the form of a co-operative. Stockholm's local government authority planned to operate hospitals and nursing homes in the form of co-operatives: this was already the case of nursing homes at Vaderkvarnen and Framnas Skolhem.

On the initiative of the municipality of Borlange, the local housing co-operative, the Folksam insurance co-operative and local residents, and under the auspices of one authority, Kopperberg County Council, plans had been drawn up in 1991 for a consumer-owned health co-operative which might be opened within a year. Already in 1992 staff of a number of local government operated facilities were discussing the establishment of provider-owned co-operatives for provision of health and dental as well as support services such as caretaking and janitorial services.17/

However, the process of decentralization and privatization which was proposed during the early 1990s, and which included some experiments, did not proceed further, and achieved rather limited results, at least in respect to the development of user-owned health co-operatives. The primary level co-operative health centre at Borlange never moved beyond the planning stage. The joint "Medicoop" initiative started by Folksam and HSB was discontinued in

1992. HSB subsequently chose to proceed alone, adopting a different organizational model. This consisted of a wholly owned HSB subsidiary, in the form of a joint-stock company ('Grannskapservice or "neighbourhood service"), engaged primarily in provision of home-care for the elderly. In February 1996 it employed about 700 persons.18/

In the **United Republic of Tanzania** the ILO, as part of its programme of support for small industrial co-operatives, is promoting health protection for informal sector workers through five co-operatives and other associations formed by them. 19/

(ii) Operating in previous societal circumstances, but not at present

This type of user-owned health co-operative appeared during the 1920s in Yugoslavia, where an extensive system was in operation until it was brought to an end by the Second World War. It provided the model for a younger and smaller movement in **Poland** where, before the Second World War, there were about 12 health co-operatives organized on the Yugoslav Model 20/

The best developed of these early systems was that in **Yugoslavia**, where in the 1920s and 1930s a substantial health co-operative movement came into operation. Here, the first health co-operative was founded in 1921. In 1923 there were 13 societies, which had formed the previous year a Union of Health Co-operatives. By 1938 there were 134. Of the 125 of these for which information was available, membership was 65,600 households, representing about 390,000 persons. They employed 95 doctors, operated 25 nursing homes and a mobile dental clinic. 21/

This system originated after the First World War as a result of collaboration between the General Federation of Co-operative Unions, a Serbian doctor (Dr. Kojic) and the delegate of the Serbian Child Welfare Association of America. At that time health conditions were extremely poor. The movement was based upon three principles: (a) improvement in health conditions, particularly in rural areas, requires the understanding and active support of the community; (b) it is not enough to provide information and advice, not even through education at school: certain material conditions must be created as a prerequisite for sufficiently widespread understanding, including the use of such necessary articles as means for personal hygiene, medicines, medical attention - if these are available, improved habits will develop automatically; and (c) health problems cannot be resolved in the same way in highly diverse rural environments as they can be in urban centres.

For these reasons the founders of the movement decided that health co-operatives were the best organizational means for attaining their goals. The decision was strengthened by the fact that health co-operatives would be able to draw strength from the traditions, experience and assistance of a broader co-operative movement already firmly established in rural areas.

The health co-operatives were financed in part by member contributions. These were supplemented by a health fund, constituting a health insurance fund. Payments into the fund were in some cases optional: however, by decision of the general meeting they could be made compulsory. These were lower in the large health co-operatives, higher where membership was small. The availability of sufficient financial resources made possible by these funds allowed for provision of health services to members at lower rates, and maintenance of a relief fund.

Health co-operatives employed doctors and nurses at fixed prices according to regulations agreed by the Union of Health Co-operatives, supplemented by a variable salary, decided upon by members of each individual health co-operative in the context of local conditions. Each health co-operative set up a clinic - in many cases at first these comprised a few rented rooms, a dispensary, and rooms for seriously ill patients. Such facilities were gradually improved: the first fully equipped clinic ("health house") being established in 1928. These were available also to members of all other

village co-operatives. Services, including drugs, were provided at an estimated one third the cost of private for-profit provision.

Rural health co-operatives undertook to vaccinate, free of charge, all inhabitants in the districts in which they operated. In some cases they operated day nurseries and preventive programmes for children. Village sanitary conditions were improved - the labour being provided mostly by members themselves. Health education was provided; youth and women's sections were operated; and attention was given to improved nutrition and agricultural production. Villages were divided into groups of houses for each of which a designated person was responsible for giving preventive health advice, encouraging improved hygiene, and promoting healthy living.

From 1927 the Government's Central Institute of Hygiene, aware of the significant contribution of rural health co-operatives, provided technical and financial support, and established its own section for health co-operative development. The Ministry of Social Affairs and Public Health also assisted the health co-operative movement. In 1930 legislation was adopted which recognized their contribution, freed then from restrictive legislation, provided permanent financial assistance to the Union of Health Co-operatives, and authorized them to act in the name of the Government and as partners of the public health service. As such they were entitled to assistance from local administrations.

It is believed that after World War II, and with the establishment of the socialist centrally planned systems in both countries, these health co-operatives formed the basis for the public sector health service in rural areas, and were absorbed within it.

(b) <u>Large-scale diversified health co-operative complexes at middle and advanced developmental phases [type 1.1.1.1/D]</u>

Only in the United States of America have user-owned health co-operatives developed to an advanced phase in spite of having been set up in isolation from, and not currently affiliated with, other broad co-operative movements.

In the **United States** user-owned primary health co-operatives in **predominantly rural regions** first appeared in the late 1920s. The first to be set up was in 1929 in the State of Oklahoma, where over 2,000 families contributed $ 50 each in share capital to build and equip a community hospital. Subsequently, they paid annual membership fees of $ 25, and received in return free medical and surgical care provided by doctors employed by their co-operative as staff. The initiative had been taken by a health professional, Dr. Michael Shadid, who argued that the co-operative form of organization of health care was both a preferable alternative to the expansion of public programmes in the health sector (a possibility presented by the reforms of the New Deal, which created a momentum for state-controlled medicine), and at the same time constituted a means to combat the growing commercialization of medicine. The societal environment in the Great Plains States was highly favourable to such a development, as it was characterised by populist traditions and an already substantial development of co-operatives, primarily in agriculture.

Although Dr. Shadid argued that consumer-controlled health co-operatives would provide an organizational environment that would free doctors from financial insecurity and provide them with enhanced opportunities for professional development, the majority of the medical professional were opposed to his ideas. At this time the power of the medical professional was beginning to be felt nationally through the American Medical Association. Through their state professional associations doctors began to actively oppose the establishment of such user-owned health co-operatives. Medical associations succeeded from 1939 onwards to secure legislation in 26 States that effectively barred consumer-controlled health plans, including those that were co-operatively organized. Within Oklahoma itself the medical association strenuously opposed Dr. Shadid's attempts in 1931 to establish a

health co-operative in Elk City: the enterprise was saved only by means of help from the Oklahoma Farmer's Union.

In spite of such opposition, during the 1930s and early 1940s many other user-owned health co-operatives were established, notably in Oklahoma and Texas: as of 1950 most of the 101 rural health co-operatives that had ever existed had operated in the South-west, more than half in Texas, where State legislation had actually promoted the formation of health co-operatives. It may be presumed that most were community-based user-owned co-operatives, although some have originated in existing co-operative associations.

During this period of economic depression user-owned health co-operatives received governmental support. The Federal Government used a New Deal programme, the Farm Security Administration, to combat rural poverty. Specifically for this purpose, it introduced a rural health programme which at is peak served more than 600,000 people in one third of rural counties in the United States. This Administration encouraged the formation of rural health co-operatives as a means to implement its health programme, part of an approach that included promotion of agricultural supply and marketing co-operatives. The Farm Security Administration provided low-interest loans to farm families. These pooled sufficient financial resources to form a health association, to which membership fees were paid according to ability to pay and type of services included in the medical benefits package. The associations, administered by community members, paid participating doctors, who received additional payment from medical review boards.

The rural health programme was decentralized and control remained in the hands of local consumers and doctors. The latter were willing to participate in order to have a reliable income at a time when rural doctors experienced a decline in their incomes of as much as 50 per cent. The community health associations established within this context were not fully co-operative in organization because control was exercised by community representatives who were not solely responsible to user-members, and because capital and operating costs were provided by participating user members only to a limited extent.

By 1941 the wartime economic boom had brought prosperity to most rural families, who consequently had wider health care options. As rural households became better able to pay fees for service, they and participating doctors became less interested in participation in health associations, and both users and providers withdraw from them. During the later 1940s reduction in Federal Government support to rural communities and households, and financial problems caused by their small size, brought about the closure of many genuine health co-operatives also, and by 1949 only 54 remained in operation.

However, the concept of community-based health centres remained an organizational option, and again took hold in the 1960s, notably after the adoption of Medicare and Medicaid in 1965 and the accompanying introduction of the Neighbourhood Health Centre Programme, which later became the Community Health Centre Programme. The latter continued after the demise of the responsible Federal Department, the Office of Economic Opportunity, and was extended by addition of a programme of Migrant Health Centres. Many State Governments established community-based rural health centre programmes. By the late 1980s more than 800 Community and Migrant Health Centres were in operation, serving 4.2 million persons. The 350 Community Health Centres in rural areas alone provided care for 2.7 million patients in 1989.22/

The Yakima Valley Farmworkers' Clinic, an example of a Migrant Health Centre, operated in 1994 seven clinics in south-central Washington and north-central Oregon States. In 1992 it served 45,250 medical and dental patients, of whom 29,400 were either migrant or seasonal farm workers. Of the total population served by the clinic, 68 per cent had incomes at or below the federal poverty line.23/

Community Health Centres were organized on the basis of the principle of "maximum feasible participation": this resulted in a significant involvement

of users, including the poor, in the design and control of local health services. The emphasis was on primary care and group practice, which included paraprofessionals. As the majority of users were poor, the greater proportion of income was provided by the Federal Government rather than by the users, who did not own or control the Centres, as they would have done in the case of a genuine health co-operative. Nevertheless, this programme kept alive interest in community-based forms of health service, including the potential constituted by genuine user-owned health co-operatives. In many contemporary rural communities various forms of community-based health care practices have continued to operate, many being group practices controlled and led by community boards of directors.

Support has been provided also to local community initiatives by the United States Department of Agriculture's Agricultural Co-operative Service. The Department of Health and Human Services has funded innovative organizational developments in rural health care.

Funding for community-based health centres as well as genuine user-owned health co-operatives has been provided by the National Co-operative Bank, whose Development Corporation has made the financing of Community Health Centres a priority during the early 1990s.

Recently, further attempts have been made in a number of rural communities to establish genuine user-owned health co-operatives: in some cases initiatives have been taken by existing co-operative enterprises. Indeed, a source of health service coverage within a co-operative framework which has a considerable potential for expansion in predominantly rural regions of the United States is the provision of health insurance by existing co-operative organizations to their members, already promoted by the National Rural Electric Cooperative Association.24/

The early development of user-owned primary health co-operatives in **predominantly urban regions** in the United States has been strongly influenced by the concepts and experience of those interested in rural health co-operatives. Immediately after the Second World War, certain members of these farmers' associations and farm co-operatives joined with trade union members and members of consumer and student co-operatives to establish the first urban user-owned health co-operative, the Group Health Co-operative of Puget Sound, in Seattle, Washington State. In many cases there was significant initial participation by persons already members of other co-operative enterprises operating in the community. The founders of this health co-operative were accustomed to working toward common goals through such organizations. The history of the development of this, now one of the largest urban-based user-owned health co-operative in the United States (and, probably, in the world) has been fully documented.25/ Certain salient aspects are summarized here because they appear to be relevant to an understanding of the difficulties faced by this type of institution and of the means whereby they can be overcome.

Already in the 1930s, when little or no medical care was available from either Government or employers, members of consumer co-operatives within the Seattle region in the State of Washington had envisioned a health co-operative as a means whereby consumers might gain control over the management and costs of health care. A form of prepaid health care had been developed already among workers in the timber industry, in the form of the Western Clinic and Hospital Association located in Tacoma, Washington State. During his tour of farm and co-operative groups in the North-West of the United States, sponsored in the late 1930s by the Pacific Supply Co-operative, a farm supply co-operative, Dr. Michael Shadid had met with representatives of a number of farmers' associations (known as "Granges"). They were concerned with finding practical means to protect themselves from the threat of bankruptcy due to major illness: at this time middle income households were in a particularly precarious situation: whereas the poor were provided with care in the county hospitals, and the wealthy could pay for private care they had neither their own sufficient resources, or access to outside help.

The co-operative attracted support from some dedicated doctors, but the medical community in general opposed it, particularly after it purchased an existing group practice clinic located in the city's central business district and a hospital. The co-operative was able to attract membership from within the local community because its medical staff provided high quality services.

During their Second World War military service, doctors had gained experience of a medical service made available to a defined clientele on a prepaid basis. Similarly, individual citizens had become used, again during their military service, to the availability of a medical service for which they did not have to pay fees for each service rendered. At the initial organizational meeting of the Group Health Co-operative, held in August 1945, it was agreed that the health co-operative would be a consumer-owned enterprise based on the Rochdale Co-operative Principles. It was considered desirable to provide members with a relative wide range of services, greater than those that could be supplied by means of an arrangement with a single doctor, who could only refer patients to reserved beds in a hospital. Indeed, it was thought more appropriate to have a hospital facility and a diverse group of doctors providing services. A small hospital (St. Luke's), owned by a branch of the Western Clinic and Hospital Association, the Medical Security Clinic, was available for purchase. Doctors employed there felt that it was unethical to capitalize on people's illness: but the local Medical Society considered their prepaid clinic to be unethical and banned its doctors from taking patients to other hospitals. Consequently, there was much interest in new forms of health service. These doctors perceived advantages in the availability of common support services - such as a library - they would not be able to afford alone.

During 1946 negotiations took place between the doctors of the Medical Security Clinic - who faced the prospect of a reduction in clientele as war industries were scaled down and demobilization occurred - and the Group Health Co-operative, whose membership had reached a ceiling because of absence of a facility of its own. Although some members argued against departing from the co-operative principle of limiting capitalization to member shares - a step which would be necessary if a mortgage were initiated in order to purchase the hospital - others felt that the health co-operative could not proceed further if this was not done, for it could not afford to wait until member contributions provided capital sufficient to purchase or construct a medical facility for the co-operative. They considered that the financing of a user-owned health co-operative might require different ground-rules from that applicable to other types of co-operative. As it happened, member share capital and personal loans from members were used as a down payment, followed by payments made over a period from 1 January 1947, derived from operating surplus when the co-operative was already operating the hospital. Subsequently the Co-operative raised further capital by selling bonds bearing 4 per cent interest to members, many of whom made financial sacrifices in order to buy them.

The Group Health Co-operative negotiated a contract with the doctors it now employed which fully recognised that its health professional staff would operate in a largely autonomous manner without interference in their practice of medicine by the Board of Directors of the Co-operative. It felt that members would be best served by a satisfied staff and that staff of high quality and commitment could be attracted by such conditions. Conversely, it was understood that the medical staff would not be involved in other aspects of the management of the Co-operative, including financial matters.

The Medical Society in Seattle continued to take the position that a prepaid group practice was unethical and opposed the health co-operative. Consequently, there was difficulty in obtaining consultants when needed, the Co-operative's doctors could not attend some speciality board meetings of the Medical Society, there was considerable opposition from surgeons who were unwilling to accept referrals from the Co-operative, and certain post-graduate courses were closed to the Co-operative's doctors. After repeated attempts to negotiate with the Medical Society the Group Health Co-operative decided to take legal action, charging the Society with conspiracy in restraint of trade.

In November 1951, after an appeal to the State Supreme Court, the Co-operative won its case: this resulted in an initially Court-enforced, but then progressively accepted, normalization of working relations between the Co-operative and the traditional health care system in the region.

During the first years of the Co-operative's operation there were considerable tensions within the professional Staff, within the Board, and between Staff and Board, concerning the management of the co-operative, in particular concerning the respective roles of Staff and Board, and of Board and management. By 1955 these had been largely overcome, in part by the establishment of a Joint Conference Committee involving Staff and Board, responsible specifically for resolving differences between these two components of the Co-operative. A chief executive officer implemented Board policies and acted for the Board in its relationship with the medical staff: the Board contracted directly with the self-managing medical staff, for the purpose of providing services to user-members and other clients.

By 1955 membership had increased to 36,000, the clinic had relocated to a site adjacent to the hospital, which had been remodelled and extended, and a satellite clinic had opened. During the period 1969 to 1984 a period of very rapid growth occurred, with enrolment tripling from 122,000 to 332,000: indeed, growth was so intense that in 1973 the Co-operative adopted a year-long freeze on accepting new members. During the 1970s there was expansion to adjacent regions and in the 1980s to the adjacent State of Idaho through an affiliate, Group Health Northwest. The staff model health maintenance organization (i.e. an organization providing health services on the basis of prepaid contributions by prospective user-members, and employing its own health professional staff) which constituted the core of the co-operative enterprise was augmented with a primary care network, using selected community physicians. During the 1980s considerable competition from non-co-operatively organized health maintenance organizations occurred. To combat these, and to provide increasingly effective services to members, the Co-operative continuously introduced innovations in management and in programmes offered.

As of February 1993 there were 478,000 members and "enrolees", about 86 per cent of whom were covered by health insurance through their employment (i.e. in group contracts negotiated by their employer with the Co-operative). They constituted 1 in 11 of the residents of the State of Washington, and 1 in 9 of the residents of the five-county Puget Sound region. One sixth of the "enrolees" were members, having paid a lifetime membership fee of $ 25. They elected a Board of Trustees composed of volunteers. There were also three member-elected regional councils and 23 medical centre or local advisory councils, the majority of whose members were elected volunteers. Consumer special interest groups were organized from the membership to deal with the situation of women and the elderly and with mental health issues. By the end of 1994 the total had risen to 510,000.

As of May 1993 the Group Health Co-operative remained one of the largest consumer-governed health-care organization in the United States, the seventh largest non-profit health maintenance organization and the 18th largest of the total of health maintenance organizations (i.e. both profit and non-profit). As a co-operative it was a consumer-governed organization that provided services to members: as a health maintenance organization, it was a plan that provided comprehensive coordinated medical care for a fixed prepaid fee with minimal co-payments. It provided managed care - involving the full integration of healthcare delivery and healthcare financing - which had five characteristics: comprehensive coverage, coordinated services, strict performance standards, consumer involvement and predetermined payment.

As of early 1993 the Co-operative operated two hospitals, or an in-patient centre, a skilled nursing facility, five speciality medical centres, and 30 primary care or family medical centres, with a total of 694 licensed beds. The Co-operative contracted with 38 other major institutions for special services and for services where it did not operate its own hospitals. A primary care network of community physicians worked under the Co-operative's

medical and preventive care guidelines. The Co-operative employed 1,007 doctors and other medical staff, 1,533 staff nurses, and 7,274 other personnel. With a total labour force of 9,814, it was the ninth largest employer in the State of Washington. In addition the Co-operative had contracts with 1,950 other non-staff doctors to provide services in locations where there were no appropriate staff doctors, or to serve as temporary staff. The Co-operative collaborated with the University of Washington on teaching, research and patient care programmes.

The Co-operative was committed through its bylaws to "projects in the interest of public health". These included hospital acute care and emergency subsidies for those in need; monetary grants and services for community health care; support of research in the public interest; public leadership to improve access and affordability; and collaboration with community organizations on health promotion and education and disease prevention, all targeted to high-risk populations.

The Co-operative has introduced numerous innovations within the services it provides to members and other "enrolees". Its Centre for Health Promotion offers health promotion and disease prevention programmes for "enrolees", both at worksites and in the community. Innovations have included individualized life-style assessments for new "enrolees"; screening programmes; educational offerings, including classes and supply of printed and video materials; and research and evaluation. Its Centre for Health Studies is recognized as a national leader in primary care, and in geriatric, mental health and cancer care research, with emphasis on prevention and health promotion. Its Institute for Healthcare Innovation looks into new ways of providing efficient and effective care.

Community health and long-term care services provided by the Co-operative have included comprehensive homehealth, hospice, bereavement, family outreach, community volunteer, geriatric nursing, HIV/AIDS and long-term care planning and a skilled nursing facility. Care of patients with HIV infection has been coordinated by a personal primary care physician, supported by a consulting practitioner and a registered nurse with special expertise in AIDS/HIV care, supported by infectious disease and other specialists. A multidisciplinary task force monitored AIDS/HIV issues.

Registered nurses were available by telephone 24 hours a day to answer user's health questions. Under the "HealthPays" programme, fees were reduced for those Individual and Family Plan members committed to healthy lifestyles. Preventive care visits were scheduled on the basis of research and not arbitrarily decided schedules. Programmes for older adults include a volunteer staffed Resource Line which received 18,000 calls a year, a Geriatric Assessment Unit, a Geriatric Nursing Service, health promotion workshops and the distribution of pamphlets and preventive care.

"ADAPT", an alcohol and drug treatment programme, offered in-patient and out-patient services, including a comprehensive biopsychosocial assessment and individual treatment plan. Teen health services coordinated an adolescent multispeciality centre and other clinics, teen-pregnancy and parent clinic, consultations and other services.

Subsequent to the establishment and early growth of the Group Health Co-operative of Puget Sound (and to the earlier established Group Health Association of Metropolitan Washington DC), the concept of user-owned health co-operatives has spread to other major urban areas in the United States. By 1947 health co-operatives together with group health associations provided health care to over 900,000 persons. Six co-operative hospitals were already functioning, and forty others were in the process of being organized.26/ Early in 1996 the National Cooperative Business Association, the national apex organization, although stating that firm statistics were not available, estimated that membership of those health maintenance organizations which were organized as co-operatives was about one and a half million. In 1980 estimated membership had been 740,000.27/ These enterprises are considered to

be co-operatively organized types of "health maintenance organization" (HMO).

In an article published in 1984, whose authors were the President and Vice President of the Co-operative League of the United States (CLUSA), subsequently the National Co-operative Business Association, 10 user-owned health co-operatives were identified. These were health maintenance organizations defined as co-operatives because their members and/or users exercised control over the Boards of Directors by means of elections held according to co-operative principles. They were particularly numerous in those regions where co-operatives of many types were already well established and co-operative forms of organization well understood, as in the Mid-West: here were located the Group Health Plan Inc. of Minneapolis (subsequently Group Health Plan, Inc. of Minneapolis, St. Paul, and then Health Partners); the Community Health Center Inc., Two Harbors, Minnesota (subsequently the Community Health Center of Two Harbors, Minnesota); the Group Health Co-operative of Eau Claire, Wisconsin; the Group Health Cooperative of North East Minnesota, Virginia, Minnesota; the Group Health Co-operative of South Central Wisconsin, Madison, Wisconsin (subsequently Group Health Cooperative HMO); the Central Minnesota Group Health Plan, St. Cloud, Minnesota; the Family Health Plan Cooperative HMO, Milwaukee, Wisconsin; and the Metro Health Plan, Indianapolis, Indiana. Members of the health co-operatives at Eau Claire and at Two Harbors, Minnesota were primarily rural.

Large user-owned primary health co-operatives have developed in other urban regions: the Group Health Association of the District of Columbia (the first such enterprise, founded in 1932, becoming subsequently the Group Health Association of Metropolitan Washington D.C. and now the largest user-owned health co-operative), the Capital Area Community Health Plan of Albany in New York State and the Health Insurance Plan of Greater New York. It is believed that a similar health co-operative exists in the Boston metropolitan region. The differences in listing over time reflect changes in name and amalgamations, but also changes from co-operative forms into non-cooperative forms, whether not-for-profit or for-profit.28/

In 1994 the largest concentration of health maintenance organizations (of which not all were genuine co-operatives) was still in the Minneapolis region of Minnesota, where nine such organizations provided coverage to 1.2 million persons, 70 per cent of the local population.29/

An example of a smaller co-operative health maintenance organization (HMO) is provided by **Family Health Plan**, which operates seven health centres in southwestern Wisconsin, at Milwaukee and adjacent Elm Grove, Waukesha and Glendale. This is a non-profit, locally managed HMO which began operation in 1979 and by mid-1995 had over 100,000 members. Through their pre-payments members have access to the services of full-time family physicians, nurses, chiropractors, optometrists, pharmacists, technicians, counsellors and other professionals at the co-operative's own health centres, as well as to referred services at collaborating hospitals and rehabilitation centres. Most prescribed drugs are supplied free of charge at the co-operative's pharmacies. Preventive health is emphasized.30/

An example of a large user-owned health co-operative in a major metropolitan region is the **Health Insurance Plan of Greater New York (HIP)**.31/ As in the case of most user-owned health co-operatives in the United States, HIP combines a health insurance function (it is a not-for-profit corporation operating under the provision of the Insurance Law of the State of New York) and a health service provision function (it is a certified Health Maintenance Organization under the provision of the Public Health Law of the State of New York).

Established almost fifty years ago its members are almost all "enrolees" in employment-related health (insurance) plans. In 1994 39.4 per cent of the 914,000 "enrolees" comprised members of health plans provided to their employees by private businesses in the Greater New York region, while 29.7 per cent comprised members of health plans provided by agencies of the city

government in New York. This total represented both employees and their dependants. Only 5.6 per cent were in the "other" category, which included individual members. The remaining one quarter of "enrolees" were persons entitled to medicaid, medicare and other federal and state public programmes.

In 1994 the Board of Directors included representatives of major trade unions in the region. In order to meet the growing needs of small businesses, HIP has entered into agreements with the United States Life Insurance Company, making available a wide range of benefits (including also life, disability and dental insurance), and with the New York State Business Group, representing more than 300,000 small businesses of 50 or fewer employees in the New York area.

Because the Greater New York region includes parts of both the States of New York and New Jersey, which are different jurisdictions in respect to both health insurance and health service provision, an affiliate enterprise was established in the latter. A second affiliate was established in the State of Florida, because of the substantial retirement there of "enrolees" from New York.

Health services are provided at multi-service medical centres owned by the health co-operative, at which services are provided by primary care professionals employed by it. In addition members may use the services of doctors practising in neighbourhood offices and forming an affiliated network. Moreover, a recently introduced programme, "CHOICE PLUS", allows members to choose to use, in addition to those employed by the co-operative or affiliated with it, physicians not affiliated with HIP. If they do so, then approved costs are reimbursed from the insurance facility of the co-operative. Local employers may add additional options to tailor the health plan they offer to their employees to their particular needs.

HIP medical centres are multi-service facilities which provide a broad range of primary and speciality care services. Many also provide routine laboratory and x-ray services. They offer a variety of health promotion and educational programmes and health screenings. To supplement the core clinical services available at HIP medical centres, a number of programmes are intended to help members help themselves: for example, diabetes education, cholesterol reduction, asthma care training.

Special community outreach programmes include grants, scholarships and other contributions to community based, not-for-profit organizations to help strengthen access to health care and related social services for those in need, especially disadvantaged persons, elderly, children and young adults. Jointly with public television stations, HIP organized during 1994 an AIDS Awareness Day, a Women's Health-A-Thon (a day-long televised event that addressed women's health, with a hot-line/help-line staffed by HIP medical centres and affiliated hospitals). HIP also provided free mammogram screenings and breast health education.

In 1994 228,000 of the total of 914,000 "enrolees" were under 15 years of age, and 380,000 were aged 15-44. An outreach programme for young persons was a significant component of the health co-operative's activities. Together with local public (not-for-profit) television stations during 1994 HIP organized a "Teen Leadership Day", supported the "Junior Achievement Program, an organization that promotes the value of education to millions of school children throughout the country, organized jointly with the American Health Foundation a "Harlem Child Health Day", and supports the work of YMCA, whose programmes serve almost 250,000 persons annually.

A 1984 article noted that there also operated a number of user-owned health co-operatives which operated on a fee-for-service basis, such as the Midpenninsula Health Services in Palo Alto, California.32/

Many community health centres financed by the Federal and State Governments operate in low-income areas of major urban regions, including in particular inner cities, as well as in rural regions. Other stakeholders, such as

local schools of medicine, particularly in predominantly low-income regions and cities, have promoted other types of community-based health associations which, although not fully co-operative in organization, are characterised by most of the features of genuine co-operatives. As in the case of rural health centres, it is possible to envisage their conversion to full health co-operatives. For example, the Health Promotion Research Centre of the Morehouse School of Medicine in Atlanta, Georgia, developed a pilot project in a low-income neighbourhood which placed great emphasis upon community involvement: community representatives made up at least 60 per cent of the board of directors, working as part of a coalition of community consumers and public and private organizational and financial sponsors. The project subsequently expanded into adjacent rural communities.33/

Community health centres are typically established in communities with a large number of low-income residents who are not adequately served by doctors who practice basic medicine: notably pediatricians, family practitioners, obstetricians and gynaecologists. They are democratically governed, community-owned medical care providers located primary in rural areas and in inner-city neighbourhoods. They are designed to provide care to everyone, employ sliding fee scales for persons without health insurance, and employ multilingual staff where appropriate. In 1994 it was estimated that 60,000 persons a day received medical care from co-operatively organized community health centres. In 1994, the United States Public Health Service provided funding to over 500 such centres, which operated about 1,800 primary care sites (outlets). The National Association of Community Health Centres estimated that there were about 400 community health centres that did not receive federal government funding: possibly the majority of these were funded by State Governments.34/

A particularly innovative co-operative enterprise in the health and social services sector is the **United Seniors Health Cooperative (USHC)** located in Washington D.C.35/ Founded in 1986, the co-operative is committed to democratic action and self-help, believing that informed consumers are those best able to help themselves. It is a co-operative whose members include both older persons working together to help and encourage individuals of all ages to be healthy and independent, as well as advocates of and professionals engaged in, provision of effective, appropriate and affordable health and social services to the elderly. By the end of 1993 it had 7,000 members, and provided services to elderly persons in the community who were not members.

USHC provides information and assistance that enables people to be informed consumers and thereby better able to promote their own good health. Its management and professional staff collaborate closely with members in order to develop and test practical solutions to the concerns of older persons. It develops creative programmes that encourage and enable people, particularly the elderly to help each other. It develops and provides innovative technologies and leadership in the expansion of health and human service networks, collaborating closely with other groups in the Washington D.C. region in order to implement new programmes and services. Finally, it promotes health care for all in the United States that is comprehensive, high quality and affordable.

The co-operative was formed in large part as a means to deal with the fact that many eligible persons did not receive the public and private benefits to which they were entitled, partly because it was difficult to obtain the relevant information and to make the necessary applications, and partly because few service providers themselves understood all of the complicated requirements for the many available programmes. USHC has continued to improve its computer services to help low-income persons of all ages obtain the public benefits to which they were entitled.

The Co-operative is the only known case of a user-owned co-operative whose members are primarily older persons, and whose business goals are primarily concerned with the health of one section of the population. It also combines health with social care issues, distinguishing itself in this way from co-

operatives whose primary concern is health, but which have extended their activities from this focus to related social care. Those aspects of the Co-operative's activity concerned with social care for the elderly is examined below.

The co-operative has grown in membership and in the scope of its activities because its professional staff and management listen carefully to members in order to learn their real needs, then use that information to build relationships, become actively involved in areas of concern and create programmes to meet the needs and desires of older persons.

Members meet regularly to discuss and plan activities and services. They do so formally within "United Seniors Groups" which meet bi-weekly or monthly. They are supported by a Task Force on Successful Aging, made up of a group of members who encourage a positive attitude to aging. Regional Councils in Washington D.C. itself, and in each of the adjacent States of Maryland and Virginia, meet regularly to discuss and plan action on local and state health issues. Their activities have led to an improvement in the financial status of spouses of nursing home residents and helped stop legislation in Maryland that would have reduced a person's eligibility for nursing home care.

Based on what members have told management and professional staff, and after extensive research into options available, USHC developed a variety of tools to meet members' needs: computer software, consumer publications, demonstration projects and public policy recommendations.

Members can obtain counselling on health insurance, advice on housing, help in finding a health provider who accepts Medicare, information on legal matters and assistance with financial planning. During 1993, over 2,000 members obtained such services, either by office visit or telephone. Members receive a newsletter five times a year which provides objective information on good health practices, developments in health care, and changes in Medicare and other kinds of insurance.

Members of the co-operative receive discounts on a dental insurance plan, a medical claims filing service, purchase of medical equipment not covered by Medicare and books sold by USHC. In 1993 the Washington D.C. Office on Aging, with funds received from the Health Care Financing Administration, awarded the Co-operative a contract to establish the Health Insurance Information and Counselling Programme, designed to help residents aged 60 and older find health insurance appropriate to their specific needs and budgets.

USHC contributed to the formulation of the proposals made by the President for health sector reform in the United States and to public understanding of the issues. This was accomplished by providing analysis and recommendations to several working groups of the President's Task Force on Health Care Reform and by giving expert testimony to Congressional committees. In keeping with its commitment to education, USHC convened forums throughout the region in which it operates to inform older persons about issues relating to health care reform.

During 1993 the co-operative was funded by membership dues (only 8 per cent of the total), by sale of publications and software (29 per cent), by contracts with governmental agencies (10 per cent) and by contributions from corporations (11 per cent) and foundations (42 per cent). The AFL-CIO, a national trade union organization and the National Cooperative Bank were among the contributors.

It might be noted that establishment of the co-operative may have owed something to location in the national capital, in which a concentration of experienced persons existed. In 1993, for example, the chairperson of the board of directors was the former Secretary of the United States Department of Health, Education and Welfare and the vice chairperson was former Special Assistant to the President for Consumer Affairs.

2. User-owned health co-operatives operated as fully independent primary enterprises but affiliated through simultaneous membership or organizational linkages with a broader co-operative organization (type 1.1.1.2)

In **Japan** individuals already members of the consumer co-operative movement have set up their own health co-operatives as fully independent enterprises, although at the same time perceived as a specialist component of the broader movement. They have combined at the national level to establish their own tertiary organization, which at the same time a specialist component of the tertiary level organizational structure of the consumer co-operative movement.

In Japan two separate systems of user-owned health co-operatives exist. One evolved as part of the consumer co-operative movement and has a primarily urban focus: its national tertiary organization is the **Medical Co-operative Committee of the Japanese Consumers' Co-operative Union**.36/ A second system has evolved within the agricultural co-operative movement, and consequently has a rural focus: its national tertiary organization is the **National Welfare Federation of Agricultural Co-operatives**.37/

User-owned primary-level health co-operatives, designated "medical co-ops", or "medical-health" co-operatives, are autonomous enterprises which have been established within the consumer co-operative movement by individuals on behalf of themselves and their families as a means to solve problems concerning their health and well-being. Most such persons are also members of a retail consumer co-operative, although such membership is not a requirement.

At the end of March 1995 a total of 1,810,000 households were members of such co-operatives, an increase from 1,505,580 in March 1992. If the average size of household is taken to be 3 persons, this implies an individual membership of 5,400,000. As of March 1995, there were 118 such health co-operatives, and they existed in 38 of the 47 prefectures. The Five-Year Plan for 1995-2000, adopted by the Medical Co-operative Committee in September 1995, aims to increase membership to 3,000,000. The number of in-patients treated during the previous year was 4,050,000, and out-patients numbered 15,240,000. Health co-operatives operated their own facilities: 80 hospitals and 246 clinics, with a total of 13,028 beds. The five-year plan aims to operate 500 hospitals and clinics by the year 2000. Doctors employed totalled 1,605, nurses, 9,204 and other staff 9,322: a total of 20,131. These health co-operatives may vary in respect to membership and facilities, although all follow the same strategy. The largest is the Saitame Central Medical Co-op which in September 1991 had 46,000 members, operated a hospital, three clinics and a dental clinic, had share capital equivalent then to US$ 6,000,000 and an annual turnover equivalent to US$ 3,000,000. A national apex or tertiary organization, the Medical Co-op Committee of the Japanese Consumers' Co-operatives Union, became an independent section of the Union in 1961 and has been active in linking autonomous health co-operatives within a single national movement.

Health co-operatives within the Japanese consumer co-operative movement are juridical persons defined in terms of the "Consumers' Livelihood Co-operative Society Law" of 1948. They are defined as autonomous organizations established by inhabitants to solve problems concerning their own health and daily life. They own, administer and use medical facilities. Construction of the hospitals and clinics operated by health co-operatives within the consumer co-operative movement is financed by members' share capital and by loans from members. This commitment is considered an important means to promote consciousness and voluntary participation in the programmes of the health co-operative. In September 1995 it was reported that about 95 per cent of the income of these co-operatives (which in the previous year had been 22.7 billion yen) was derived from the public health and social insurance system in payment for services provided to citizens who were also members of the health co-operative. The rest was obtained from charges for health examinations. Because of retrenchment in the public health and social security sector, involving reduction in coverage for many individuals, notably elderly members,

income from this source was no longer increasing. This had caused financial difficulty in many health co-operatives: in 1994 only fourteen per cent had a surplus. For this reason considerable efforts were being made to persuade members to contribute larger shares to capital: it was hoped by this means to increase member capital to 20 per cent of the total.

Information concerning the development of co-operatives in Europe is thought to have been introduced to Japan as early as 1878. More comprehensive reports on consumer-owned co-operatives were introduced into Japan in 1902, and in the following years a group of intellectuals, labour leaders and members of Christian communities attempted to create health facilities as part of the early consumer co-operative movement. They were unsuccessful at this time, and the first full health service provided by co-operatives is thought to have been operated from 1919 by an agricultural co-operative, the concept spreading rapidly within this sector of the country's co-operative movement during the 1920s and 1930s.

Influenced by this experience urban consumer co-operatives began to establish health co-operatives serving for the most part low-income households, then excluded from the benefits of public programmes. Establishment of health co-operatives was a response to poverty, one aspect of which was the inability of poor households to afford the services of private for-profit health professionals and facilities.

User-owned health co-operatives were set up within the consumer co-operative movement, particularly in the larger cities, and notably in Tokyo and Osaka. Trade unionists, social workers, socialists and co-operators were the principal initiators. In 1931 one of the oldest, the Tokyo Medical Co-operative Society, was founded by the Christian social reformer, Dr. Kagawa, who later, in 1951, founded the Japanese Consumers' Co-operative Union (JCCU). By 1940 there were 89 hospitals and 137 clinics.

After the war-time period of direct control, the consumer co-operative movement re-emerged and obtained a new legislative basis in 1948. The law regulating this sector of the co-operative movement, including user-owned health co-operatives, prohibited non-members from utilising co-operatives, except where the health co-operative had been designated an emergency hospital.

Health co-operatives continued to develop in Japan as a popular response to the inadequacy of both public and private for-profit services. Until 1961, when the entire population came to be covered by some form of public health insurance, health co-operatives were the only means whereby low-income households could afford adequate health services, and whereby the inhabitants of communities without doctors might secure services. Even when the public sector system was in operation the health co-operatives continued to contribute significantly, shifting their emphasis to prevention, principally by "healthy living", and to meeting the needs of the elderly.

In 1961 a public health insurance system covering the whole population was introduced. It was then thought by many outside the co-operative movement that the public sector programmes would make the functions of health co-operatives redundant. However, this did not prove to be the case, particularly as the health co-operatives adjusted their focus from provision only of curative and rehabilitative services to the poor and those in communities inaccessible to health services, to an emphasis upon preventive services and healthy living among a wider population, given that the new public health insurance coverage did not extend to preventive measures, and private for-profit providers considered these areas as unprofitable. Indeed, there was some interest during the 1950s in setting up a co-operative national social security and health system to complement the public sector.

During the 1960s and 1970s the nature of health problems changed considerably: from a situation dominated by communicable diseases to one in which geriatric and chronic diseases became increasingly important. At the same time growing urbanization and rising stress within employment and daily

life added increased pressures upon individual health. Health co-operatives have constantly adjusted their programmes to these new circumstances.

A significant phase in the evolution of health co-operatives began during the late 1980s in the context of the Government's decision to adjust the national social security and health systems, primarily by means of reduction in the central public budget, decentralization of financial and administrative responsibility to local authorities, and transfer of responsibility for health and social care to communities, families and individuals. It was largely in response to this new context that the first five year plan was adopted, for the period 1988-1992, by the Medical Co-operative Committee. The process of privatization of the public health and social security systems has continued during the early 1990s, in response to which the health co-operative movement adopted in September 1995 a second Five-Year Plan, for the period 1995-2000. Because one element in the transformation of the social security and health system has been the decentralization of responsibility to local authorities (although without appropriate decentralization of financial resources), a significant component of the current policy of health co-operatives is development of complementary relationships with local government authorities.

The objectives of this system of health co-operatives within the consumer co-operative movement are health education; activities to improve the national social security and welfare systems; and management of the hospital and clinic facilities owned by the co-operative. High priority is given to the promotion of healthy living within a broad emphasis upon preventive health. Members are encouraged to undertake regular self-administered tests and to monitor their nutritional status, living conditions and other aspects of their immediate environment. Within the Five-Year Plan for 1995-2000 it is intended to persuade all members to take an annual health check-up. This element of the co-operative's activities is undertaken largely within the organizational context of the "han-group", which had been consciously organized from the early 1960s on the basis of the experience of the consumer co-operative movement. Health examinations are also provided at the clinics and hospitals operated by these health co-operatives: in recent years 500,000 persons annually received such examinations.

The "han groups" are units established by a group of members (the minimum allowed is three) resident in the same neighbourhood. Their function is to promote study and individual self-education in health matters, particularly in preventive health and healthy living; to undertake certain types of self-administered health examinations and then to follow-up by means of individual actions designed to remedy causes of ill-health and to develop thereby a broad basis for healthy living; to promote the application by members of information provided to them by newsletters circulated from the national Medical Co-op Committee; to undertake mutual assistance among members; and to purchase equipment or material required by members. Programmes are worked out at regular "han group" meetings, at which health professionals employed by the health co-operative often participate. It is not compulsory for members of the health co-operative to become members of "han-groups": for example, in September 1991 in the Saitama Central Medical Co-op only about thirty per cent of members had joined "han-groups". Within its membership of 46,000 persons there were about 1,000 "han-groups", which met on average 2.5 times a year.

Attention is given to increasing the professional capabilities of the "han groups". A form of training in local leadership in preventive health is provided to ordinary members within "health colleges", introduced during the 1970s and now organized by an increasing number of health co-operatives. Graduates become members of "health committees" which operate at the neighbourhood and community level and act as leaders of the activities undertaken within "han-groups" and branches of health co-operatives in respect to healthy living and preventive health. In September 1995 there were already 31,000 such committees.

Membership of the consumer movement's health co-operatives is open to everyone, resident in their areas of operation (usually at the prefecture or sub-prefecture levels). Considerable efforts have been made to ensure that

members participate fully in their organization, direction, management and operation. The co-operative constitutes a form of organization which allows healthy citizens, concerned to maintain their health, to collaborate with health professionals: thereby avoiding too narrow an emphasis upon professional/client relationships developed only in the context of illness. Collaboration between informed citizens and concerned health professionals is considered essential if the health problems faced in contemporary society are to be overcome: neither citizens nor health professionals acting independently of each other are considered likely to be able to resolve such problems. For this reason, the health co-operative movement places considerable attention upon citizen member participation and the institutional means whereby this may be achieved, such as the local "han-group", whose functions are perceived to reconstitute in modern and more effective form those formerly carried out by the extended family and local community, now substantially altered and reduced by demographic and social change.

In 1991 the consumer-owned health co-operative movement adopted its "Charter of Patients' Rights", and is now actively working towards the goals set out in this document. Within its Five-Year Plan for 1995-2000 it intends to introduce full implementation of the Charter in all clinics and hospitals owned and operated by health co-operatives. A major objective is to secure both for co-operative members and for the population at large, the right to learn and know about health and medical procedures (See Annex III for the text of this Charter).

Considerable attention is given to the education not only of both members but of employed health professionals in the nature of administration of co-operative enterprises: recently a correspondence education course for staff was introduced for this purpose. Within the Five-Year Plan for 1995-2000 considerable attention will be given to improved management, including personnel policies, particularly in respect to recruitment and retention of high quality health professionals. Attention will be given also to improvement of the services the national Medical Co-op Committee provides to its member health co-operatives, including development of a common purchasing enterprise, provision of managerial information and training, and international representation. The entire movement has been active in public discussion of health policy.

In spite of continuous and substantial progress during recent years, health co-operatives within the consumer co-operative movement still account for only a small share of total activity in the health sector: in September 1995 it was reported that the total of in-patients and out-patients served was equivalent to only one per cent of the national total.

The Medical Co-op Committee of the JCCU emphasises that the consumer-owned health co-operatives within their system are organizations "composed mainly of healthy people established by inhabitants to solve problems concerning their health and daily life" emphasis is given to the responsibility of the individual to "reform themselves". This emphasis is considered to be of particular importance given the demographic and social changes which have brought about a significant decline in family and community mutual support systems, previously capable of providing for a substantial proportion of health and social needs. Of particular relevance to these systems had been the multi-generational structure of families and their consequent capacity for caring for both children and the elderly.

Such systems would have constituted a sound basis for the building up of an effective preventive and health promotional programme based upon collaboration between user-members and health professionals. However, with the increasing break-up of the family and community, growth of individualism and increasing physical isolation of individuals, it is considered that they can no longer function as the base for such collaboration: this has to be re-established in new forms: of which one of the most appropriate is felt to be the han-group, almost all members of which are women. In the new demographic and social situation it is the continuing central function of women which is

recognized as being of basic relevance to further expansion of the health co-operative movement.

In these circumstances, the movement perceives its role to extend from preventive health through the promotion of healthy living and the expansion of social services to development of the function as of health co-operatives as the organizational focus not only of health but of daily life within neighbourhoods and communities, characterised by increased co-operation and solidarity among all members, and particularly between generations.

Many of the individual branches of the user-owned health co-operatives which exist within the Japanese consumer co-operative movement have specialized departments which organize training courses for leaders and particularly active members of local han-groups: these are termed "health colleges". They were introduced during the 1970s. The graduated graduates return to their communities where they constitute a "health committee" which undertakes promotional and preventive health measures among members at the local neighbourhood level. The more intensive courses in the "health colleges" are complemented by broad user education programmes, including member education by correspondence.

The user-owned health co-operatives within the Japanese consumer co-operative movement have given particular attention to the means whereby user-members, whether patients or not, may be able to participate effectively within the policy-making process as well as within the management and operation of their health co-operative and its hospital and clinic facilities. For the last 15 years members and patients have been encouraged to complete questionnaires on the extent of their satisfaction with the services offered by their co-operative. More recently, and now within most hospital and clinic facilities, the opinions of members and patients has been solicited through suggestion and complaint boxes ("rainbow boxes"). This material is reviewed and appropriate action taken by a "utilization review committee". As of September 1995, such committees had been established in about half of all hospital facilities. They are made up of members of the co-operative who are elected directly by the membership. They complement the work of the directors and managers by participating in the process of recruitment of professional staff in order to ensure their suitability for working in the special environment of user-owned health co-operatives. These committees are also beginning to have a say in recruitment of professional staff, and in hospital administration. Expansion in the numbers and activities of these committees, as also of the local "health committees", branch offices and "han groups", is considered a most important goal within the Five-Year Plan adopted in September 1995. Attention is also being given to such improvements as reducing waiting time, and ensuring reserved appointments for consultations.

To this end also, within the health co-operative movement's own clinics and hospitals innovations have been introduced in order to ensure effective participation of user-members in the operation of clinics and hospitals. Special attempts are being made to involve members of han groups in the operation of hospitals and clinics: increasingly han-group meetings are held within hospital wards, their members meet with professional staff, and participate in educational programmes concerning issues both of health and the effective operation of a user-owned health co-operative.

Within the **agricultural co-operative movement**, of which almost all rural households are members, multi-functional agricultural co-operatives within each prefecture have set up specialist organizations responsible for health and social care services to all their members. These are known as "koseiren". They have in turn set up a National Welfare Federation of Agricultural Co-operatives, known as "Zenkoren". They were established in response to adoption in 1947 of the Agricultural Co-operative Society Law. As of March 1993 the Welfare Federation system operated a total of 191 health and welfare facilities, largely for the benefit of members of agricultural co-operatives, but also for that of others resident in rural areas. These included 115 hospitals, with 38,012 beds, 57 clinics, 25 rural health centres (examination centres), six geriatric health centres and six home visit nursing centres, six

home visit nursing centres and seven home care support centres for elderly persons. A total of 3,207 doctors (including those engaged part-time), 18,733 health and hospital nurses, 4,168 medical technicians, 1,158 pharmacists and 10,450 other persons, were employed. A total of 26 of the 39 prefectural federations had set up hospitals. Facilities existed in 34 of the 48 prefectures, that is in 70 percent. Membership in the 34 prefectures is not known, but can be estimated at 6 to 7 million households. In 1990, it was reported that about 87 per cent of agricultural co-operatives had some health facilities for the use of members.37/ Facilities were used not only by member families but by rural inhabitants in general.38/ In 1996 the total membership of the Central Union of Agricultural Co-operatives was 8.8 million, representing households with a total population of 17.3 million. 39/

The first health programmes carried out by co-operatives in Japan were those organized in 1919 by the then Aobara "Industrial" Co-operative (in fact an agricultural co-operative, now the Nichihara Fraternal Hospital of Kanoashi-gun Welfare Federation of Agricultural Co-ops) in Shimane Prefecture. Such activities spread rapidly in agricultural areas, particularly during the 1930s, in agricultural areas. They were undertaken by farm communities *themselves as a response to the fact that neither private for-profit nor* public health services were available in most rural areas: only in serious cases would rural residents travel to urban centres to consult doctors, whose charges they could not usually afford.

In 1936 almost one third of villages and small towns had no resident doctors, a result of both a national shortage of doctors and depressed rural conditions. During the 1920s and 1930s an increasing number of rural communities set up what were termed "agricultural medical co-operatives". These were initially in some cases affiliated with agricultural co-operatives, in most instances were organized independently of them. They rapidly expanded to serve a larger number of communities, promoted by social workers, farmer-activists and co-operators. The first successful example of these more recent user-owned rural health co-operatives was set up in Aomori prefecture in 1928 with 700 members. After five years its membership had increased to 6,000, and it had built a general hospital. By 1937 there were 1,461 of these health co-operatives, serving 1,960 villages and 378 towns. After the Second World War the system of agricultural co-operatives was restructured, as a result of amalgamations of smaller co-operatives assumed a prefecture-based structure analogous to that already assumed by "agricultural medical co-operatives", now termed "koseiren".

These Welfare Federations in each prefecture were formed from the directorates of the previously existing "agricultural medical co-operatives". Thus, the health services within the agricultural co-operative movement are essentially independent user-owned health co-operatives having close organizational affiliation and a common membership with the multi-functional agricultural co-operative structures operating in the same sub-region.

This system comprises the provision of facilities and programmes by individual agricultural co-operatives, themselves multi-functional entities providing a wide range of economic and social services to rural populations, and characterised by substantial horizontal integration. They now constitute large co-operatives covering entire prefectures or major sub-regions, supplemented by additional facilities and programmes, as well as a coordinating function, provided by the national apex tertiary organization, itself a component of the Central Union of Agricultural Co-operatives (JA-ZENCHU). This Union is actively engaged itself in improving the general circumstances of the rural population, and provides complementary support to the Welfare Federation. The National Mutual Insurance Federation of Agricultural Co-operatives (ZENKYOREN) also complements the work of the Welfare Federation.

In 1951 the Welfare Federation was designated by the Government as an organization responsible for implementation of public health programmes in rural areas. An important function has been provision of regular annual health screening to rural populations. It was reported early in 1993 that

2.5 million persons a year received health screening provided by the Welfare Federation within this public capacity. For this purpose, the Welfare Federation maintained a total of 19 vehicles equipped for the provision of medical examination and treatment in remote areas, 87 vehicles equipped for health screening for adults, particularly for women, and 76 vehicles equipped for other health management functions.

Given that the process of demographic aging is even more advanced in rural areas than within the urban population in Japan, the welfare federations have given particular attention to problems of geriatric health and social care for elderly persons. Particularly following the adoption by the 19th National Congress of Agricultural Co-operatives in 1991 of policies giving priority to the provision of care to the aging rural population, and amendments adopted in 1992 to the Law of Health for the Aged, the National Welfare Federation introduced in April 1993 a more intensive system of care for the aged, including home care after hospital treatment, consisting of visits by doctors, nurses and physical therapists. Costs were met by the public health and social security system. Home help services providing cooking, washing, cleaning and other forms of help have also been introduced.

As a result of changes in the public health and social security system adopted in 1993, which involved substantial decentralization of responsibility from central to local government authorities, the Welfare Federation has begun to work very closely with the urban and village authorities of predominantly rural regions in the design of comprehensive health and social services in which the Federation would be a principal contributor and partner. However, the reduction in expenditures in the health sector has caused severe problems for the many Welfare Federation facilities and programmes whose income had been derived directly or indirectly from expenditures made by the public health and social security system.

As of March 1992 2.2 per cent of total national expenditure on health care was accounted for by the Welfare Federation system: in some prefectures the proportion was higher - Akita (25), Nagano (15), Niigata (11) and Tochigi (10).

3. User-owned health co-operatives operated as autonomous primary enterprises but sponsored by broad user-owned co-operative or trade union organizations with which there are operational linkages and common membership [type 1.1.1.3]

In **Senegal** a 1975 law authorized the establishment of health co-operatives by workers in the private sector at their places of employment. Workers in the public sector, and self-employed persons, were not included. This new type of health care organization - the Provident Health Care Institute (Institut de Prévoyance Maladie (IPM) developed from discussions between trade unions, employers and the government during 1974 and early 1975. Every enterprise with more than 150 employees could set up such an institution - smaller enterprises combined to establish one. Experience showed that about 600 members were necessary in order to accumulate sufficient funds. While members retained majority control, employers were guaranteed two places on the Administrative Council and appointed the treasurer. Funds were provided by a surcharge of 3 per cent of basic salary for each member, to which was added an equal contribution by the employer. After four to six months waiting period, the health costs of members and their families were reimbursed at the level of between 40 and 80 per cent, depending upon the funds accumulated. Members could choose the doctors, clinics or pharmacies which would provide them with services, accounts being sent directly to the cooperative. The cooperative paid the salaries of a manager and assistant: premises and operating costs were usually provided by the employer. Much of the support for their development, and membership of the Boards of Directors, was provided by union members and militants. As of 1980 there were about 40 such cooperatives in the country, all in the Dakar region. 40/ Since that date no further information has become available.

In **Singapore** co-operatives engaged in the health sector have been sponsored by the National Trade Union Council (NTUC) on behalf of its members [type **1.1.1/2.1**]. They are a form of user-owned health co-operative: members of component trade unions within the Council automatically enjoy membership. The oldest co-operative is the NTUC Co-op Dental Care Society, Ltd., founded in 1971, which in September 1995 operated two clinics. It was intended to open an additional clinic each year. In 1992 a second co-operative was founded: the NTUC Health Care Co-op, membership of which was not restricted to union members. This was to develop a pre-payment plan (health maintenance plan), and to construct its own hospital facilities. It was developing a chain of pharmacies, located primarily within the supermarkets operated by a NTUC sponsored and consumer-owned retail co-operative.41/

In the 1950s in the **United States** trade unions in Philadelphia and Chicago combined to establish health insurance plans for their members. By 1960 it was estimated that these provided health care to about five million persons through health centres which had various forms of co-operative structure, but always including user control. It is not known if these programmes continued into the 1980s and 1990s. A 1984 article reported that a Co-operative Services Optical, Inc. had operated since the 1960s, providing eye examinations, glasses and contact lenses to its members, who were also members of trade unions. Trade unions represented their members in the direction of the co-operative.42/

4. User-owned health co-operatives operated as autonomous primary enterprises but sponsored by provider-owned health co-operative organizations with which there is no common membership but close operational linkages [type 1.1.1.4]

In **Brazil** since 1993 the provider-owned health co-operative system, Unimed, has encouraged the establishment of user-owned co-operatives (**Usimed**) by which citizens, particularly those with lower incomes and for whom employers provide no health plan, establish their own group health plan in collaboration with the Unimed Complex. These are co-operatives formed by persons who are already individual users of Unimed health schemes. They are designed to reduce health costs to members through their contracted association with Unimed co-operatives, which provides them with access to the full range of their high quality health services. The first such co-operative started operations in February 1994: by mid-1995 there were six, with an additional ten planned to begin by early 1996. The number of users was 50,000 in mid-1995, and by early 1996 it was planned that this would double. 43/

Unimed works with its associated user-owned health co-operatives - Usimeds - for the diffusion of health education, and particularly for the restoration of a community-based health service. Charitable and local government hospitals, which formerly were of considerable significance, have suffered a notable decline in recent decades, and it is hoped by Unimed that collaboration between providers and users, each members of their own co-operative health enterprises, would be a means to reinvigorate these local services. This would appear to be the first and only known case of a user-owned health co-operative originating as a result of sponsorship by a producer-owned health co-operative

B. Jointly owned (user-and provider-owned) health primary co-operatives [type 1.1.2]

Health co-operatives of this type are known to exist only in Costa Rica and Spain. In **Costa Rica**, the health co-operative "Coopesana" was founded in May 1993 in the canton of Santa Ana, 15 kilometres west of San José, and served a population of 27,000. In January 1995 it had 67 members, including both doctors and 13 community associations (individuals could be members only through their associations). Each paid identical shares (equivalent to 226 Canadian dollars in 1995).

In **Spain** a jointly-owned primary level co-operative hospital, the "Sociedad Cooperativa de Instalaciones Asistenciales Sanitarias (SCIAS)", operates in Barcelona in close association with a complex of provider-owned health co-operative organizations, which provided most of the capital for its establishment. This is a true joint service provider- and user-owned co-operative: members include health professionals, support personnel and patients (persons holding a "policy" with the Asistencia Sanitaria Colegial/Autogestio Sanitaria). Transformation of an existing incomplete building (originally intended as a Hilton Hotel) began in 1983 and was completed in 1989.44/

C. User-owned social care primary co-operatives [type 1.2.1]

Information in each of the following sections will be presented by country, irrespective of the type of social care co-operative. Social care co-operatives of this type are known to exist in Canada, Finland, Lebanon, Philippines, Poland, Romania, Sweden, the United Kingdom and the United States. Resources did not permit a comprehensive global survey, and it is very probable that they exist also in other countries.

In **Canada**, child-care and nursery school co-operatives are well developed. The oldest known co-operative nursery school began operations in 1937 in central Toronto. A study undertaken during 1991 and 1992 identified over 900 such co-operatives serving 40,000 families in all parts of the country. Although some operated in isolation, many had established regional organizations. In September 1991 the Parent Co-operative Preschools International, which had acted as a resource organization for these regional councils, set up a Task Force on Canadian Childcare Co-operatives to review the condition of this type of co-operative. It also studied the feasibility of forming an Association of Canadian Childcare Co-operatives, and recommended that it be established. This Association was set up in Toronto in May 1993. In a number of Canadian cities, parents who had been members of childcare co-operatives when their children were young continued their interest in co-operative forms of education by later setting up co-operative primary schools.

These co-operatives were the first to develop programmes for children with special needs: this occurred in Hamilton, Ontario in the early 1970s and by the early 1990s three such programmes, in Hamilton and also in London and Toronto, were in operation. They received public funding to provide consultation and support services to day care and nursery co-operatives serving children with special needs.45/

During the 1990s in the Province of Quebec, Canada there has been a growth in the number of co-operatives providing home services, particularly to elderly persons. Some were provider-owned, but the majority were user-owned. Most received ad hoc subsidies from regional or national government authorities. The third level apex cooperative organization in Quebec (Conseil de la cooperation du Quebec) recently adopted a resolution asking the provincial health ministry to reserve at least half of home service contracts for this type of co-operative. 46/

In **Finland** in late 1995 there were six co-operative creches and one co-operative residence for elderly persons.47/

In **Lebanon**, in 1985 a group of persons with disabilities joined a previously existing Friends of the Handicapped Association, transforming it into an organization operated by, as well as for, persons with disabilities. It was this newly constituted association which promoted the first independent living centre run by persons with disabilities, formed in 1986 in Tripoli, others being set up subsequently elsewhere. The Association has promoted development of transportation, education, health and social care services, job creation and lobbying for the rights of persons with disabilities.48/

In the **Philippines** a number of co-operatives affiliated with the National Confederation of Cooperatives (NATCCO) established daycare centres for their members. These were so successful in meeting needs within the communities in which the co-operative operated that they were subsequently opened to non-members. This was the case, for example, in the Palompon Community Credit Cooperative, in Leyte, and in the Oyao Multi-Purpose Cooperative in Nueva Vizcaya.49/

Worker-owned production and service provision co-operatives whose members are persons with disabilities have been particularly well developed in the form of "sheltered work places" in some eastern European countries, notably in **Poland**. This is an example of a system which originated in the need to resolve the problems of large numbers of war-disabled persons, many of whom displaced persons. It is particularly relevant to the current situation in many countries, where there are very large numbers of persons in similar personal circumstances. Begun immediately after the Second World War, they were integrated in the centrally planned economic and social welfare structures of the socialist regimes. In 1980 in Poland, for example, there were 435 such co-operatives, employing 272,000 persons, of which 74 per cent were persons with disabilities. They were grouped into 17 regional unions, and had a national apex organization: the Central Union of Invalid's Co-operatives. These co-operatives produced goods which were protected as State monopolies. With transition to a market economy, these monopolies ended, and although the disabled workers' co-operatives continue to operate, they now face considerable financial difficulties.50/

In **Romania** in 1992 there were 850 handicraft co-operatives, with 300,000 members of which 20,000 were persons with disabilities. These cooperatives provided medical and social insurance, health treatment, holidays, training and vocational education for their members.51/

From the late 1980s until 1994 in **Sweden** national and local governments (municipalities and county councils) created a legal and economic environment increasingly favourable to operations undertaken by entrepreneurs, both co-operatively organized and others, within the social care sector. User-owned, provider-owned and multi-stakeholder social care co-operatives have appeared.55/ However, since 1994 there has occurred a change in local government policies reversing the earlier trend. In some cases, pressure has been exerted on the new provider-owned social care co-operatives to return to the public sector.52/

Users - for example, a group of elderly persons - have first formed an association, then applied for public financial support, and finally hired professional and paraprofessional workers to provide the required services, to themselves or to persons in need for whom they have responsibility (as family members or as individual or institutional guardians). As of September 1995 there were an estimated 1,600 such user-owned co-operatives, of which 1,400 were childcare co-operatives. About 64 per cent of their income was obtained from local or national governmental authorities as payment for care provided to beneficiaries of the national health and social security insurance system.53/

Citizens perceive user-owned social care co-operatives as a means to more directly influence their living conditions and to ensure better quality services. They have been willing to participate in their development and to contribute to their operation.

Psychiatric care has been provided by co-operatives owned primarily by patients, with, in some cases, membership by professional staff, at Husomtarna and in the Enskede-Skarpnack psychiatric section of Stockholm County. This type of co-operative has increased substantially in numbers in recent years.

Residential service co-operatives have been established by persons with disabilities in Goteborg, Jonkoping and Stockholm in the form of residential co-operatives. They engage employees to provide the personal services they need, mostly home help and personal assistance, but they own and manage the

co-operative themselves. Those whose members were primarily persons with mental disabilities employed resident staff. They have been set up also by elderly persons. An example is provided by the Stockholm Association for Independent Living (STIL), established in 1987 by persons with serious disabilities which required them to seek regular care. Members wish to avoid dependence upon a single carer, and each manages the work of their carers, giving them the status of employer and not client. They are able to choose their own carers, rather than be dependent upon an inflexible public service. The co-operative functions as a recruitment and organizational enterprise on behalf of its members. In November 1992 it had 85 members, and by 1994 over 100 in the Stockholm metropolitan region. It manages about 400 carers, each engaged on a temporary basis.54/

Child-care and nursery school co-operatives, in the form of parent-owned user co-operatives, were first started in Sweden during the mid-1970s. Some were sponsored or supported by housing co-operatives: but the majority were autonomous ventures undertaken by parents.Prototypes were often the "anti-authoritarian kindergartens" which had been set up in the then Federal Republic of Germany. To a significant degree parents wished to gain greater influence over the daily care received by their children: that is their objective was to some extent ideological. However, they were motivated also simply by a wish to obtain a satisfactory day-care service, given the absence or inadequacy of contemporary arrangements: more recent surveys showed in fact that the ideological goal, although still present, had been surpassed by that of a simple interest in securing satisfactory day-care. Member (parent) satisfaction was high, so that even when places became available in public sector day care centres, they preferred to keep their children in a co-operative centre. Here, although required under the terms of membership to contribute a considerable amount of voluntary work, they felt they were able to influence directly the type of care provided to their children.

Most co-operative daycare centres looked after between 12 and 20 children. Some had a particular pedagogical profile (such as Montessori), but this was not generally the case. The co-operatives' members were the parents and, in a few cases, the staff, and together they formed either a type of non-profit organisation or an economic association. The latter was usually considered the more suitable structure, with limited liability for board members and a requirement for each member to participate. There were no legal regulations governing the price of shares, so often the members "purchased" only a symbolic share for membership. The members elected a board with a chairman and a treasurer. In many cases the board was comprised of one representative for each family, and thus equal opportunity for direct participation in important decisions concerning finances and fees, employment of teachers and educational principles. When the board made a decision all members were informed and a high degree of member acceptance could be expected. This model could result in a certain lack of efficiency - arriving at decisions could be time-consuming but as acceptance by members was usually high, implementation was relatively easy. Each member was expected to provide voluntary assistance with administration and/or maintaining the premises. In many co-operatives they also worked directly with the children and helped with cooking on a rota basis. The time required from each parent varied from one to 60 hours per month.

The position of the employees could vary considerably between co-operatives and could sometimes cause problems. Teachers in parent-owned co-operatives were formally subordinated to a board of parents. On the other hand, the teacher instructed the parents in the performance of day-to-day work at the facility. Normally the staff had great influence in the management of the co-operative, both participating in board meetings and providing a co-ordinating function. Staff conditions of employment (such as wages, hours and fringe benefits) seemed a little more favourable than those of their municipally employed counterparts. The employees of co-operatives had to learn how to work with amateurs and be prepared for the possibility of having their professional role questioned, without feeling threatened or defensive. They had to be certain of their objectives, but on the other hand, be sensitive to the needs and opinions of parents. Establishing a good

relationship between parents and staff could sometimes be hard, but studies showed that in a majority of co-operatives the parents and employees were satisfied in this area.

Most income of parent-co-operatives came from municipal subsidies. The basis on which they were granted could vary from town to town, but commonly a co-operative received an annual amount per child, depending on age. The local authorities also granted the co-operative an annual contribution corresponding to the costs of the premises. Before commencing operations, parent-owned co-operatives also normally received a one-off amount for buying necessary equipment.

The board decided annually about the fees charged to members. The members could influence their level of payment by doing more or less voluntary work, but the final decision was made by and for the group of members, i.e., parents could not determine their own fees simply by doing more or less work. Normally the total of parents' fees covered about 20% of the co-operative's costs.

During the late 1970s and the 1980s government authorities were on the whole reluctant to permit and even less to fund such user-owned co-operatives. However, numbers grew from five co-operatives in 1975 to 150 ten years later, and then to 500 in 1989, 933 in 1992 and 1,400 in 1995. In 1994 12 per cent of all children in day-care centres were in co-operative centres, which existed in 80 per cent of municipalities. Most were in the larger urban centres, but they were numerous also in rural districts, where the demand for their services was very great. They were largely financed by subsidies from central and local governments.55/

In the **United Kingdom** there were in 1995 between 40 and 50 "social employment co-operatives" which provided work for persons with disabilities, or recovering from mental illness. Among the best known were Daily Bread, a wholefood retailer and wholesaler that employed persons recovering from mental illness; Pedlar Sandwiches, a catering co-operative employing persons with mental illnesses; Adept Press, a printing business employing persons with hearing impairment; Rowanwood, a producer of wooden panelling products, which employed persons with learning disabilities; Gillygate Wholefood Bakery, an employer of persons with learning disabilities; and Teddington Wholefood Co-op, which had developed recently from a day care centre, and which employed persons with learning disabilities.56/

In the **United States** the United Seniors' Health Co-operative in Washington, D.C., a service co-operative owned by elderly persons provides programmes concerning both the health and social well-being of elderly persons.57/ It constantly seeks innovative ways in which to achieve its objectives. In 1992, for example, it initiated as founder member the "Cooperative Caring Network", through which volunteer members help each other remain independent. This Network expanded rapidly during 1993, when 12 community service organizations joined the network. During 1994 it was hoped to bring the total of such organizations to 20, and the number of volunteers to 3,000.

This is a volunteer "service exchange" programme which encourages those people who receive help to serve others as well. It links generations and increases opportunities for independence. It is based on the concept of "giving and receiving". Its purpose is to assist older people and persons with disabilities to remain in their homes by offering ways in which they can continue to be active and valuable to the community and to themselves. This arrangement contributes to the removal of the emotional difficulties experienced by many obliged to receive help, by transforming their situation into one of both receiving and giving within a network for mutual self-help.

Participants in the Network earn "care credits" by providing voluntary services such as friendly visits, telephone reassurance, respite care, transportation, shopping, counselling and help with financial management. These credits can then be used to obtain help they may need for themselves

(whether at the same time or later), or they may donate the credits to another individual participant or to one of the participant organizations.

Software has been developed to manage the Network: for example, to keep track of volunteer hours, match providers with recipients, report recipient activities, credit and debit individuals' accounts and generate quarterly reports. By this means an expansion in the participants in the Network can be managed effectively, and a larger base of services, volunteers and other resources established and kept operational. A programme of this type could be applied to a very wide range of social care services.

The Co-operative has undertaken a number of research projects, working in collaboration with research, consumer and professional organizations. During 1993, for example, it completed a review of international trends in measures taken by governments to help people with disabilities to continue to live at home and operate within their own communities. During 1994 it was intended to develop a new programme in the area of mental health and aging.

During 1993 USHC undertook a research study of home care for older persons. Its professional staff interviewed more than 30 experts and researchers and conducted focus groups made up both of consumers and providers of home health care. On the basis of this combination of expert knowledge and first-hand experience, a practical guide for elderly persons who want to find reliable at-home care was prepared and published. (Anne Werner and James Firman, Home care for older people: a consumer's guide). The Cooperative employed the same methods to produce or update other major publications, some of which have become best sellers for mass market distribution by commercial publishers.

USHC has continued to improve its computer services to help low-income persons of all ages obtain the public benefits to which they were entitled. The co-operative was formed primarily to deal with the fact that many eligible persons did not receive the public and private health and social care benefits to which they were entitled. This was so partly because it was difficult to obtain the relevant information, and partly because few service providers themselves understood all of the complicated requirements of each of the many available programmes.

To remedy the situation USHC developed Benefits Outreach Screening Software, created to meet the needs of elderly persons. By 1993 it had been installed in over 400 sites in 23 States and in the District of Columbia. In 1993 the Cooperative developed a version of the programme to help persons of all ages. As a result service organizations could quickly and easily determine an individual's or family's eligibility for all entitlements.

Applications of the software have been widespread and successful. In the State of Ohio it has been implemented throughout the public service. During 1993 USHC worked for the Social Security Administration with Howard University and the service organization Bread for the City in Washington D.C. on outreach projects. This collaboration resulted in the distribution of over one million dollars to eligible people who had never applied for such benefits or who had become too discouraged to continue their applications. With funds from a foundation, USHC conducted a feasibility study to determine the best approach to implementation of this programme in the State of Maryland. The Co-operative also began a major new demonstration project in New York City in collaboration with the Jewish Association of Services for the Aged, Catholic Charities and the Urban League. The service will screen persons of all ages, and automatically complete applications to major entitlements programmes.

During 1994 it was intended to launch a new Personal Advocates Service through which volunteers would help frail persons to understand and obtain the health and social services to which they were entitled.

D. <u>Joint user- and provider- owned social care primary co-operatives [type 1.2.2.]</u>

In most countries with developed market economies which have had well established welfare state structures, public programmes formerly catered for the needs of most persons in need of care. As these structures have retracted, scope for the formation of jointly-owned co-operatives has expanded. "Multi-stakeholder" social care co-operatives of this type are known to exist in El Salvador, France, Italy, Portugal, Spain, Sweden and the United Kingdom.

In **El Salvador** in 1980 a group of young women and men with disabilities established the "Independent Group for Integral Rehabilitation" (GIPRI), registered as a co-operative association in 1981 under the name ACOGIPRI. Some members produce finely glazed and finished pottery, subsequently exported, and a main source of income. By the early 1990s the co-operative operated a transport service for those persons with mobility-constraining disabilities, produced a newsletter for a wider readership of persons with disabilities in El Salvador, and was active in the development of national policy for persons with disabilities. At various phases of its development it was supported by the Canadian co-operative movement and by UNESCO 58/.

In **France** parents of children with severe mental disabilities have established the Syndicat National des Associations des Parents d'Enfants Inadaptés, representing a large number of co-operatively organized societies throughout the country. 59/

In **Italy** this type of co-operative is particularly well developed. 60/ In 1986 there were 500 such co-operatives, at the end of 1988 there were 1,242 and in 1990, 2,125. In September 1995 it was reported that there were about 2,000 "social" co-operatives, of which, in June 1993, 1,826 were affiliated with either Lega Cooperative or Confcooperative. They employed about 40,000 persons as well 15,000 volunteers, and provided services to about two hundred thousand persons. In 1993 about 13 per cent of public spending on the health and social sectors was used for financing social co-operatives.

These include co-operatives providing only health services, or both health and social care services. However, in a sample of 549 studied in 1992, only 13 per cent provided health services. Clients included elderly persons, persons with disabilities, drug addicts, children and young persons, persons suffering from AIDS, ex-prisoners and prisoners, and immigrants: many provided services to several types of client. Some comprised disabled persons' sheltered work places.

There are numerous social care co-operatives whose members are simultaneously users or beneficiaries and providers of non-professional services. In some cases members who are young persons with problems, including alcohol and drug abuse, operate as providers of social care to persons with disabilities and the elderly, also members of the co-operative. In return, older persons act as counsellors and as vocational trainers to the young members. Most members are not beneficiaries of social care, but are voluntary or paid para-professional and professional workers. Membership is in fact highly diverse, including clients, providers, volunteers and suppliers of finance, including local governments, and other supporters.

In **Portugal** during the second half of the 1970s, in response to the insufficiency of provision for children and young persons with mental disability, care-providers and other concerned persons established the "Movimento Cerci" (Cooperativas de Educacao e Reabilitacao de Criancas Inadaptadas). At first these co-operatives focused their attention on children and young persons of school age, for whom the then education system offered no acceptable pedagogic or social response. Subsequently, it was increasingly felt necessary to create new conditions appropriate to the different stages in the development of users, whether children, young people or adults, whereby their integration in society might be realized fully and effectively. To meet this need there were created Centres for Professional Training, Centres for Occupational Support, Residential Units, Early Intervention Units (Unidades de Intervençao Precoce), Centres for Protected Employment and Shelters. 61/

In **Spain**, parents of persons with mental disabilities have joined with professionals to establish "sheltered workshops". By 1991 about 40 such co-operative work centres, employing 3,900 persons with mental disabilities, were members of the Catalonia Workshops Co-ordinating Body.62/

In **Sweden** parents have become members of a number of the day-care co-operatives established by providers. 63/ In the **United Kingdom** members of a number of worker-owned co-operatives have decided to employ, as part of their corporate employment policy, persons with mental, physical or social disabilities (in the case of one co-operative, the proportion of such persons within the total work-force was up to half). This is termed an "integrated employment policy". These co-operatives function in a normal manner, achieving and maintaining their viability within the market by means of their effective operation. They produce a wide variety of goods: for example, wooden murals, bulk quality foods, and bakery products. Persons with disabilities who have been supported by inclusion in the work-force of such co-operatives include not only those suffering from physical or mental handicap, but those with a "social" disability, such as ex-prisoners, persons addicted to drugs or alcohol, single parents, victims of domestic violence, homeless persons and persons who have been unemployed for long periods.

The persons with disabilities who are employed participate fully in management, it being co-operative policy to help build their self-confidence by not placing restrictions on their opportunities to participate fully in the life of the co-operative. They are recruited primarily with a view to their ability to carry out tasks in the same way as any other employee, although such worker-owned co-operatives also have a policy of making operations as flexible as possible, in order to help persons with disabilities to carry out their work effectively. Although only a small number of such co-operatives have so far been established, they have been relatively successful in integrating persons with disabilities within the labour force.64/

E. Provision of social care services to individuals by user-owned health co-operatives

In addition to the services provided by social care co-operatives, many services are delivered by health co-operatives, particularly by user-owned enterprises, for which social care is but an extension and specialization within their community-based, member-participative approach and their emphasis on healthy living. Such provision could be considered a basis for distinguishing sub-types among user-owned health co-operatives, but this aspect is not pursued as only a few examples are included, in this comprehensive review.

The emphasis which most user-owned health co-operatives place upon preventive health, including outreach to the communities in which they operate, particularly to disadvantaged persons, allows for an easy progression to programmes in social medicine and to those in social care and welfare. An increasing proportion of health co-operatives, in response to the concerns of their members, extend their activities to social care. This expresses the entirely pragmatic view that alleviation of the social problems faced by many individuals will in the long-term bring an improvement in their health, and that of their families and other carers, and consequently a reduction in the cost of curative and rehabilitative care which would be charged eventually to the co-operative. In this context also, it reflects the view of members that the facilities and staff of their health co-operative provide the best base from which to provide social care services, at least until such time as the demand becomes so great that autonomous social care co-operatives within the same community are the most appropriate organizational response to social conditions. It also expresses the co-operative principle of concern for the community. In the summaries of the current situation set out below, information was obtained from the same sources to which reference is made in the earlier entries on health co-operatives proper, with few exceptions, which are noted separately.

In **Canada** most co-operative health clinics provide social care for the elderly, and act as the base for programmes such as that of Alcoholics Anonymous.65/

In **Japan** the health co-operatives within the consumer co-operative movement are concerned with all aspects of the well-being of their members, and particularly, given the demographic character of the population, that of elderly persons. This concern has taken on an added dimension with changes in government policy which have included decentralization of responsibility for social care programmes to local governments, to communities and specifically to the families of persons requiring care. Given that demographic and socio-economic processes have brought about a disintegration of communities and families, the consumer-owned health co-operative movement perceives its own function to be one of partial replacement of the capability of communities for mutual assistance and supported self-help. The movement uses for this purpose the "han-groups", backed by the advanced facilities and trained staff of their health co-operatives.

The movement has recently extended its priorities and services to the provision of support and rehabilitation services to persons particularly in need. Given the demographic aging of the Japanese population, the special needs of the elderly are being given increasing attention. Health co-operatives are currently promoting various kinds of home care for the elderly. Attention has been given to the use of networks of members and other volunteers to provide support for daily living in their own homes by helping in shopping, housework, preparation of meals and taking baths. Within its Five-Year Plan for the period 1995-2000 it is intended that each health co-operative establish specialized institutions for the care of elderly persons, including day-care centres, home-care programmes and residences with full-care. The role of health co-operatives is of particular importance given that public health insurance caters only for curative and rehabilitative, but not for preventive, treatment.66/

In the agricultural sector health co-operatives have developed as part of the broad responsibilities of the "welfare federations" which exist in each of the agricultural co-operatives. These formerly existed at the local level, now amalgamated into large and multi-functional entities at sub-prefectural and even prefectural levels. Social care programmes have been a primary concern from the inception of these bodies and constitute a natural complement to the activities of health co-operatives per se, rather than as an extension of these. In 1979 the Central Union of Agricultural Co-operatives (JA-ZENCHU) adopted a "Basic Policy of Better Living Activities of Agricultural Cooperatives" which included, together with components on health, consumer and cultural activities a section on co-operative activities for elderly persons.

The demographic aging of rural communities has been greater than the national average, and welfare federations have given increasing attention to the problems of social care for elderly persons, in association with emphasis to geriatric health within their health co-operatives. To complement a more intensive system of health care for the elderly, introduced in April 1993, home help services were also introduced. Welfare federations have begun to work very closely with local authorities in predominantly rural regions on the design of comprehensive health and social services in which they would be a principal contributor and partner.67/

In **Sweden** the co-operatively organized and community-based health care model "Medikoop", developed in the early 1990s by housing and insurance co-operatives in collaboration with local government authorities, envisages coordination of preventive health care with care for the elderly. Elderly members of housing co-operatives have taken an interest in the organization of co-operative primary health care, associated with home nursing and home help services. For example, in Snopptorp, a housing area in Eskilstuna, home help and home nursing have been provided by a co-operative since 1991.68/

In the **United States** health co-operatives usually extend preventive and rehabilitative services to areas of "social medicine" such as geriatric

nursing and hospice care. Some have taken on purely social care services: for example the Group Health Co-operative of Puget Sound provides alcohol and drug treatment and teenage pregnancy programmes. The United Seniors Health Co-operative (USHC) in Washington D.C. is a prime example of the combination of health and social care functions for the elderly.69/

F. Provision of social care to individuals by joint user-owned and provider-owned health co-operatives

In **Costa Rica** the "Coopesana" co-operative provides social care services to the 27,000 inhabitants of its service area. In **Italy** a small proportion of the "social co-operatives" provide only health services, a larger proportion provide both health and social care but the majority provide only social care.70/

G. Primary level user-owned co-operative pharmacies [type 1.3.1]

In Europe in 1994 there were 2,500 co-operative pharmacies operating at the primary level. They served 30 million members, and had a market share of about 10 per cent. This type of primary co-operative in the health sector exists to a substantial extent only in a few countries, notably in Belgium. Members of the European Union of Social Pharmacies include not only co-operatives but other types of organization within the "social economy" such as mutual associations. Members operated in **Belgium, France, Italy, the Netherlands, Switzerland** and the **United Kingdom**. Similar types of organization existed in Finland and Ireland. Co-operative ("social") pharmacies supplied drugs and equipment not in isolation, but within the context of a broad health service approach which included advice, follow-up, background information and preventive measures. They sought the efficient and rational use of medicines.71/

With assistance from the Belgian tertiary organization, prototype primary co-operative pharmacies have been set up in the **Czech Republic**.72/ In January 1996 10 co-operative pharmacies had already been set up. They had a very high standard of equipment and distributed a wide variety of drugs to their members. The establishment of two further co-operative pharmacies was being prepared. 73/

In **Haiti** the International Labour Organization, as part of its programme of support for co-operative development, is encouraging the organization by co-operatives of community pharmacies.74/

In **Germany** there were two pharmacy co-operatives in operation during the period 1990 - 1994 (there had been three in 1980 and five in 1970). Their turnover (umsatz) was 4,021 million DM in 1994. 75/

In **Niger** the International Labour Organization, as part of its programme of support for food security, is encouraging the establishment of ten village pharmacies managed by local co-operatives.
76/.

In **Singapore** a chain of what might be described as primary level co-operative pharmacies have been set up within the co-operative supermarkets promoted by the National Trade Union Congress. Membership of these co-operatives consists of all members of the unions within the Congress.77/

It should be borne in mind that many health co-operatives provide their own pharmacy services for members, seeking to provide affordable and appropriate medicine and equipment. For example, in Brazil the user-owned Usimed co-operatives set up in 1993 already operated a chain of pharmacies in mid-1995.78/

H. Secondary level co-operatives owned by user-owned retail co-operative pharmacies [type 1.3.2.1]

In the **United Kingdom** National Co-operative Chemists Ltd. is a secondary co-operative established in 1945 and owned by about 25 primary consumer-owned retail co-operatives with a total of 230 pharmacy outlets. In 1994 net sales exceeded 86.8 million pounds sterling, rising in 1995 to 91.5 million pounds.79/

I. User-owned comprehensive system of health and social care insurance and service delivery operated as specialist subsidiaries of co-operative organizations [type 1.1.1.5]

In **Israel** probably the most comprehensive co-operative health system to have existed in any country originated in 1926 and expanded until by the early 1950s, and thereafter until 1995, when it was fully nationalized, it provided comprehensive health insurance and service coverage to more than 70 per cent of the population. This was provided as a benefit of membership in the national trade union organization, Histadrut, which operates as both trade union and co-operative apex organization, and which includes 85 per cent of wage earners and all members of cooperatives.

All members of Histadrut are simultaneously members of and shareholders in a parallel system of co-operative business enterprises, of which the apex and holding organization is Hevrat Ha'Ovdim (General Co-operative of Labour in Israel Ltd.). This has a considerable number of subsidiary organizations engaged in many sectors of the economy. A significant proportion of the remainder of the economically active population are members of independent co-operative organizations which are affiliated with Hevrat Ha'Ovdim, and are also members of Histadrut.

One of the specialist subsidiary organization of the Histadrut, Kupat Holim, was one of a number of mutual aid service organizations of Histadrut. It was responsible for provision of health insurance and services to all members of Histadrut (who were simultaneously, through Hevrat Ha'Ovdim, its members and owners). Founded on the mutual aid principle, each member paid progressive fees based on salary and size of family but without regard for the scope of medical needs, in return for which they and their wives/husbands and children up to 18 years of age were eligible for all required health services, including primary care, hospitalization, etc.

At its peak, this co-operative health system employed about 30,000 persons, including over 8,000 doctors. It owned and operated more than 1,300 family clinics, which also provided paediatric care; more than 800 specialized clinics; and 14 major hospitals, including two geriatric hospitals and one psychiatric hospital. All members of Histadrut were also eligible for membership of one of seven pension funds. These owned convalescent homes and holiday resorts operated by Kupat Holim.

In 1995, after a period of intense debate, and with opposition by many of those associated with trade unions and co-operatives, the health system in Israel was fully nationalized. Health care is now government financed; its costs are covered through a universal health tax. There is no linkage between the payment of this tax and membership in the Histadrut. Kupat Holim and its institutions continue to serve as a major supplier of health care but it is now no longer a co-operative framework. The Histadrut continues to hold some share in the ownership of Kupat Holim but this is not seen as a long-term situation. 80/

J. User-owned comprehensive systems of health and social care insurance and service delivery operated as mutual, not co-operative, organizations

Mutual assistance associations, usually termed "mutuals" are similar in many ways to co-operative enterprises. Historically, in many countries they developed from the same roots, in the same societal conditions, and for the same purposes as co-operative enterprises, from which they were distinguished in many cases only by the specifics of legislation and administrative usage. Mutual societies in Europe have the same historical origins as trade unions and co-operatives, but have constituted a separate juridical form since the end of the nineteenth century. They developed first in the agricultural sector as societies for mutual help in order to protect farmers from occupational losses (livestock mortality, fire, etcetera), then developed in urban centres among workers as a form of social insurance against accidents, ill-health and unemployment. There are various definitions of mutuals, depending on the configuration of the national social security scheme, with which they are closely related. However, the basic difference from co-operative enterprises lies in the form of ownership. While a co-operative belongs to members, the mutual organization has no social capital, does not pay dividends, and in case of liquidation its assets are not distributed among members.

Contemporary co-operative movements and mutuals maintain the distinctions between them, but there is considerable strategic collaboration - for example, the specialized body of the International Co-operative Alliance concerned with insurance is the International Co-operative and Mutual Insurance Federation (mutual insurers having been admitted to membership with co-operative insurers in 1993. More broadly, co-operative, mutual and other associations, such as trade unions, are perceived as forming complementary, if distinct, components of what is termed the "social economy" - as is the case of the responsible Directorate within the European Union.81/

Although this global review is concerned explicitly with co-operative organizations, given the mandates provided by the General Assembly, it is considered relevant to its purpose, and specifically to its consideration of strategies for more effective contribution by the co-operative movement to health and social well-being - which will involve strategic alliances with other stakeholders - that the nature of the engagement by "mutual organizations" be explained. While resources did not permit a comprehensive review of this engagement, the contribution of such organizations is included below as an example.

In **France** mutual assistance groups, whose function was to come to the help of persons working within the same profession, and their dependants, when confronted by unemployment of illness, were common as early as the Middle Ages. They achieved legal recognition in 1852 as "mutual aid societies" (Sociétés de Secours Mutuels or "Mutuelles"). They increased from 2,000 (with about 100,000 members) in 1850 to about 13,000 (with about 2,100,000 members) by the end of the century. The first legal code devoted to them (the Mutualité Code of 1898) defined them as follows:

> "Mutual Aid Societies are providence associations which propose to attain one or more of the following goals: assure assistance for members and their families in case of illness, injury or disability; establish retirement funds for their members; take out private or collective death or accident insurance policies to benefit their members; provide for funeral expenses and grant assistance to the descendants, widowers or orphans of deceased participating members. In addition they can create for their members professional courses, free placement services and allocate funds in case of unemployment, on the condition that these three expenses be provided for by contributions or special revenues."

During the remainder of the nineteenth century an increasing number of Mutual Aid Societies combined in unions at local and departmental levels, and in 1902 a National Federation of the French "Mutualité" (Fédération Nationale de la Mutualité Française) was created.

During the nineteenth century the basic insurance function of Mutual Aid Societies had been expanded to include establishment and management of social

charities, doctors, pharmacies, maternal and child welfare health centres, employment services, training courses, public baths, soup kitchens and other facilities and programmes. During the twentieth century further expansion occurred, including creation of funds designed to pay hospitalization expenses (caisses chirugicales), as well as mutual aid clinics. From 1895 onwards Mutual Aid Societies could contract with other non-profit organizations in order to create or manage health-care, social or cultural establishments.

When a National Insurance System (Assurances Sociales) was introduced in 1930, with compulsory membership for salaried employers in industry and commerce, the Mutual Aid Societies were assigned management of 500 Health Insurance Funds (Caisses d'assurance maladie), which covered 40 per cent of the total number of persons insured by the National Insurance System, as well as management of 63 pension plans (Caisses d'assurance vieillesse) which covered 60 per cent of those insured. By 1938 there were 22,000 "mutuelles" with 9,800,000 members.

In 1945 a comprehensive national system of compulsory social security was created, covering at first a large but incomplete proportion of citizens. It was gradually extended over the next 33 years to cover sections of the population with particular needs, and by 1978 achieved a virtual universal coverage. The system of Mutual Aid Societies ("la Mutualité") continued to play an important role as a formally acknowledged partner to the public sector in the administration of this national system. They provide complementary health insurance, whereby members, who must pay providers directly for health services and then obtain reimbursement of part of the cost from the Social Security System, are able to obtain reimbursement from their "mutuelle" of that part of the health-care expenses recognized by the Social Security System but left to be paid by the insured person ("ticket modérateur"). Mutual Aid Societies may assume responsibility also, under the "tiers payant" arrangement, for direct payment to health providers on behalf of members not only the "ticket moderateur" but also that part covered by the Social Security System. This is particularly useful for persons for whom direct payment would be financially burdensome. The system allows for the co-existence of a public sector health insurance system and private provision of health services, with an intermediate moderating arrangement which favours the less advantaged.

By 1990 there were about 6,000 "mutuelles", with 12,500,000 members and a total of 25,000,000 persons covered. Societies of public sector employees (civil servants) accounted for 4 million members; those associated with the labour force of single enterprises or groups of enterprise accounted for 4.3 million members; and "interprofessional" societies accounted for 4.2 million members. By mid-1995 there were 27 million persons covered: half the French population. The "mutuelles" had 60 percent of the complementary health insurance market.

In addition to providing health insurance, the mutuelles offered privileged access to health and social services of high quality and lower than average cost. By mid-1995 there were more than 1,300 enterprises providing health-care, social or cultural services and owned by Mutual Aid Societies. They had a total annual turnover of six billion francs and employed about 20,000 persons. They included pharmacies, optical and dental services, medical centres and other health institutions, including 42 hospitals and 295 optical centres. Home-care and treatment services for elderly persons are provided as well as "logements-foyers", consisting of small apartments in which elderly persons are able to live independently while having access to collective services. Specialized centres are operated for persons with disabilities: they are designed to increase their personal autonomy and support their effective social integration. Leisure and vacation centres are also operated.

The Mutual Aid Societies also manage contingency plans designed to complement compulsory Social Security System programmes. They are managed centrally by the Fédération Nationale de la Mutualité Française as a specialist subsidiary: "Prévoyance Mutex". By the mid-1990s MUTEX offered a wide range of plans. 200 Mutual Aid Societies managed 86,000 contingency

contracts covering over four million persons. Many were intended to serve particularly the needs of small businesses. They include family protection (death benefits, allowances for persons with disabilities, survivors' annuities, spouses' allowances); protection of income for economically active and retired persons in case of incapacity; as well as savings plans and insurance of loans in circumstances of illness, death or unemployment.

The Fédération Nationale de la Mutualité Française has a specialist health and social care research institute (Laboratoire d'Innovation Sociale), an organization responsible for promoting preventive practices (Association PREMUTAN), and undertakes numerous and varied health education and preventive health programmes and campaigns.

Mutual Aid Societies play a particularly important role in the management of health insurance for civil servants, employees of state enterprises and students (each of which group being members of their own "mutuelle". About 60 per cent of unsalaried non-agricultural workers and about 10 per cent of unsalaried agricultural workers are members of Mutual Aid Societies which manage their health and maternity insurance.

Mutual Aid Societies are non-profit associations of persons having common occupations or resident in the same areas. In exchange for member contributions, which can be a fixed sum paid periodically or a percentage of income, the Societies offer guarantees against certain risks and a number of services. Members exercise effective controls and each has a vote for use in the election of a voluntary Administrative Council. This has real control over business strategy. The General Assembly of members has final decision-making authority. While each society is independent, they are able to establish unions or federations in order to increase their effectiveness. The basic principle is that of solidarity.82/

K. User- and worker-owned co-operatives which provide health and social security benefits and/or access to health and social care services to their members and employees and to their dependants and which give special emphasis to high standards of occupational health

1. In market economies

In many countries health and social services available to the majority of co-operative members from either public or private for-profit providers are either too costly or of poor quality. In response to this situation, member-owners of many co-operative enterprises and organizations have decided that within the benefits provided to them by their co-operative enterprise from the surplus it generates should be included means for improving health status and social well-being for themselves and their dependents, and in many cases for employees of the co-operatives. In some cases such means take the form of the enterprise's own health insurance fund or payments to an external health insurance enterprise. In other cases they take the form of subsidized or free access to health facilities and personnel, sometimes owned and operated by the enterprises as a subsidiary department. In many instances benefits consist of a mix of insurance and use of our own facilities. Several types of situations can be observed:

(a) co-operative enterprises provide only the health and social insurance coverage required by law or by collective bargaining agreements of any enterprise;

(b) in addition to the above, or as a partial or total substitute for it, the co-operative enterprise provides as a benefit to members, additional health and social insurance coverage, which can be used by them to purchase services from other enterprises, co-operative or not;

(c) in addition to, or in substitution for, either (a) or (b) the co-operative enterprise provides its own services, organized as a subsidiary;

(d) in addition to, or in substitution of all the above the co-operative enterprise encourages its members to form their own autonomous (but possibly supported) user-owned health and/or social care co-operative; or:

(e) enters into an agreement with an existing and independent health and/or social care co-operative - or promotes the establishment of such an enterprise - for the provision by it of services on a preferred basis to its own members, employees and dependents.

The total impact of direct and indirect provision for the health and social well-being of members, employees and dependents has been substantial in some cases. This has been true particularly of benefits provided by major consumer co-operatives organizations as one among the many types of goods and services provided to the general membership. In those countries where significant
proportions of households have been members of the consumer co-operative movement at certain periods or recent history, or are still, this co-operatively organized component of the health and social care sectors has assumed major national significance. For example, in the **United Kingdom**, for large proportions of lower income households their membership if consumer co-operative health and social insurance and services was of vital importance until 1945 when they were superseded by those of the Welfare State, for which they served to some degree as a model. In 1922 43 per cent of all households in the United Kingdom were members of the consumer co-operative movement. They received half of their food and a tenth of all other goods and services from their co-operatives. Among these services were health, disability and life insurance and funeral services.83/

As enterprises within the formal economy it is the case that almost all co-operative enterprises make provision in the same way as do other enterprises for the health and social security coverage of employees, including, in the case of producer and provider-owned co-operatives, their worker-members. In many countries, because they are classified as self-employed, coverage may be different, less complete or more costly.

In **Israel** the Kibbutz, a type of comprehensive agricultural co-operative, is managed on the basis of cooperation in all aspects of daily life, including provision of health services. The Moshav Ovdim, a type of agricultural co-operative in which production is organized individually not collectively, also have health services organized co-operatively.84/

The Regional Office for West Africa of the International Co-operative Alliance has reported that in this region a number of co-operatives and women's organizations have contributed funds for the construction of premises, as well as operating costs, for rural pharmacies and health centres. This arrangement is made also in some Central African countries. In **Zaire**, for example, an organization of 5,000 handcart drivers in Kinshasa and Ludumbashi operates a common fund, into which members pay the equivalent of 10 US cents per day, which is used to provide a health care unit, a life insurance fund, and a primary school. 85/

Where advantageous for their members, co-operative enterprises and groups have preferred to supplement or replace national coverage on behalf of members, employees and dependents. This has been the choice of the Mondragón Co-operative Corporation (Mondragón Corporación Cooperativa) in the Basque Autonomous Region in **Spain**.86/ In response to the exclusion in 1958 by the public social security system of co-operative members, because they were considered self-employed, the Corporation set up within its financial component, the Caja Laboral Popular, a special insurance branch, "Lagun-Aro", which provided members with health and unemployment insurance and pensions. In 1973 Lagun-Aro became a separate component of the Corporation. Members of each of the individual industrial, agricultural, housing and school co-operatives, as well as of the three other secondary co-operatives, are automatically members and benefit from the social security and welfare

services, including health insurance, which it is the function of this secondary co-operative to administer.

The Board of Directors of Lagun-Aro are appointed by the Association of Co-operatives, which is the directorate of the Group and which includes representatives of the membership of all the primary co-operatives, who, thereby, participate in the policy process of the Lagun-Aro.

The Mondragón Corporation, including Lagun-Aro, does not maintain its own health services, so the health insurance provided to members is used by them to purchase services when needed from outside the co-operative group. They are free to choose from public or private for-profit providers: their financial outlay is repaid by Lagun-Aro to the provider or to themselves. Special agreements have been reached from time to time over the last three decades with the public social security and health insurance system as this has evolved in the region where the Corporation operates. Consequently, the separate existence of the Mondragón Corporation's own system has been allowed by the public authorities since 1985 rather than integration in the system for self-employed persons, which applies to members of all co-operatives. Benefits in the Lagun-Aro programmes are greater than in the public system: hence members of the Group are satisfied. At the same time there is some relief of pressure on the public system in the Basque region.

This arrangement is very similar to those set up by many co-operative enterprises in the form of a jointly-owned but organizationally independent insurance co-operative [type 2.3.2] (Chapter IV, section E). The distinction rests on the fact that the Mondragón Co-operative Corporation integrates in respect to many functions its component co-operatives within a single organization. This integration is not undertaken solely as the basis for organizing a health and social care co-operative. Thus Lagun-Aro, although a separate co-operative, is in a sense a specialist subsidiary of the Corporation, with shared membership. At the end of 1993 there were 19,005 members, simultaneously members of 125 co-operative enterprises in the Corporation.

In **Japan** JCCU launched a nation-wide mutual scheme for co-operative employees in 1973, and a similar scheme for members in 1979. Its medical insurance products were first offered in the mid-1980s. Daily payments for hospitalization were introduced in 1987.87/.

In **Canada** the Saskatchewan Credit Union Central provided a wellness programme for employees who have accumulated at least 540 hours of sick leave. The value of any hours in excess of this could be converted to cash, to an annual maximum of CAN $ 500, but had to be used to pay for such preventive actions as physical fitness, smoking cessation, stress management and financial planning programmes.

User owned utilities co-operatives provide significant health and social care services in some countries. In **Argentina** the electricity supply co-operative in the Pergamino area of Buenos Aires Province allocates five per cent of turnover to social and health services, including an orthopaedic bank which makes available wheelchairs, orthopaedic beds and other equipment needed by persons with physical disabilities. It also provides funeral services. In the **United States** the National Rural Electric Cooperative Association (which represents over 1,000 rural electric co-operatives, supplying electricity in 46 of the 50 States) provided health insurance coverage to the 131,000 employees and voluntary officers of its member co-operatives, as well as to their dependants. In 1994 it sought Congressional approval to establish health benefit trusts that would extend such coverage to customer-members in rural communities. The Association believed that both rural residents and health care providers would benefit from an expanded health care coverage which would increase financial flows into rural health systems. It contended that in many rural communities health care needs remained unmet, and would not be met by the current proposals for health care reform, which it considered to be predominantly based upon an urban model.88/

2. In transitional economics

In the **transitional economies** the national public health and social security system was largely enterprise-based, and the parastatal "co-operative" element was but one component of it. "Co-operative" enterprises provided services to members and employers, just as was the case for all other enterprises and public agencies. In many of these economies, with privatization such services have been discontinued. However, where parastatal co-operatives have continued to function, and even where they are now in a process of privatization to genuine co-operative status, they have tended to maintain at least some of these functions. With some adjustment they could remain a significant component of new multi-stakeholders structures.

Information is available for Byelorus, Moldova and the Russian Federation. In **Byelorus**, most health services continue to be provided through enterprises, including parastatal co-operatives and collectives.89/

In **Moldova**, under the previous regime most large enterprises, including rural collectives, as well as government departments, universities, and other institutions had their own medical service, provided to their own labour-force and dependants. The parastatal "co-operatives" also had their own medical service - described as the "medical service unit" or department of the "co-operative", that is the "coopmedsanchast".

During the process of privatization there was reluctance to allow fully private enterprises to enter the health sector, previously considered the responsibility of the State alone. After independence, a number of large enterprises continued the system of medical service provision, but separated the former subsidiary departments or "medical service units" from their own central organization, continuing the relationship by means of a contract with the newly autonomous "medical co-operative". Some enterprises, including collectives and parastatal co-operatives", continued.

The concept of private health insurance was "in the air", but not yet implemented. The Ministry of Health was interested in the concept, but felt that the Government could not afford to establish a public health insurance system. Some of the "medical co-operatives" had attempted to organise health insurance schemes. The new private insurance enterprises had not so far taken an interest in health insurance.

No initiatives by individual citizens to establish user-owned health co-operatives were known to have occurred: probably because the great majority continued to consider that it was the responsibility of the State (and of municipal authorities) or of the enterprises where they were employed to provide health services (a perception which prevailed even though the continual decline in the adequacy of those services was apparent to all).90/

As of mid-1995 in the **Russian Federation** health services were provided by Centrosojuz (the national consumer co-operative organization) for its employees and members.91/ This continued the practice which operated prior to the restructuring of the health sector, which took place on the basis of the 1991 Law on Medical Insurance of the Citizens of the Russian Federation. Centrosojuz operated a 210 hospital (Medical Centre, "Medcoop") which was also the base of the "N. A. Semashko" Stomatology Institute. High quality services were ensured by the quality of staff, equipment and material (in part an expression of the fact that the parent organization was the national consumer co-operative system). The facility offered an innovative combination of in-patient, sanatorium, out-patient and rest programmes.

Users of the hospital were participants in the national system of compulsory health insurance introduced by the 1991 Law. They might also be participants in voluntary health insurance provided either through the enterprises at which they were employed, or by private insurers. This complementary system was currently best developed in Moscow. Many enterprises continued to operate their own health services and facilities,

financed from their surpluses, and usually with higher quality staff and equipment than those of the public sector.

Polyclinics were operated at the headquarters of Centrosojuz in Moscow, and at other consumer outlets as well as in subsidiary enterprises owned by the co-operative. In addition Centrosojuz operated sanatoria in Kislovodsk and Essentuki, which were mineral water resorts in the Caucasus region, at Bedokurikha in the Altai region, and at the "Udelnaya" medical-prophylactic complex in the Moscow region. A rest home was operated at Djubga, Krasnodarsky Krai, on the Black Sea. As these sanatoria were located in different climatic regions, it was possible to provide rest, prophylaxis and rehabilitation in response to a wide range of medical conditions. Formerly financed largely from the surplus of the consumer co-operative system, now considerably reduced, and more recently also by payments for treatment of beneficiaries of the national health and social security system, these facilities currently faced severe financial conditions. Tourists and patients from outside the Russian Federation, mainly from other countries of the Commonwealth of Independent States, were also able to utilise these facilities.

Representatives of the Medcoop of Centrosojuz participated in the International Co-operative Health and Social Care Forum held on 18 September 1995 at Manchester, United Kingdom. 91/

L. Population served by user-owned health co-operatives

As is shown in Table 2 it would seem that at least 52,220,000 persons are users of health co-operatives: this is a total based upon reasonable estimates. To this total should be added a possible 900,000 members of other co-operatives and trade unions in Malaysia and Singapore who are eligible to use health co-operatives. It would be reasonable to state that about 53 million persons use health co-operatives at present. Of course, it is not known what proportion of the health needs of the individual are met as a result of their use of health co-operatives. About 79 per cent (42,265,000) are in developed regions (Japan, Europe, Israel and North America).

About 75 per cent, at least 39,081,000 persons are served by their own user-owned health co-operatives. The largest national groups of users are those in Japan (29,740,000), the United States (4,000,000), Israel (3,500,000), Canada (1,000,000) and India (750,000).

Information on the numbers of persons who use social care co-operatives is not available. In 1995 almost one hundred million people were members of mutual social insurance enterprises in the European Union. Mutual social insurance has been well developed also in many Latin American countries since the late nineteenth century, but statistics of membership are not available for that region. 92/

III. DEVELOPMENTAL DYNAMICS AND CONTEMPORARY GLOBAL SITUATION OF PROVIDER-OWNED CO-OPERATIVE ENTERPRISES WHOSE BUSINESS GOALS ARE SOLELY CONCERNED WITH HEALTH AND SOCIAL CARE

A. Primary level provider-owned health co-operative [type 1.1.3.1]

1. In market economics

This type of health co-operative is known to exist in Argentina, Benin, Bolivia, Costa Rica, Germany, Italy, Mongolia, Philippines, Poland, Portugal, Sweden and the United States of America. In the cases of Benin and Costa Rica health providers formed provider-owned primary health co-operatives as a result partly of governmental initiatives. In India, a self-employed persons trade union was responsible. In Italy co-operative organizations, trade unions and local government authorities supported action by health professionals and in the Philippines religious organizations provided some support. Elsewhere, as far as is known, establishment of a health co-operative resulted from the independent action of provider-members.

In **Argentina** a provider-owned health co-operative Cooperativa de Residentes y Especialistas (COOPRES) was set up in San Miguel de Tucuman in 1993. It is probable that other health co-operatives are active elsewhere in the country, in view of the existence in Buenos Aires of a Gabinete de Estudio y Promocion del Cooperativismo Sanitario. It was established by doctors, bio-chemists, dentists, physiotherapists, psychologists and other professionals in order to satisfy the needs of local residents for most of whom a public hospital, and social care provided by unions and other associations, were inadequate. In March 1996 about 10,000 persons were affiliated as users with the co-operative, whose professional members were able to provide adequate services at low cost at a central clinic in San Miguel de Tucuman, a health centre at Ranchillos and at members' practices.93/

In **Benin** in May 1991 the Sikecodji Co-operative Health Clinic was established in a suburb of Cotonou by recently graduated health professionals who were then unemployed because of retrenchment in the public health sector. This had included the freezing of all public health service recruitment. The idea of establishing a health co-operative as a means to simultaneously improve health services and provide professional employment had been suggested by the Government, which formulated a "Clinic Co-operative Project". Seed capital in the form of a loan of between $ 9,200 and 13,000 was provided by the World Bank to this and to nine other similar health co-operatives in other parts of Benin. This was to be repaid over five years. It was intended to cover equipment, remodelling of premises and staff salary for the first two months. UNDP and WHO have also supported the project.

Each clinic has a doctor, two midwives and two health assistants. The Government has proposed that a further six health co-operatives be established. However, income for the co-operative and its provider members and owners, must be obtained through fees paid by patients. The clinic offered three types of service: consultations and short duration hospitalization (up to three days); home visits to out-patients; and training of health assistants. Trainee health assistants paid the equivalent of $ 93 for their course, which compared favourably with the fee of $ 278 for training at a public hospital.

After four years' experience it was felt in early 1995 that the co-operative clinics have had a positive impact upon the health of the communities in which they operated. They have provided employment to young graduates and school leavers. They have also inspired interest among other

unemployed persons in co-operative solutions to their situation: as a result they have set up co-operatives for inter-city transport and for the distribution of school supplies and stationery.

However, these health co-operatives have encountered problems arising from the unfamiliarity of members with business methods and particularly with the special type of organization and management characteristic of a co-operative enterprise. There have been difficulties in deciding the distribution of income among members with different levels of qualification: this has been exacerbated by the fact that income is limited because only low fees can be charged to a predominantly poor clientele. The result has been that some members do not participate fully in the activities of the co-operatives. In addition there is strong competition from non-co-operatively organized private sector health services, particularly in urban areas. To help to resolve these difficulties the Regional Office for West Africa of the International Co-operative Alliance was to begin, late in 1995, to provide training by means of a programme for which $3,700 had been set aside.94/

As part of its Inter-regional Programme, undertaken as a Follow-up of the World Summit for Social Development, the International Labour Organization has prepared a provisional list of social services that might be organized on a mutual basis. This has been based on experience of ongoing projects undertaken by ILO in collaboration with the Belgian NGO Wereldsolidarieteit (World Solidarity: WSM), and on requests received from the governments of the countries concerned. It includes support to the development of health co-operatives in Benin, in partnership with Benin Credit Mutuel, the Federation Générale des Travailleurs, the Centre Régional de Developpement de la Santé and a number of other organizations. 95/

In **Bolivia**, a 1977 report stated that provider-owned co-operatives whose members consisted of 18 doctors and two dentists served 15,000 persons.96/

In **Costa Rica**, within the context of a several experiments in health services delivery involving contractual arrangements between the Government and the private sector, groups of providers have established three co-operative clinics in recent years: Coopesalud, formed in 1988, Coopesain, formed in 1989, and Medicoop, formed in 1992. There was also a fourth health co-operative owned jointly by providers and local associations (Coopesana, formed in 1993). 97/

Coopesalud is situated in the Pavas district in the southern periphery of San José. It was set up by 20 doctors in October 1988: by early 1996 it had 25 doctor members and 178 employees. In 1994 it had a budget equivalent to 3.5 million Canadian dollars, of which 99 per cent was provided by the Costa Rican social security system (CCSS), which also leased to the co-operative 10 community-based centres, operated by an "Integrated Health Service Basic Team (EBAIS)". A contract between the co-operative and CCSS defined the services which it would provide, the tariff paid per user (capitation), and the norms and controls to be observed. The users paid no fee to the co-operative, which is paid by the CCSS to secure the health of the population and not for separate medical interventions, thereby contributing to maintaining a balance between the economic interest of the co-operative and the social goal of the public service it provides.

Coopesain (Cooperativa Augestionara de Servidores para la Salud Integral), is located at Tibas, north of San José, where it serves a community of 60,000 persons. In 1993, it had 170 employees of which 30 per cent were professionals. 85% of its activities are financed by the sale of its services to the CCSS and Ministry of Public Health. The remainder is provided by the sale of dental services, occupational health and other services to local enterprises. It retains elements of health promotion and disease prevention derived from the public health system, while introducing innovations designed to achieve increased organizational efficiency and client satisfaction. The clinic provides ambulatory surgery, pharmacy service and home visits more easily to the community, and at lesser cost to the Government, than was previously the situation. The former inappropriate use of area hospitals had

been reduced. There was a commitment to community participation, and the clinic's programmes permitted greater responsiveness to community needs. Both providers and clients reported greater satisfaction than with either public or private for-profit health service institutions. 98/

Medicoop was set up by 16 doctors in November 1992, a number which had increased to 19 by early 1996. It serves the cantons of Barva and San Isidro in the province of Heredia and parts of the province of Alajuela, with a total population of 75,000 in 1993. It is totally financed by the CCSS.

In **Germany** during the period 1980 to 1994 there were three doctors' co-operatives (presumably provider-owned health co-operatives). In 1970 there had been seven. 99/

In **Italy** health co-operatives can be considered a specialized type of what are termed "social co-operatives". They are solely or primarily concerned with health rather than social care. The national apex co-operative organizations have promoted development of this type of service provider owned co-operative. According to statistics issued in June 1993 by the two major national apex organizations, Lega Cooperative and Confcooperative, the number of social co-operatives associated with them was 1,826. Other social co-operatives were known to exist, and the national total was estimated conservatively to be at least 2,000. In 1986 there had been about 500 "social co-operatives", by the end of 1988 there were 1,242 and in 1990, 2,125. 100/

A survey of 660 of the 1,826 social cooperatives associated with the two national apex organizations, carried out in December 1992 by the Centro Studi of the Consorzio Nazionale della Cooperazione di Solidarietà Sociale, "Gino Mattarelli", and published in 1994 as the "First Report on Social Co-operation" indicated that 422 were engaged in providing social, educational or health services; 110 were engaged in integrating disadvantaged persons in their communities through employment; and 128 were engaged in both of these categories of activity. Of the 549 "social cooperatives" providing either social, educational or health services alone, or these services combined with provision of employment for disadvantaged persons, only 13 per cent (71 co-operatives) were engaged in the provision of health services, usually in association with social care. 101/

Development of such co-operatives was recent. Of the 660 "social co-operatives" surveyed at the end of December 1992, only 12 had been established prior to 1976: 77 had been established between that year and 1980, 250 between 1981 and 1985, 226 between 1986 and 1990, and 43 during the two years 1991 and 1992.

The survey results did not provide separate information for health co-operatives in respect to the population group they served: disabled, elderly or young persons were most frequently the target clientele of social co-operatives as a group. The users of the 660 co-operatives surveyed totalled 42,000: the numbers using health services provided by health and mixed-activity "social co-operatives" alone was not reported.

The survey revealed that these were combined user- and provider-owned cooperatives of a particularly complex type. Membership included ordinary worker members, who worked in return for a wage (that is they were on the payroll and had their social contributions paid by the cooperative); paid collaborator-members - professionals, administrators or consultants, receiving a fee for services; voluntary members, providing their labour free of charge, although insured against work-place accidents and occupational disease; subsidiser-members, providing financial capital but not working in the cooperative; legal-person members, institutions including public agencies subscribing to shares in the co-operative's capital and thereby financing its activities; and user-members, drawing benefits from the co-operative, including disadvantaged worker-members in the case of those social co-operatives providing employment for disadvantaged persons. The survey also recorded a large number of what could be called "inactive" members, who were founders of or sympathizers with the cooperative, but who neither participated

in its activities nor used its services. However, the majority of active members were workers, collaborators, volunteers, subsidisers and "legal persons" - totalling 21,300 compared with 1,638 user members and 1,523 disadvantaged worker members.

Hence, it might be argued that functionally these are a particular type of provider co-operatives. This characterization is likely to be particularly true for those of the "social co-operatives" providing only health services, given the professional qualifications required of provider members. From the point of view of the system of classification used in this study, therefore, health co-operatives within the group of Italian "social co-operatives" are considered provider co-operatives (but the remaining social co-operatives are considered more likely to be jointly-owned enterprises and they are so classified for the purpose of this review).

The persons who founded most social cooperatives had as their primary objective their more effective participation in management of the enterprise in which they performed their profession. They considered also that, largely because of the complex nature of personal services provided by such cooperatives, not only their own participation, but that of clients and collaborators, was essential, and could be satisfactorily achieved by the co-operative form of organization. Most of the 660 social co-operatives surveyed were small in terms of workforce: 72 per cent had less than 30 workers, paid or volunteer. On average they had a paid workforce of 32 persons and a voluntary workforce of 11 persons. For "social co-operatives" as a whole, the majority provided services mainly to persons unable to pay for them: consequently, costs were met by a third party, usually a governmental agency, which also provided grants, subsidies, and the use of equipment and facilities. Such expenditures were increasing significantly: by 1993 about 13 per cent of public spending on social welfare was allocated to the financing of "social co-operatives".

In **Mongolia** dental physicians trained in Japan recently established a provider-owned dental service co-operative, the Enerel Dental Clinic, in Ulan Bator. In a Report to the International Co-operative Health and Social Care Forum held at Manchester on 18 September 1995 in the context of the Centennial Congress of the International Co-operative Alliance, the Medical Co-op Committee of the Japanese Consumers' Co-operative Union noted that this co-operative faced considerable organizational obstacles. 102/

In Mindanao, **Philippines**, in 1982 eight young doctors combined to form a "Medical Mission Group" and set up a small clinic in Davao City, borrowing equipment if needed for operations from a colleague and owner of a private hospital. They provided services to low-income communities on a "pay-what-you-can" basis. In 1985 their first small hospital opened in Barrio Obrero, Davao City, and received official accreditation as a Medicare and Philippines Health Authority hospital. In 1986 a second small hospital opened in Tagum, Davao del Norte, and a community-based self-help health insurance scheme was started in Barrio Obrero to which every family contributed 20 pesos a month. The fund was used to subsidize the salary of one of the doctors in the Medical Mission, from whom members could obtain free consultation.

In May 1990 the Board of Directors of the Medical Mission Group decided to transform the Group into a co-operative, the "Medical Mission Group Hospital and Health Services Co-operative". Early in 1991 the community-based health insurance scheme established in 1986 was transformed and expanded, forming the Co-operative Health Fund. The first general meeting of the Co-operative Health Fund was held in May 1992. The Fund provided comprehensive health coverage to all 50,000 members of the 150 co-operatives in the region. These co-operatives deposited contributions from their members in the Co-operative Rural Bank of Davao City, which managed the Fund jointly with the Health Services Co-operative and the Federation of Co-operatives. Members of the Health Services Co-operative included not only contributors to the Fund, but doctors, nurses and other staff, including janitors. In November 1991, with a loan from the Co-operative Rural Bank, a 60 bed tertiary hospital was set up at Agdao, in Davao City, to provide services to members of the Co-operative

Health Fund. Plans for the establishment of other co-operative hospitals were under consideration in 1992, with good prospects for extension of the programme to other parts of the country. The first hospital established, in Bairro Obrero, was to be converted into a paraprofessional training centre (the Adolescent Health Development Centre) for young persons from poor communities.103/

In **Poland** provider-owned health co-operatives first appeared in 1945. Members were health professionals, often specialists, already employed in the public health system. Fees charged to patients could not be reimbursed, as there was no private health insurance, consequently clients were drawn from a very small proportion of the population. These health co-operatives complemented the public system of local health centres by providing special services: usually they had better equipment and facilities, and were able to meet client's needs with limited delay. Some provided occupational health services, particularly for disabled persons who were members of worker-co-operatives, with payment made by the public health insurance system. In many cases the co-operatives rented space from housing co-operatives.

By the end of the 1980s a national association had been formed which had a membership of 27 out of the then operating 31 provider-owned health co-operatives and nine other worker-owned co-operatives in the health sector, including dentistry co-operatives. The 27 members operated 325 health centres with a labour force of 9,262, including 3,532 doctors and 1,100 dentists.

With the dismantlement of the socialist centrally-planned system, the fiscal and legal environment for this type of co-operative became unfavourable: a number transformed themselves into private for-profit enterprises, others ceased operation, but an unknown number continued to operate. In early 1996 it was reported that there no longer existed a national federation for health co-operatives and information on those still operating was not available. It was considered, however, that in the new societal conditions there was still a function for such health co-operatives, particularly in those areas where the public health system no longer provided adequate services. They would cater in particular for the relatively high income sections of the population. 104/

In **Portugal** early in 1996 one provider-owned co-operative existed in Lisbon and two in Porto, the second largest city. In addition an educational co-operative, the "Higher Polytechnic and University Education Cooperative" (Cooperativa de Ensino Superior Politecnico e Universitario (CESPU)), has established two Higher Institutes of Health Sciences, one in the north, one in the south of the country. These provide degree courses, and also post-graduate and continuing education courses in health sciences. Their teaching facilities are made available to the general public: already operating at the beginning of 1996 were a dental clinic and a polyvalent laboratory capable not only of undertaking clinical analyses, but toxicological and criminological analysis, as well as support for consumers, principally by analysis of foods. It was planned to establish progressively a number of specialized clinics. 105/

In **Sweden** early in 1996 a small number of provider-owned co-operatives operated in the health sector: they comprised two primary health clinics and one physiotherapy clinic. There were about 20 dental clinics, located in Stockholm and Kronoberg Counties, which were sometimes considered to be co-operatives, but were organized in such a manner that their co-operative character was open to question. 106/

In the **United States**, where most development has been of user-owned co-operatives, a 1984 article noted that there were many examples of small provider-owned health co-operatives. However, there was neither a formal association nor even an informal network of such co-operatives. In the early 1990s a number of provider-owned co-operatives existed whose members were health professionals, including doctors, nurses and midwives. 107/

2. In transitional economies (temporary and pseudo-co-operatives)

Information is available for Byelorus and Moldova. It is probable that similar developments have occurred in other of the transitional economies. In **Byelorus** the development of independent provider-owned health co-operatives has been controlled by changes in the legislation concerning privatization and that concerning co-operatives. During the period of "perestroika", from 1987 to 1900 private enterprises were not permitted, but entrepreneurs unwilling or unable to operate within the still dominant state and parastatal system, were able to take advantage of the continuing legitimacy of "co-operative" enterprises to set up de facto private for profit enterprise under the name "co-operative". These appeared in large numbers in almost all sectors of the economy and regions of the country, and included "medical co-operatives". It was during this period that the terms "co-operative" and "co-operator" become synonymous with the worst type of entrepreneurial exploitation and abuse. With national independence, the new constitution and laws permitted fully private, investor driven "enterprises with limited responsibility". Moreover, responsibility was in fact extremely limited, to an amount equivalent to US$ 2, so the risk to investors of losing capital through failure or of highly speculative, even illegal ventures was minimal. "Enterprises registered as "co-operatives", in contrast, were subject to seizure of all capital, equipment and buildings in case of bankruptcy or fraud. Consequently, almost all of the new "co-operatives" changed their status to enterprises with limited responsibility." These included the so called new "medical co-operatives", which continued to exist as private investor-controlled enterprises. Proposed changes in the law which will raise the levels of responsibility of private enterprises are unlikely to bring about a shift to true provider-owned health co-operatives and the term co-operative has an even worse reputation than that derived from the period of social central planning.108/

In **Moldova** the first "medical co-operatives" appeared in 1985 when it was first permitted to establish genuine co-operatives in the then USSR. However, the majority of currently operating "medical co-operatives" have been established since 1992, when the country became independent, adopted its own constitution and issued its own legislation. In this new situation the Ministry of Health issued an instruction that allowed the activities of "medical co-operatives". These were conceived of either as small individual enterprises, owned by a single natural and juridical individual (an entrepreneur), or as a subsidiary or component of an existing enterprise. Registration and licensing took place under the law relating to small private enterprises. The professional staff of the "medical co-operative" was hired by the owner-entrepreneur or by the parent enterprise. None of the "owners" (entrepreneurs) were themselves doctors. It was not possible for a group of doctors to combine to establish a provider-owned health co-operative because the current law precluded ownership of an enterprise by a group: to ensure responsibility, either an individual, or an existing enterprise, had to be the "owner".

There were considerable bureaucratic obstacles to be overcome by an entrepreneur or (although perhaps less so) by an enterprise. It was necessary first to register the "medical co-operative" and to obtain a license from the Ministry of Justice. This required presentation of numerous papers, including one from the Institute of Linguistics of the Academy of Sciences stating that the name of the co-operative had been examined and truly corresponded to the official nomenclature. After licensing by the Ministry of Justice it was necessary to register and obtain a license from the Ministry of Health. There was considerable hostility to such "medical co-operatives" on the part of this Ministry, partly because it perceived that the services they provided might be of low quality, at least in relation to prices charged. As of October 1995 there were about 20 such enterprises in operation, although between 60 and 70 licenses had been issued by the Ministry of Health.

The term "co-operative" had been utilised because it was more acceptable to the Government than a fully private enterprise, particularly perhaps as applied in the health sector, which was perceived to be an area in which only the State had the responsibility and obligation to operate.

To improve their acceptance the new entrepreneurs within the health sector continued to describe their enterprises as "co-operative medical/sanitary units" ("coopmedsanchast"). They are equivalent to for-profit medical practices in market economies: they are not provider co-operatives. A few may be the subsidiaries of larger co-operative enterprises.

Typically the 20 odd "medical co-operatives" employed five to six doctors and an additional two to three nurses as well as seven to eight other personnel. The doctors were employed primarily in the public health service, and worked in the "medical co-operatives" as a second job: for this reason the enterprises were open only in the afternoons. Most provided general medical services but some specialized in dentistry, gynaecology, urology and other areas. They operated only in the capital and two other of the largest cities: they did not exist in small towns or in rural areas. Some of the "medical co-operatives" operated on the area of large enterprises, with whom they had a contractual agreement.

There was no restriction on the type of client - except their ability to pay for services. The cost of a general examination varied between the equivalent of three and ten US dollars, that of examination and some treatment between five and ten dollars, and a complete course of treatment averaged between 80 to 100 US dollars. These costs could be compared with salaries in Moldova of 40-50 US dollars a month for doctors in the state hospital system, 20-25 dollars a month for high school teachers. Doctors employed in the "medical co-operatives" earned up to $ 100 per month.

Consequently, the greater part of the population were unable to pay for their services, and were obliged to use the public health system. Those that could pay consisted of included members of the new business class, but these were not numerous. Some of the "medical co-operatives" had invested in expensive equipment, were obliged to rent office space, and to pay staff. Consequently, most "medical co-operatives" faced considerable financial difficulties: a number operated at a loss.

To obtain additional income some manufactured medicines and medical equipment. Another source of income was to provide, under contract to large enterprises and some collective farms, lectures on health topics to their labour forces, and to undertake medical inspections. Payment was made to the "medical co-operative" by the enterprise on behalf of its labour force.

The various "medical co-operatives" had not yet formed a national association (although the collective title "Moldcoopmedsanchast" - Medical and sanitary component co-operative of the Moldavian Co-operative Union - was employed.109/

B. Secondary level provider-owned health co-operative networks [type 1.1.3.2]

This type of health co-operative is known to exist in Brazil, Chile, Colombia, India, Malaysia, Paraguay, Spain, the United Kingdom of Great Britain and Northern Ireland and the United States of America.

In **Brazil** the largest system of provider-owned health co-operatives in the world has been established: this is Unimed do Brasil (translated by the co-operative itself as the National Confederation of Health-care Co-operatives but more recently described by it as "the Co-operative Businesses and Enterprises Complex Unimed do Brasil"), a system based upon secondary provider-owned co-operatives but which has developed strongly at the tertiary level.110/

The Unimed system began with the establishment on 18 December 1967 of the first provider-owned health co-operative to operate in Brazil, located in the port city of Santos. A group of 21 local doctors, led by Dr. Edmundo Castilho and Dr. Pedro Kassab, were responsible for this development, which was in large part a reaction to the situation caused by the Government's establishment of a unified national social security system in 1966. This had

proclaimed the right of all citizens to medical attention in public health centres or through contracted services. As funds were insufficient for the provision of such services to the entire population by means of public agencies alone, the Government made a contribution to each private enterprise equivalent to five per cent of the minimum wage for each worker, but held the enterprise responsible for making medical services available to its employees and their dependents. Group medical schemes were set up by enterprises, and new types of for-profit health centres were established in order to cater to this new market, although opposed by the Brazilian Medical Association (AMB).

The health professionals who founded the first health co-operative defended the importance of a patient's right of choice and of services provided by a doctor in his or her own premises to persons whose personal circumstances and health record were well known to them, rather than in commercial health centres whose efficiency could not be guaranteed. The founders were also concerned to eliminate intermediaries - constituted by the private for-profit enterprises owned and managed by non-professionals who had set up health centres and entered into group contracts with enterprises.

Each primary provider-owned co-operative is a society whose owner-members are independent health-service providers, including both doctors working alone and group practices. They are essentially worker-co-operatives. By 1975 there were 40 provider-owned health co-operatives, by 1980 80, by 1990 180 and by mid-1995 there were 304 such co-operatives. Their member doctors totalled 73,000, over 30 per cent of the national total of 207,000.

The concept of a health provider-owned primary co-operative was diffused to other regions by the founders, secondary networks were established in each State, and in 1978 Unimed do Brasil was established as a national tertiary co-operative organization. In 1994, at its 24th National Convention, held at Salvador, State of Bahia, a Unimed Charter, or Constitution, was adopted. It delineated the basic principles governing the Co-operative Businesses and Enterprises Complex Unimed do Brasil.

In mid-1995 the Unimed system provided services to about 9,000,000 users: a ratio of nine doctors per thousand. These had either individual or group contracts arranged through the enterprises in which they were employed. Although standardized, coverage varied to some extent to reflect local conditions. In September 1995 the principal of the 30,000 enterprises and other organizations having contracts with Unimed whereby that system provided services to their employees or members included one co-operative (Cooperativa de Consumo do Grupo Rhodia), two trade unions (metal workers and banking workers), two universities (Campinas and Pontifica Universidade Catolica), a technical school, two scientific foundations, four banks, and three service and 19 manufacturing corporations. As the Unimed system has become an integrated nation-wide network, contract "enrolees" at any member secondary co-operative are able to obtain medical services from any other members throughout the country.

Through operational agreements reached recently with associations of doctors in Uruguay and in the Province of Buenos Aires in Argentina, medical attention is provided in those countries to those Brazilian tourists, travellers and temporary residents who have individual or group contracts with Unimed. A similar agreement is planned in the near future for Paraguay, where a Paraguayan Unimed was to be established in 1995.

During the first decades of operation of the Unimed system referrals were made either to clinics owned or operated by member health providers, or to hospitals on the basis of contractual arrangements. More recently, Unimed has begun the operation of its own hospital and support facilities. The Unimed co-operative in Brasilia was the first to begin operation of its own hospital, in 1983. This was established in response to opposition by providers of other health plans, concerned with the high quality competition provided by Unimed: to counter this, they had persuaded local hospitals to cancel their agreements with the Unimed co-operative. In this situation the co-operative decided to establish its own facilities by leasing an existing

hospital, using for this purpose its own financial resources, supported by those of the national Unimed system. By March 1992 eight Unimed primary co-operatives were operating their own hospitals, and by mid-1995, 19, with 14 others under construction. It was planned in mid-1995 to increase the number to between 40 and 50 by the year 2000. The number of beds has grown from 600 in 1991 to 1,176 in mid-1995, and will increase to 3,300 in 2000. In addition, in mid-September 1995 the Unimed system owned and operated 14 X-ray laboratories, 22 clinical analysis laboratories, three diagnostic centres and 66 mobile first aid units.

Unimed has developed a comprehensive tertiary level organization which has its own subsidiary institutions (see Chapter V), but a number of its characteristics appear relevant at this point. Unimed adopted in September 1990 a policy of self-sufficiency in respect to the operation of its hospital facilities: it intended to up-grade and modernize loaned, rented and leased hospitals and reserved bed units and to construct its own new health centres, surgeries and polyclinics, as well as administrative and support facilities. This strategy was thought necessary in response to the serious running-down of the public health service, and the lack of resources available to health services operated by philanthropic and beneficent associations, many of which were on the verge of bankruptcy. Because of this situation, Unimed could only provide high quality services to its clients upto the point when they needed hospitalization: referral of its clients to hospitals operated by other organizations usually involved a serious reduction in quality and hence user satisfaction.

Consequently, a Division of Hospital Self-sufficiency was established within Unimed's Board of Planning and Development in 1991. Among other functions, it prepares a series of manuals concerning, for example, setting up specialist units within hospitals, planning entire hospitals, and establishing technical specifications for road, air and water ambulances. It also undertakes upon request diagnosis of the financial and technical situation faced by individual Unimed co-operatives and recommends the most appropriate solution - for example, the best choice between various possible partnerships with other enterprises and operation of own facilities. An agreement has been made with the Department of Architecture and Town Planning of the Catholic University of Campinas, on the basis of which standardized models for hospital development are being developed.

This system-wide programme will be financed in part from the Unimed systems' own financial subsidiaries, including in particular Unicred. The provision of this professional service has encouraged confidence by individual members in investing in their co-operative, perceived by them to have considerable viability and potential as part of a single national system which has been able to accumulate progressively greater financial, institutional and human resources. Consequently, members have become an important source of capital for the entire system's development.

In **Chile** the health co-operative "Cooperativa de Servicios de Proteccion Medica Particular Ltda., PROMEPART", was established in May 1968. It continued the work of an association founded in December 1962 (Corporacion Particular de Asistencia Social y Technica Ltda.) with the purpose of providing medical care to the work-forces of a number of enterprises. At that time a number of major enterprises operated their own welfare services which provided health, housing, education and other services for their work-forces.

In 1981 PROMEPART, taking advantage of legislation which permitted the provision by "Instituciones de Salud Previsional (ISAPRE)" of services to employees who decided to withdraw from the national health scheme, extended its services to the larger number of persons then able to choose their health providers. In 1988 it was reported that PROMEPART/ISAPRE was one of the largest health service institutions in the country, and the largest in the Santiago Metropolitan Region, with about 80,000 members and a total of 200,000 beneficiaries, including family members. In 1992 it was reported that the co-operative provided services to employees of large and medium-sized enterprises, as well as individuals, totalling 134,500 members (and hence about 336,000 beneficiaries). Programmes included partial payment of the

costs of medical attention, payments during periods of illness, and the organization of an incipient system of preventive medicine, child health and maternity care. During 1992, it inaugurated a new health centre at San Joaquin, which would specialize in infant and child health and in health services for the elderly.111/

In **Colombia** the co-operative "Cooperativa Medica del Valle y de Profesionales de Colombia (COOMEVA)" originated as a multi-functional mutual insurance co-operative whose user members happened to be health professionals. It subsequently expanded geographically, and then extended its membership - and provision of multiple services, some directly through its own resources - to all professionals. It later expanded its health insurance services to non-members in the communities where it operated. Finally, it assumed (with some organizational adjustment) the status of one of the officially recognized providers of health insurance within the national health insurance and social security programme.112/

"Cooperativa Medica del Valle" was established in 1964 by a group of 27 doctors for the purpose of meeting the needs of doctors in the Cali region to obtain social security for themselves and their dependants. It was also perceived as a means to meet concerns for their professional futures in the context of a newly public social security system (Organization for Social Security). It was felt necessary to organize collectively for the better performance of their activities.

Choice of a co-operative form of organization reflected the fact that the co-operative tradition was already well established in this region of Colombia, in which primary co-operatives of various types had already established secondary and tertiary organizations. Moreover, during the late 1950s and early 1960s the co-operative movement in Colombia experienced a considerable expansion, supported by the co-operative movement of the United States within the context of the Alliance for Progress. This expansion resulted in the adoption by the national legislature of a new legal statute on co-operatives, law 1598, in 1963.

The co-operative's services began with the organization of savings and credit services for the health professionals (mostly doctors) who were members. Life insurance was offered in 1967 and vehicle insurance in 1968, when membership was opened to doctors in neighbouring areas. In 1969 membership was opened to all professionals and persons with technical training in the Cali region, and in 1970 the services were extended further to their family members.

It was only in 1973 that a health care service for members was introduced. It was the first prepaid health service in Colombia. However, it was only one component of the multi-service activities of the co-operative, and other services continued to be introduced and extended. Only in 1986 was the prepaid health service complemented with a dental service. Thus in 1975 the life insurance service was expanded into a comprehensive coverage, termed "Solidaridad". This was a standard service, protecting members and their families in case of death of the member, temporary incapacity resulting from occupational causes, ill-health or accident; as well as permanent disability. It also covered funeral costs.

In 1977 services were expanded to provision of housing and educational tourism for members. In 1980 the housing co-operative "Los fundadores" was organized, and in 1985 a residential unit was constructed. In 1988 a programme designed to contribute to the funeral costs of family members and dependants was introduced. By 1995 insurance had been extended to civil responsibility of doctors, and to property insurance. Members were insured also in respect to the continued education of children in case of their death or incapacity.

In 1978 the first step was made toward the geographical expansion of the co-operative from the Cali region, with the opening of a regional office in Medillin. By 1995 there were regional offices and agencies in most parts of

Colombia. As an expression of this expansion the name of the co-operative was changed to Cooperativa Medica del Valle y de los Profesionales de Colombia.

Thus in 1995 the co-operative could be characterized as a multi-functional service co-operative owned by professionals and designed to satisfy their socio-economic and cultural needs, including social security and professional and entrepreneurial development. Members were professionals with university or technical qualifications, their spouses or partners and their parents, their children or siblings, as well as employees of the cooperative. Juridical persons - that is, enterprises - within the public, co-operative and not-for-profit sectors could also be members. The term "medica" in the name of the co-operative refers to the fact that the original members were health professionals, and not to the function of providing health services, either to the community at large, or even to members, despite the fact that health insurance was included in the services provided. The advantages of co-operative membership were those of bulk-buying of a wide range of insurance, including health insurance, and other services.

By means of courses in co-operative management members have been encouraged to participate actively in the direction and administration of the co-operative. A health committee exists within the Administrative Council, and within the administration a department responsible for health programmes.

The specialized health insurance service subsequently developed as a separate component: "PREPAGADA COOMEVA", still a user-owned (or policy-holder owned) co-operative. These prepaid health services, which formed part of the benefits of co-operative membership, were provided to members by health professionals who were themselves members. In 1994, 2,319 specialists and 934 general practitioners, 126 radiological laboratories, 340 clinical laboratories and 267 clinics, hospitals and medical centres were part of the scheme, providing agreed services to members. These services were offered also to non-member users, at higher cost. Arrangements had been made for provision of health coverage of members when travelling outside Colombia. As of December 1994 the total number of users was 237,600, of which 144,000 were members: the annual change in membership, which had been an addition of 10 per cent in 1990 and 1991 had slowed down in 1992 and 1993 and declined in 1994. The 144,000 members constituted 15 per cent of the total covered by various health insurance plans in Colombia as of December 1994 (960,000 persons in 23 plans). COOMEVA was in 1995 the third largest co-operative enterprise in Colombia, the third largest service enterprise in Colombia and the 144th largest enterprise overall.

The latest phase in the development of COOMEVA began in mid-1995 when, pursuant to Law 100 of 1993 on Social Security, social security coverage was introduced for all Colombian citizens based on the principles of obligatory membership but free choice of provider. In addition to pension coverage in case of disability, old age and death, and occupational health insurance, the General System of Health Insurance established the conditions for access by all to an Obligatory Health Plan (Plan Obligatorio de Salud: POS) by the year 2000. Health coverage could be provided by approved "Entidades Promotoras de Salud (EPS)." In these circumstances the Cooperativa Medica del Valle y de Profesionales de Colombia "COOMEVA" contributed 94 per cent of the capital of a new entity "COOMEVA E.P.S., S.A." which could act as a provider under the new Social Security Law. It began to function on 19 July 1995, providing both the basic coverage of the POS as well as specific complementary services at moderate rates to persons able to afford them. The parent co-operative PREPAGADA COOMEVA continued to provide services to its members and other users who had higher incomes. One purpose of this association with the national health plan was to permit the continued generation of employment and income of those members of the co-operative who were health providers.

In September 1995 Unimed do Brasil reported that it had encouraged and supported the establishment in Colombia of the "Femec" health co-operative and worked in partnership with it and a second health co-operative, "Unimec". Presumably these were provider-owned enterprises.

In **India** the only known provider-owned health co-operative is at an early and tentative phase of its development: it is an enterprise set up in the late 1980s by the 44 community health workers who have been trained by the Community Health Committee of the Self Employed Women's Association (SEWA) to operate, under its professional supervision, to operate centres in villages and urban slums. The workers are themselves very poor, formerly self-employed women. The purpose of their co-operative enterprise is to increase the effectiveness of their mutual collaboration, exchange of experience and training, thereby developing their skills, and eventually generating resources to run a collective programme. The co-operative has become one of the occupation-oriented worker-owned co-operatives which SEWA has promoted among its union membership.113/

In **Malaysia** a secondary provider-owned health co-operative (Koperasi Doktor Malaysia Berhad (KDM)) was established by doctors in July 1988 with the objective of protecting their professional and socio-economic interests. This followed a process which had begun in 1983 with the carrying out of a study of health sector financing and with the announcement by the Government in 1985 of its intention to privatize health care. The College of General Practitioners formed a committee to examine the impact of privatization on its members, and the possibility of setting up an organization to meet the new circumstances. During 1987 the option of a co-operative form of organization was put forward, and meetings were held at the Co-operative College with the Governments' Department of Co-operatives and with the Malaysian Co-operative Insurance Society Ltd. (MCIS). Initial discussions were begun also concerning the possibility of setting up a broad national co-operative health plan involving providers, insurers and consumers; the acronym for which was KOSIHAT.114/

While this proposal remained under consideration, an inaugural meeting of the co-operative of providers (KDM) was held in March 1988. They felt it necessary to combine in a co-operative in the face of a combination of circumstances: the commercialization of the health sector, characterised by an aggressive private sector providing health care services for purely profit motives and concerned primarily therefore with cost-control; and the adoption by the government of a policy of privatization of certain components of the public sector health services, already very substantially developed. Doctors felt that the commercialization of health care threatened traditional relationships between doctors and patients and between doctors themselves. They decided to establish a co-operative rather than a private for-profit company, considering that their objectives included service to the community as well as to their own interests (which were, perhaps, felt to be best served in the long term by inclusion of the lower income strata within the effective market for health care).

The immediate task of the co-operative was to establish a Health Care Provider Network throughout the Peninsular part of Malaysia, whereby members' clinics could be linked with each other, and with selected hospitals. This arrangement would be advantageous to patients: clinics would be able to standardize procedures, reduce operating costs through bulk purchase and cost-sharing activities, upgrade the quality of health care, provide continuing care to patients, refer them to specialists and hospitals where necessary, and continue to provide care after hospitalization. There would be advantages also for the participating doctors: by establishing a network instead of operating independently, it would be possible to develop closer and more beneficial partnerships with hospitals and with insurance providers.

It was considered also (and perhaps most importantly) that co-operative organization might result in preferred treatment by Government as part of its privatization programme. When the proposed National Health Insurance Scheme was established, members would be in a stronger position to be accredited for reimbursement of patient care costs. The network would be in a better position to negotiate contracts with corporations and other major employers. Finally, as a co-operative, it would be easier to develop collaboration with other co-operatives and to provide their members with health services at a discount on the basis of mutual collaboration: this would increase the number

of users while at the same time benefitting co-operators otherwise unable to afford full health services. Significance was attached to solidarity with other co-operative societies, with their potential clientele of 3 million members: it was proposed that such collaboration should aim at a Consumer Cooperative Health Scheme at the national level.

Individual members, through their clinics, would provide primary care, with emphasis upon continuing promotive and preventive as well as curative services at the primary level to individuals and families, with whom a close and permanent relationship could be established by collaborating doctors and nurses. It was anticipated that financial benefits for members would result also from their ability to obtain capital at affordable cost from the accumulated assets of the co-operative. Their membership of a national network would facilitate referrals to secondary and tertiary care: facilitate the treatment of mobile patients; and serve as a vehicle whereby quality and affordable care could be provided to individuals and families on a fee-for-service basis, as well as to those registered with insurance schemes and health maintenance organizations on either a fee-for-service or captation basis. Such a Network would allow for the development of a clientele with an established doctor/patient relationship in preparation for introduction of the National Health Insurance Scheme.

The Network would comprise clinics belonging to members, selected specialists and private hospitals with which joint venture or contractual arrangements would be made, government hospitals, under-utilized government facilities which could be utilized by members, as well as new community hospitals which would be constructed where necessary, and common facilities such as central diagnostic centres, day surgeries and home nursing services. Establishment of the network would be carried out in phases, beginning with the upgrading and standardization of clinics and development of additional services and facilities, followed by introduction of bulk-purchase and cost-control monitoring measures, and finally by development of new facilities owned by the co-operative.

Membership was open to doctors in private practice and also those in Government employment. Advantages were considered particularly great for doctors working alone, although those already in group practice would also benefit significantly.

The Health Care Provider Network was officially launched by the Prime Minister in August 1991 and commenced operations in August 1991. Later in 1991 and during 1992 a joint working committee of KDM and Malaysian Co-operative Insurance Society (MCIS) began examination of a health insurance package scheme for co-operators, while a working group which included KDM, MCIS and the Co-operative College examined possible mechanisms for the organization of an alternative health delivery system for co-operative members involving providers (KDM), insurers (MCIS) and consumers (members of co-operatives). The scheme was to be designated "Pertubuhan Koperasi Kesihatan Malaysia Berhad - KOSIHAT". At a workshop held in October 1991 it was determined that the purpose of KOSIHAT should be to provide a "health component" within the co-operative movement, making possible thereby an ethically acceptable means to provide health care to co-operative members, as well as contributing to the professional and economic welfare of provider members. After consideration of such aspects as membership, and democratic management through appropriate representation of providers, insurers and consumers, it was decided that KOHISAT would be set up as a secondary co-operative, i.e. one whose component members would be KDM, MCIS and the various co-operative organizations whose own members would be consumers.

In September 1995 the Medical Co-op Committee of the Japanese Consumers' Co-operative Union (JCCU) reported, on the basis of its survey of health co-operative development in Asia, that the Malaysian Doctors' Co-operative (KDM) had 472 members. Together with MCIS, co-operative banks, consumers' co-operatives and others already participated in KOHISAT, organized as a secondary co-operative. It operated hospitals, nursing homes, pharmacies and homes for elderly persons.

In **Paraguay**, it is believed that a provider-owned health co-operative system, modelled on Unimed do Brasil, and receiving some support from that organization, has recently been established.115/

In **Spain** a distinctive type of provider-owned health co-operative system exists, in which members and owners are doctors, but services are provided to a specific clientele which comprises individuals and households who hold various forms of contract with the provider co-operative. It is characterized in Spain itself as "a health service provider-owned and promoted but user-oriented" a special form of "integrated health co-operative".116/

This type of health co-operative developed from what might be described as a "pre-co-operative" situation. For a long period up to the 1930s and 1940s, a system was widespread whereby a large number of potential clients within a community entered into a pre-payment contract (sometimes monetized, sometimes in kind) with a doctor. The arrangement was known as an "iguala". With increased specialization in medicine and socio-economic changes in many communities this system evolved into that of a more sophisticated arrangement, known as an "igualatorio", in which a group of doctors (some already in group practice, others working independently) combined to offer their services to a defined clientele on the basis of a more formal type of pre-payment contract. The first such "igualatorio" was set up in Bilbao in 1934: however, the principal period of expansion was delayed until the 1950s.

Not all doctors were interested in participating in this system. Those that did so were particularly interested in bringing about an improvement in the health of those sections of the population not covered by the then limited public health insurance and health care system, but unable to afford private for-profit health care. Although still predominantly curative in orientation, there was an element of emphasis on preventive health care, within the "igualatorio" system even if achieved only by means of the familiarity of doctors with their permanent clients, and their families and communities. Although co-operative enterprises were legal during this period, legislation was out-of-date and its administration complex. Consequently, most "igualatorios" took the legal form of an "autonomous society", although they functioned essentially as provider-owned health co-operatives. They transformed themselves into registered co-operatives only after the adoption of new legislation in 1974. It may be presumed that some at least of members continued in private practice outside the co-operative, whether or not within a residual form of the "igualatorio". Such co-operatives may be considered a secondary common service network, rather than a primary worker co-operative.

Although "igualatorios" existed throughout Spain, their transformation into health co-operatives was particularly well developed in Catalonia, and notably in Barcelona. In 1957 an "igualatorio" was established as an "autonomous society": Asistencia Sanitaria Colegial, S.A.. Its share-holders - and member-owners - were doctors who provided services through their practices and clinics to "policy-holders" ("abonados/usuarios") who made monthly pre-payments which gave them access to professional services and referrals to hospitals at established fees. There was in addition a fee-for-service element, but this was at a reduced rate compared to that payable to doctors and hospitals not within the "autonomous society".

In 1974, when it became legally and politically possible to establish co-operative enterprises, the doctors who were members of the Asistencia Sanitaria Colegial, S.A. established a registered service provider co-operative, the "Autogestio Sanitaria", 70 per cent of whose capital was provided by the former. Subsequently, they established, by means of capital provided also by the Asistencia Sanitaria Colegial, S.A., a legally distinct hospital co-operative, the "Sociedad Cooperativa de Instalaciones Asistenciales Sanitarias (SCIAS)" in Barcelona. Health professionals who were the owner-members and service providers of the Autogestio Sanitaria co-operative referred as many as possible of their clients to the SCIAS hospital.

In 1988 members of Autogestio Sanitaria who were interested particularly in family medicine and community-based preventive health established an additional and distinct provider-owned health co-operative. Given that its members were also members of Autogestio Sanitaria and SCIAS, there was close functional collaboration between the three health co-operatives. During the 1980s and early 1990s branches of Autogestio Sanitaria were established throughout Catalonia. In order to support the entire system of health co-operatives a secondary co-operative, ELAIA, was established, functioning as a type of holding and common service enterprise.

During this period similar developments occurred throughout Spain. On the initiative of the Barcelona "iqualatorio" a national association of these associations was established in "Asistencia Sanitaria Interprovincial (ASISA)". In 1976, after an initial period of formation of provider-owned health co-operatives by members of each of the "iqualatorios", a national level secondary co-operative "LAVINIA" was established, with 4,273 health professional members. By 1988 membership within the provider-owned co-operatives which were themselves members of LAVINIA had grown to 19,396 and there were over 800,000 "policy-holders" associated with these co-operatives as privileged clients. Although existing in all regions of Spain, the greatest concentration was in Catalonia, where in 1988 there were 4,021 professional provider-members and 194,549 policy holders.

A final element of the national structure of health co-operatives was added in 1982 when Autogestio Sanitaria and SCIAS in Catalonia and the national secondary co-operative LAVINIA combined to establish the Office for the Study and Promotion of Health Co-operation (Gabinete de Estudios y Promocion del Cooperativismo Sanitario). Subsequently, research in this area was taken up by Fundacion Espriu, named in honour of Dr. D. Josep Espriu Castello, the principal instigator of health co-operatives in Catalonia as well as of the national level associations, and the leading proponent of orientation of health services toward the client as well as broad preventive measures designed to achieve a healthy society. In 1995 the Fundacion Espriu is one of the seven Spanish co-operative organizations which are individual members of the International Co-operative Alliance, and the only individual member of the Alliance which operates in the health sector alone.

An apparently quite separate development in Spain has been that of a provider-owned health co-operative whose services were initially primarily dental, and which has been closely linked with the worker-owned co-operative movement. In 1980 dental technicians converted the private enterprise in which they were employed into a worker co-operative: CES (Centro de Estudios Sanitarios) Clinicas S.Coop.Ltda (or CES S. COOP).117/ The founders sought to provide dental services by means of a co-operative form of enterprise, particularly to low-income communities within the Madrid region. Hitherto the public health services provided only inadequate services, while private for-profit dental services were too expensive for a considerable proportion of the population. After 1985 economic expansion brought about an increase in demand, the extent of control by professional associations declined and co-operative legislation was revised, allowing for larger and more diverse co-operatively organized entrepreneurial activity. Consequently, the number of clinics increased, existing ones were modernized and the services offered were diversified from dental care to gynaecology, family planning and provision of clinical tests. A secondary level co-operative, SANITAS, was established to serve the primary co-operatives. By 1992 members of CES Clinicas S.Coop comprised over 90 professional service providers. Its business strategy included very high priority attention to managerial and administrative efficiency and entrepreneurial activity.

Although provider-owned, a very strong interest in the welfare of clients characterized the co-operative enterprise, and CES Clinicas has participated very actively in the Workers' Co-operatives Union of Madrid (Union de Cooperativas Madrilenas de Trabajo (UCMTA)): the Director General of CES Clinicas is currently President of the Union. Through this Union it cooperates closely with the research and training activities of the School of

Co-operative Studies of the Complutense University of Madrid. The Director General of CES Clinicas is also Coordinator of a CICOPA-ICA programme for Latin America. Through a non-governmental organization engaged in assistance to developing countries (Associacion para la Cooperacion con el Sur - Las Segovias (ACSUR)), CES Clinicas has initiated a "Campaign of Solidarity with the South", by which its clients are invited to contribute an amount equivalent to one per cent of their account with the co-operative, which is then matched by the co-operative itself. By this means support is given to an integral rural community development programme in Nicaragua, a literacy and occupational training programme for rural women in El Salvador and a refugee support programme in Guatemala.

In the **United Kingdom** prior to the establishment of the welfare state in 1948, health and social services were provided by a mixture of philanthropic voluntary organizations, an expression of paternalistic altruism; by state poor law institutions, characterized by means testing and coercion; and by working class self-help and mutual aid.

The latter took three organizational forms: "friendly societies", co-operatives and trade unions. By far the most important was the former, which aimed to provide as comprehensive a system of mutual insurance as its members could afford and which concentrated on sickness and death benefits, and, if members could afford them, unemployment benefits and old age pensions. They also provided medical cover to their members, though usually only in the form of payments toward doctors, surgeons or apothecary's fees. For hospital services, members had recourse only to facilities operated by philanthropic agencies or by the "poor law guardians", an element of the contemporary system of local government.

Co-operatives developed during the first half of the nineteenth century as a specialized form of friendly society: for example, the Rochdale Pioneers perceived their new society as an outgrowth from the friendly society tradition, and registered under the contemporary Friendly Society Act. However, although consumer co-operatives and trade unions provided some benefits to members, and the co-operatives often provided them to their employees, during the remainder of the nineteenth century, and upto the establishment of the welfare state, direct provision of health insurance and access to health care by the co-operative movement, compared to the friendly societies, was insignificant. There were no co-operative enterprises established specifically to provide health services. Nevertheless, the total impact upon health of the co-operative movement was very significant, although indirect, acting through improvements in nutrition, reduction in poverty, provision of holidays and sanitoria etc.

The establishment of the welfare state system in the late 1940s completely interrupted previous arrangements, both those of the co-operative sector and those of friendly societies. Consequently, there is little or no continuity between them and contemporary experiments in the development of health and social care co-operative enterprises, whether user-owned or provider-owned. However, these are trying to meet the same kinds of need by means of similar organizational forms. They have responded to the health service and community care reforms of the late 1980s, which provided an opening for new forms of service delivery agencies. The new co-operative enterprises are heavily reliant on state funding, through the National Health Service in respect to health care, and through income support payments for care of the elderly. These enterprises are distinguished by democratic control by users and potential users; they are sensitive to the needs of users and providers; involve both in the formulation of objectives and control over operations; and encourage and facilitate commitment to quality of service. 118/

In these new circumstances several types of provider-owned health co-operatives have developed. The oldest established is the "General Practitioner (GP) co-operative". Members and owners are family doctors (general practitioners) practising in the community under the auspices of the National Health Service. Through the co-operative, which operates as an extended rota system, members take collective responsibility for providing to

each other's patients (as well as their own) out-of-hours coverage and care of consistent quality. They are mutually responsible to one another. Members make an equal financial contribution to the co-operative: but are paid by the co-operative only according to the number of hours they provide out-of-hours care. If these are not very many, members may receive less than they contribute: if sufficient hours are worked, members may make a financial gain from their participation in the co-operative. Presumably some part of the contribution made by members is used to employ staff to administer the roster and respond to calls. The benefit to members consists of combining with each other to fulfil one component of their obligations within the National Health Service, thereby reducing their individual costs and satisfying their client needs more effectively.

A second and newer type of provider-owned health co-operative is the "Multi-Practice" or "Multi-Fund Co-operative". Although increasingly steadily in numbers, there are not yet many in operation. Members are medical practices, composed of several general practitioners, which receive an annual "fundholding" management allowance from the governmental Family Health Service Authority, from which they purchase medical and other services at their own discretion. Member practices retain responsibility for and control of their own budgets, but pay an agreed proportion of their Fundholding Management Allowance to their co-operative. This is administered by a committee comprising representatives from all member practices, supported by paid professional staff. It is used to co-ordinate member activities, assist with the negotiation of contracts, with joint purchasing and with sharing management and information systems, providing general support and acting, as at least one such co-operative has put it, as "a forum for the implementation and development of the National Health Service in all its aspects".

A third type of provider-owned health co-operative in the United Kingdom comprises a small number established by practitioners of complementary or alternative therapies (these might be designated as "Complementary therapy health co-operative"). Practitioners in such fields as hypnotherapy, aromatherapy and acupuncture join to establish a co-operative in order to reduce the overheads of individual practices. Their co-operative may provide premises, a receptionist and booking services and joint insurance, enabling their services to be made available more cheaply and thereby allowing more people to have access to them.119/

In the **United States** co-operatives owned by dental professionals have appeared during the last two decades. One of the oldest, established in 1981, and the largest in the North-eastern region of the United States is the Northeast Dental Plan of America, a "Preferred Provider Organization" or network of over 3,000 private dentists with headquarters in New York. Provider-members benefit by an increased patient volume and stability. The 10,000 "enrolees" benefit from an estimated 50 per cent reduction on normal dental costs. 120/

C. Provider-owned social care co-operatives [type 1.2.3]

Social care co-operatives of this type are known to exist in Myanmar, Sweden, the United Kingdom and the United States. It is very probably that they exist elsewhere also. In **Myanmar**, according to a communication received from the ICA dated 26 April 1996, the Sandidaewi Health Care Women's Co-operative was set up in Yangon in June 1995 by 20 retired nurses, each of whom had contributed 100,000 kyats to the share capital. The purpose was to safeguard and extend the professional and financial status of members. The co-operative was to establish a poly-clinic and special nursing centre, provide health education programmes, undertake training courses for nursing aides, provide home care for elderly persons and set up a day nursery school. As of April 1996 the co-operative had only put into operation the latter activity: other intended activities were still at the planning stage. About 50 children aged between three and five years attended the nursery. It had already achieved a good reputation and the number of parents applying for places exceeded current capacity.

In **Sweden** a recent development has been the establishment of co-operatives which have been described as "interested parties partnership" because both service providers and users and also third parties, including local government authorities and other institutions responsible for financing the operation, are all members.121/ They provide social care services now being transferred from the responsibility of local governments to the private sector. Also significant recently has been the establishment of small worker-owned production or service provision co-operatives the majority of whose members are persons with disabilities: disabled persons special work-place co-operatives.

In Sweden in the early 1990s local governments, responsible for most social care programmes, were becoming particularly interested in co-operative modalities for the organization of these services. They perceived co-operatives as an alternative to private contractors. In 1991 policy changed also in respect to provider-owned co-operatives, which were allowed for the first time. Day-care and nursery school co-operative programmes and opportunities expanded as a result. By September 1995 there were 129 provider-co-operatives, whose owner-members were nursery school teachers.

As of September 1995 there were about 200 professional provider-owned co-operatives in combined health and social care service sectors. Although still relatively few, partly because of the lack of a worker-owned co-operative tradition in Sweden, there had occurred since 1990 a significant expansion in numbers. Most professional member-owners had worked previously in the public health and welfare system. They either transformed their previous institution or facility from its status as an element of the public sector into a co-operative, or set up an entirely new enterprise, organized as a co-operative. Usually, the co-operative worked on the basis of a contract with the municipality and county council whereby it provided services to persons who were beneficiaries of central or local government health and social security payments. They did so in order to gain greater influence over their professional work, have the chance to provide a better quality of services, an opportunity to choose colleagues with whom to work, and escape from bureaucratic and substitution of more flexible forms of administration. It appeared that these new provider-owned co-operatives had functioned well, and had satisfied the objectives of their members. They were appreciated also by their users, with the result that there existed a large demand for their services.

From 1991 in Sweden it became possible to set up provider-owned co-operative day-care centres. During the next few years there occurred a rapid increase in this type of co-operative: by 1994 there were about 100, of which over 40 were in the county of Stockholm. Many had been operated previously by local governments. They were taken over by the professional staff, preschool teachers who saw an opportunity to expand their professional experience, including greater responsibilities. The organizational transition had been eased by their being granted leave of absence by the local government, retaining the option of being re-allocated to other positions if they chose not to remain with the co-operative. Local government authorities authorized the placement of children in the co-operatively organized day care centres at the request of parents: however, in some cases they did not permit such co-operatives to enrol all those children whose parents wished them to enter the co-operative. While placement regulations vary between municipalities, not all authorities have been favourable to this type of co-operative. 122/ In some cases member-providers of day care centres have competed successfully with private for-profit enterprises for taking over institutions and programmes being privatized by local government departments. In some, parents were also members. Since 1994 expansion has come to an almost total standstill, due to a change in local government policies.

Also in Sweden in the early 1990s a number of local governments encouraged and supported the transfer of various types of social care institutions to the staff working in them as provider-owned co-operatives. This was the case of the Thamstorp convalescent home for mildly mentally ill persons, formerly operated by the Goteborg Health Authority. In Karlstad the Grasdalen Service

Co-operative provides a range of social care services previously the responsibility of the local government. There exist also a number of provider-owned nursing home co-operatives.

In order to support the transfer process, in which an increasing number of local government authorities have become interested, but concerning which there is little experience of the managerial, legal and personnel developmental processes involved, help has been provided by regional co-operative development centres supported by a national Co-operative Council. Although established prior to the period of establishment of social care co-operatives, and with different functions, the co-operative development centres played an important part in the process. They provided free information and consultation to groups interested in setting up co-operatives in the health and social care sectors. However, following the reversal of policies with respect to privatization and co-operativization, neither their mandate nor their funding allowed these centres to engage in further promotion of provider-owned co-operatives in the health and social care sectors.

The relatively short period of experimentation and growth which took place during 1991-1994 in the context of an ambitious programme of privatization adopted by the then conservative government (but one which did not achieve its goals and was not in fact seriously pursued by the administration) came to an end with the return of a labour government to power, which shelved the whole idea. Unfortunately, as a result of the earlier initiatives, further expansion of co-operatives in this sector had become associated with retrenchment in the public sector and "privatization", a process no longer viewed with such enthusiasm as previously. Consequently the interesting and normally successful pioneering experiments failed to stimulate any further development of co-operatively organized approaches, and now remain as rather isolated institutions in their respective niches.
123/

Employees of local government social care departments have been motivated to establish co-operatives in order to control better their own professional and occupational environment, to have closer contact with users, in part by avoiding bureaucratic intermediaries, and thereby allowing more flexible approaches to client needs and hence to provide better services. They perceive the co-operatives of which they are members to be entrepreneurial ventures making possible their personal and professional development.

An example of a provider-owned co-operative set up by physiotherapists is that of Kuling, situated in the small town of Lysekil on Sweden's west coast. Started in 1993, it consisted in 1995 of 11 women - physiotherapists, nurses and a secretary/financial administrator - who had previously worked for the county council. The co-operative offered many kinds of physiotherapy for patients from rehabilitation centres, nursing homes and the local health-care organisation. The initiative for starting the co-operative had come from the group itself and was, from the beginning, supported by the county council. The members wanted to function independently of the large county council which they viewed as an obstacle to their daily work. Starting the co-operative meant that they could organise and develop their own ideas and working methods, as well as types of medical treatment.

The group members prepared themselves in different ways for the "takeover". They had to learn more about preparing budgets, about financing and about other aspects of managing an enterprise. They also had to develop a completely new relationship with their former employer. It was important to know something about making contracts, so they engaged a lawyer to support them in negotiations with the county council and the municipality. Discussions, preparations and negotiations took up to five years, and by the time they started the group had signed three contracts - two with different units of the county council and one with the municipality. The contracts basically stated that the co-operative would provide the same volume of treatment, but for 10% less cost. The Kuling co-operative had to keep track of the number of services performed, and the principals agreed to compensate them accordingly, although an upper limit was established.

In 1994 the co-operative achieved a very good result and, compared to the time they were associated with the county council, costs had been reduced by 10%. By November 1994 they had reached the agreed performance limit, but continued to treat patients during December, without payment from the council. Despite this, the surplus income for the co-operative was the equivalent of about 52,000 pounds sterling, a majority of which has been reinvested in the business with part being distributed to the members as a divided. The co-operative was confident that its contracts would be renewed, since everyone involved - the patients, the county council, the municipality and the co-operative - seemed to have benefited. After two years, in 1995, members felt that they had fulfilled their goals. Everyone had tried to broaden their skills, and everyone was responsible for some aspect of running the co-operative. The former secretary had developed a new role and had become responsible for everything concerning the enterprise's economy. The co-operative had invested in education and further training for members. In the near future they planned to begin offering treatment for new groups of patients, such as those with heart disease. 124/

In the **United Kingdom**, provider-owned social care co-operatives have been set up largely due to changes in regulations governing "care in the community". 125/ These have required local government authorities to provide care to vulnerable members of the community, but to do so by purchasing from the "independent" sector rather than providing care directly. These changes have produced a new market, in which "community care co-operatives" owned by providers, have increased significantly in numbers.

Co-operatives of this type provide social care to the elderly and to persons with disabilities - help in cleaning, washing, dressing, shopping and providing company and social contacts. Some employ qualified nurses, but this is not the norm. Most is domiciliary care, that is care provided to persons in need in their own homes. Most co-operatives receive part of their income from local governments, part from client's private resources. Most operate as agency co-operatives providing central administrative, marketing and co-ordinating services to members who are self-employed. Others are "worker-co-operatives", entering into contracts with clients and employing carers directly. Some provide day care facilities with supervised leisure and educational activities and meals. There are significant differences between "agency" and "worker" models in terms of liability for income and sales taxes and social security contribution, which result in different operating costs. There were an equal number of user-owned and provider-owned child care co-operatives. A number of aid centres for women and children seeking refuge from domestic abuse were operated as co-operatives owned by staff and volunteers.

For example, a provider-owned home care co-operative was established at Walsall, Staffordshire, in 1989, with advice from the local co-operative support organization. Members provide social care, not nursing care, for persons of any age in their own homes: users included persons with physical and mental disabilities, elderly persons and mentally ill persons. Care providers owned the co-operative, to which they paid a commission on their care work. Some clients paid by means of public benefits: care for others was financed through contracts with the social services department of local authorities. By 1995 there were 170 members, all care workers. The co-operative employed five administrative staff who received referrals, made assessments and put care workers in touch with clients. They also monitored care workers, maintained quality control of services, and provided advice, support and training.

In 1993 it was reported that there were increasing numbers of co-operatives providing care, particularly home care, with some concentration in the West Midlands (Staffordshire and Shropshire), Hull and Scotland. There was one residential care co-operatives, as well as those providing sheltered employment and training. In Shropshire the Wrekin Home Care Co-operative and two to three others were small home-care co-operatives. There were between 30 and 40 childcare co-operatives.

In the **United States** the first day-care co-operative was established in 1916: by 1994 about 50,000 families were members.126/ Provider-owned social care service co-operatives have expanded considerably in recent years. One of the largest is Co-operative Home Care Associates (CHCA), a co-operative of home aides based in New York City, which has had a great impact on the level of care available in many local communities. Co-operative Home Care Associates (CHCA) is one of the largest home health-care service providers operating in New York. It was established in 1985 by the Community Service Society of New York, largely through the initiative of the then Director of a community economic development agency, R. Surpin. His research had revealed an annual rate of growth of 20 per cent in home health care, a result of health policy changes which favoured returning patients to their homes from hospitals as quickly as possible. Most care providers were employed by temporary personnel agencies on a part-time, low-wage basis. There was limited supervision, a high employee turnover, and high levels of user complaints.

By the end of 1995 CHCA employed 300 home-care providers, who were mainly African-American or Hispanic American women. Most were single parents. Eighty percent of workers were formerly themselves on welfare. Emphasis was given to selection and training. Only one in four applicants were selected. Eighty per cent of these completed the three-month entry level training period and eighty per cent of these survived the crucial first six months of work. Turnover was 20 per cent, half the average. Advanced training was also provided.

After the three-month trial period workers could become an owner-member, building up a $ US 1,000 equity investment through small weekly payroll deductions. Voting rights began after equity reached US $ 50. Workers received hourly wages 16 per cent higher than the average: combined with health benefits, sick leave and paid holidays these were the best conditions available in the industry. As a result of the attention to training, standards of reliability and competence were high and patient complaints low.

The experience of CHCA had been so positive that it was being promoted as a model by the Industrial Cooperative Association of Boston, an organization which supported worker-owned co-operatives of all types. Similar home-health care worker co-operatives have been set up in 1993 in Philadelphia, in 1994 in Boston, and in 1996 in the Mid-west. Similar co-operatives, begun independently, have operated since 1992 in Waterbury, Connecticut and in Chapel Hill, North Carolina.127/

D. Provision of social care to individuals by provider-owned health co-operatives

Provider-owned health (medical) co-operatives, by definition, have been founded and developed, and subsequently owned and operated, by health professionals. They have tended in consequence to restrict their activities to health, including preventive measures and "social medicine", but not to extend this to purely social care programmes which may fall outside the central professional concerns of the members. None of the provider-owned health co-operatives included in the review extended their functions to social care.

E. Secondary level co-operatives owned by independent (provider-owned) pharmacies [type 1.3.2.2]

In **Portugal** co-operatives at the secondary level are well developed. They act as group purchasing and common service provision networks, each within a defined region, and are owned by independent pharmacies. In 1993, out of the 100 largest co-operative enterprises of all types defined in terms of sales, they occupied fourth, sixth, eighth and tenth places. The sales of the largest four was equivalent to US $ 400 million, and they employed 649 persons.128/

In the **United States** independent neighbourhood pharmacies have been subject to intense competition from chain drugstores, mass merchandisers and supermarkets able to attract customers by means of the large amounts of capital they can invest and their very low prices. As a result, an estimated 1,000 such pharmacies went out of business during the two years 1992-1993. In order to remain competitive, independent pharmacies have formed purchasing co-operatives such as United Drugs in Phoenix, Arizona, which supplied 450 pharmacies in 11 States, and the Independent Pharmacy Co-operative in Wisconsin, which supplied 400 pharmacies in four States. Others have joined marketing co-operatives such as the Valu-Rite Group, which had 4,600 member pharmacies in 1994.129/

F. Primary worker-owned health and social care sector support co-operatives [type 1.4.1]

Only one example of this type of co-operative was found in the literature. There were early in 1996 in the Province of Quebec, **Canada**, five worker-owned and operated ambulance service co-operatives (Monteregie, founded in 1987; Metropolitan Quebec, Mauricie and Outaouais, founded in 1989; and Eastern Quebec, founded in 1990). The largest was located in the Montreal region (south of the St. Lawrence River). It included more than 200 worker-members with 30 ambulances. In 1992 these five co-operatives accounted for 13 per cent of the emergency transportation market within the Province. About 90 to 95 per cent of funding was provided by the provincial health service system (RRSSS), with which the co-operatives had contracts. The remainder consisted of fees charged to private users. Considerable attention has been given to professional training, strategic planning and education in co-operative forms of organization.130/

G. Secondary health and social care sector support (enterprise user-owned) co-operatives [type 1.4.2]

In the Province of Quebec, **Canada**, a secondary health service support co-operative (La coopérative du service régional d'approvisionnement: CSRA) provides bulk purchasing services to over 60 public and other hospitals, clinics and other health facilities in the region between Montreal and the city of Quebec (region Mauricie/Bois-Francs). This co-operative originated in an informal grouping of a number of facilities for bulk purchasing purposes. It was established in 1980. As the volume of financial transactions expanded, it was considered necessary to adopt a recognisable juridical status, and, with advice from a development counsellor of the Fédération des caisses populaires Desjardins du Centre du Québec, a co-operative organizational form was adopted.

The co-operative negotiates on behalf of its members the purchase of a wide range of inputs: heating oil, maintenance products, office supplies, laboratory equipment and material. It was in 1996 negotiating recycling of certain materials and was exploring new areas of common benefit, such as supply of natural gas and maintenance of laboratory equipment. In 1989 health facilities in the region made purchases amounting to 53 million Canadian dollars, of which 27 million were handled through co-operative, providing a saving of 3 million dollars to members. In 1993 the co-operative made an estimated savings of 4 million dollars on the purchases of members, 50 per cent of which were made through it. Early in 1996, on the basis of its success in providing services to facilities in the health sector, the co-operative was considering expanding to provide similar services to other public and community organizations, such as schools. 131/

In the **United States**, secondary co-operatives of this type (bulk purchasing, common services, specialist labour- and worker-co-operatives) are well developed. They are termed "Shared service organizations". They are owned by non-cooperatively organized health sector institutions, both private for-profit and not-for-profit. In 1990 there were 127 hospital networks or

consortia, 40 of which had been established during the previous three years. There are also numerous networks of health centres. However, probably only a small proportion are organized as genuine co-operative enterprises. In predominantly rural regions there were in 1990 about 30 networks of health care providers - mostly rural hospitals - of which six were organized as co-operatives. These included the Rural Wisconsin Hospital Co-operative and Synernet. In 1994 the largest hospital purchasing co-operative was that established by the Voluntary Hospitals of America, which in 1993 began to form regional co-operatives within its membership. An additional 12 were non-profit corporations organized in a similar manner to co-operatives. The remainder were described as "tied regional networks", alliances organized and supported by large urban hospitals which often paid the general operating expenses of the network, and provided services to its rural networks on a fee basis.

Hospitals formed co-operatives to buy supplies at lowest prices, and to maximize purchasing power on expenditures such as laboratory products, food, film, pharmaceutical, fuel oil and other goods. These items usually constituted one-third of a hospital's budget. The rural hospital co-operatives were seen by their member institutions as self-help organizations: they believed that hospitals working together could achieve results which were not possible if they operated alone. They relied on the application of their own capital for setting up the co-operative and were willing to pay dues to it until fees earned by its provision of up-graded services could support administrative costs. Each of the co-operatives had an average of 17 rural hospital members: the average number of employees was 9 and annual budgets averaged a little less than one million US dollars. Services offered to members included management support and consulting; training; shared services in areas such as biomedical equipment maintenance, physician recruitment, purchasing, computer systems and telecommunications; major equipment sharing; sharing of allied health professionals; insurance; joint contracting with third-party payers (insurance companies); and joint loan financing. 132/

The Rural Wisconsin Health Cooperative is owned and operated by 20 rural hospitals and one urban university hospital. It was established by several hospital administrators in southern and central Wisconsin as a shared service corporation and as an advocate for rural health. Services provided to the member hospitals are based on written contracts between them and the cooperative: however, with some limitations, the member hospitals are not required to buy services solely through the co-operative.

In 1995 it had over 150 staff or contracted professionals whose function was to provide services to member hospitals in such areas as advocacy; audiology; quality improvement initiatives, including multi-hospital benchmarking; obtaining grants; occupational, respiratory and physical therapy; per diem nursing; physician "credentialling"; speech pathology; emergency room physician staffing; and continuing education. The co-operative has negotiated special group contract arrangements by which members can obtain high quality consultant services in areas such as legal services, personnel consulting, market research, patient discharge studies and consultant pathology services.

The co-operative intends in the short-term to develop further a pool of administrative specialists to work with community-based professional practices to help them to be successful in a managed care environment; to identify and coordinate linkages that will enable providers to meet the needs of patients; to provide shared services such as per diem support clinic staff and locum tenens coverage; and to ensure access to malpractice insurance discounts typically available only to large group practices.

The co-operative has been a vocal advocate of improvement in rural health service provision, helping establish the Wisconsin Rural Health Development Council and working with other hospitals in New York, Philadelphia and Phoenix to implement the Hospital Research and Education Trust's Community Health Intervention Project. 133/

Syernet, Inc., is a cooperative whose members are 16 hospitals in Maine and New Hampshire. It evolved from a consortium known as the Southern Maine Association of Cooperating Hospitals, formed in the late 1970s. This had been formed for group purchasing of medical equipment, but the co-operative now provides a wide range of services, while continuing to expand its purchasing functions.

This co-operative was considered by its members to be an appropriate organizational response to a changing environment, particularly in rural areas. Rural and community hospitals have been faced with trying to achieve economies of size in adopting new technologies and delivering care. Emerging managed care systems and integrated delivery systems are challenging smaller to mid-sized hospitals to develop systems and approaches to remain economically viable. Significant developments in new diagnostic and treatment technologies have required hospitals to continually invest in state of the art technology. Keeping up with the need to purchase equipment, train technicians to operate and maintain equipment and adjust to the competitive environment has particularly affected smaller to mid-sized hospitals.

The co-operative offers a capital equipment program, comprehensive biomedical equipment services; employee benefits purchasing and administration; worker's compensation services and purchasing arrangements for a range of products including fuel oil, food, office furniture and medical supplies. Member hospitals have seen cost savings from gaining economies of size in purchasing a wide range of products and services. Purchasing contracts are negotiated on behalf of members through regional and national vendors. Member hospitals use group strategies to learn about and assess changes in a dynamic health care industry.

The co-operative has established a self-funded trust for workers compensation insurance. This serves 25 organizations with 4,000 employees. The group's annual payroll exceeds $84 million. Member hospitals can participate also in buying employee benefits. With over 4,000 employees, they can increase their purchasing power. Benefits administration, legal compliance consultation and enrolment assistance are also provided. A subsidiary offers hospitals, doctor's offices and other health care providers comprehensive biomedical equipment services. Services include preventive maintenance, repair, testing, consultation and 24-hour emergency services. Custom research and education projects are developed and delivered to members such as educational materials lending library, training programmes, regulatory compliance research and performance benchmarking. 134/

H. Secondary health service delivery co-operatives owned by non-co-operative enterprise [type 1.5.1]

There have been a number of early examples of such forms of cooperative organization. In **China**, in the early 1940s owners of small enterprises in Shanghai combined to establish co-operatively organized clinics. The first was established in 1942, the number increasing to three the following year. By 1946 services were provided to 10,000 workers employed by 476 member enterprises. A central body, the Shanghai Co-operative Industrial Hygiene Centre was formed for common administration: membership fees were made uniform. A co-operatively owned hospital was set up in 1943. Educational and preventive measures were organized, including inspection of sanitary conditions in work-places and nutrition education of workers. 135/

I. Secondary health insurance purchasing enterprise-owned co-operatives [type 1.5.2]

In the **United States**, employers - particularly large enterprises - have for some decades provided health benefits to their work-force through group health insurance plans negotiated with regional and national insurers for services provided by local and regional health service providers, whether co-operative and non-co-operatively organized. Recently, such employers, including an

increasing number of small employers, have combined to establish "business-sponsored health care purchasing co-operatives". By this means they maximise their purchasing power, providing their employees with affordable high quality care and a wide range of services. For example, in 1994 the Business Health Care Action Group of Minneapolis bought health care for the 100,000 employees of 14 large enterprises in the Minneapolis region. The Colorado Health Care Purchasing Alliance in Denver, founded in 1988, had 500 members in 1994. In Seattle the Health Care Purchasers Association, an alliance of employers, created the Employers' Health Purchasing Co-operative, representing 240 enterprise members with more than 300,000 employees and dependents, including some of the largest employers in the State of Washington. Its function was to buy health coverage on behalf of member employers.136/

During the recent public discussion of health care reform at the highest national levels in the United States the National Co-operative Business Association, the apex co-operative organization, endorsed the concept of co-operative health alliances before the Small Business Committee of the House of Representatives, provided that these were structured as user-owned health co-operatives, and not as governmental regulatory agencies. 137/

Initial discussion at the federal level on reform of the health sector had included consideration of health purchasing co-operatives sponsored in part by Federal and State governments. Although no longer a central component of proposals at the State level a considerable number of States (20 by August 1994) have passed legislation that promote state- or employer-sponsored health insurance purchasing co-operatives. At that time the total of employers already members of such co-operatives had an aggregate labour force of over 10 million. California, Florida and Washington were experimenting with State-sponsored health insurance co-operatives for small employers. A national association had been set up in Washington D.C. - the National Business Coalition on Health.

Very large employers, in some cases acting on behalf of numerous subsidiaries and associated enterprises, were joining such purchasing co-operatives, but they were of particular relevance as a solution to problems faced by medium- and small-sized employers who had not been able to afford adequate health insurance coverage for their labour force. Very considerable reductions in costs had been obtained by group purchasing arrangements and the ability to choose between competing insurers. Participating employers included both private for-profit enterprises and public sector agencies. For example, in Racine, Wisconsin three large self-insured employers had joined with three public agencies (the city and county governments and the school system) to create a health insurance purchasing co-operative. Although employees participating in such group health insurance programmes were able to use doctors and hospitals of their choice, it was to be expected that the purchasing co-operatives would develop an interest in assuring acceptable treatment. This had not extended to establishing their own facilities as yet, but some initiatives had been taken already in this direction. For example, in Tampa, Florida, an Employers Purchasing Alliance had supported an increase in State sales tax to finance the 24-hour operation of primary care centres.138/

In March 1991 a further form of health insurance purchasing co-operative was incorporated: although by early 1995 it was still not yet in operation, as a result of the complexities of setting up an inter-state business. However, its purpose is relevant to the issue of bringing together in a single system health-service providers, users, insurers and others. This was an enterprise named JustCare, based in Boulder, Colorado. Its function would be to bring together buyers and sellers of healthcare in networks within each State, linked by a national electronic claims-processing and payment system. It was organized to facilitate the purchase and sale of products and services on behalf of members admitted only on a co-operative basis. There were three provider membership categories, three purchaser categories and an adjunct services component responsible for management, accounting, legal and banking companies. Different providers of varied type would be members in each of the States in which the co-operative would operate. In California, for

example, the provider would be the California Federation for Medical Care, a San Francisco based network of doctors legally defined as an "agency co-operative". This would be the first time in the United States that members of a co-operative would include both providers and users of health services. It was intended to develop a health care credit card to be used with an electronic claims submission and payment system, possibly to be operated in partnership with a specialist credit card bank. It was projected that there would be 100,000 card-holders by the end of 1995, and five million by 2000. Payment for operational expenses would be obtained through transaction fees on claims. Start-up costs had been funded privately.139/

J. Population served by provider-owned health co-operatives

As is shown in Table 2 it would seem that of the at least 52,220,000 persons who are users of health co-operatives about 25 per cent are served by provider-owned health co-operatives. The largest national groups of users are those in Brazil (8,000,000), Spain (4,000,000), Colombia (576,000), Chile (538,000) and possibly Malaysia (2,500,000).140/

IV. DEVELOPMENTAL DYNAMICS AND CONTEMPORARY GLOBAL SITUATION OF CO-OPERATIVE ENTERPRISES WHOSE BUSINESS GOALS ARE NOT PRIMARILY CONCERNED WITH, BUT INCLUDE HEALTH AND SOCIAL CARE

Co-operative business enterprises whose principal activity is to provide services or supply commodities directly to the health sector have been identified as "Health and Social Care Sector Support Co-operatives". However, many other producer- and service provider-owned worker co-operatives, including labour co-operatives, may supply a variety of goods and services to a range of customers, only some of whom are enterprises in the health sector. Others supply goods and services to households which are of significance to the maintenance by individuals of healthy living, or of a capacity for providing their own health and social care (nutrition, safe water, sanitation, shelter, clothing, etc.). No attempt will be made here to summarize the diverse and widespread activities of co-operatives throughout the world. Nevertheless, some examples are of interest to the theme of the review: that is that many components of the international co-operative movement contribute to health and social care. The examples of interest to the theme of the review: that many components of the international co-operative movement contribute to health and social care, are intended as illustrations. They were chosen from the available literature, and should not be considered to be the selected results of a comprehensive review.

A. Co-operatives in primary production [type 2.1]

Co-operative organization of the production of foodstuffs is substantial in a number of countries. Although agricultural and fisheries production co-operatives are not of major significance, group purchasing, common service and marketing (including processing) co-operatives owned by independent agricultural producers, and by independent fisheries enterprises, are of major importance in many developed countries, and are significant also in a number of developing countries. In Europe, Canada and Japan, for example, such co-operatives account for over half of inputs to agricultural production, and for over half of the processing and marketing of products.

Because their business goals and practices are established and controlled by members who are aware of the long-term impact upon themselves, their families and their communities of imbalances between human society and the natural environment, these types of co-operatives have taken the lead in a number of countries in supporting attempts by producers to adopt and practice environmentally appropriate and sustainable methods. These have included the production, processing and marketing of safe foodstuffs, including organic products. They have taken the lead also in safeguarding occupational health in primary production.

During the last decade an increasing number of these co-operatives, as a response to the demand of members, have begun to promote, support and facilitate adjustment in the production methods of members toward greater sustainability. In some cases entire national co-operative movements in these sectors have adopted strategies for sustainable development, generally supportive of healthier life-styles. For example, the Japanese National Federation of Agricultural Co-operative Associations (ZEN-NOH), inaugurated a comprehensive environmental action plan in 1992. 141/ In 1991 the Israeli Organization of Agricultural Co-operatives reported that its members were becoming more aware of the need to change to sustainable agriculture.142/

These and other movements have given particular attention to organic agriculture and the supply of safe and nutritionally appropriate foods: often they have worked closely with consumer co-operatives to this end - such

alliances are well developed in Denmark 143/, Hungary 144/, Japan 145/, Switzerland 146/ and the United Kingdom. 147/

B. Co-operatives in secondary processing and manufacturing [type 2.2]

Co-operative enterprises in the secondary sector, including those in manufacturing, construction, transportation and utilities contribute significantly and in a number of ways to improved health. Their attention to occupational safety is central to their business practices, given that a significant proportion of their labour force comprises owner-members, while provision of training to both members and employees so they can contribute effectively to the development of their co-operatives - part of one of the principles of the international co-operative movement - has meant the extension of concern for occupational health to non-member employees.

Many co-operative enterprises in the secondary sector are engaged in food processing, either as subsidiaries of primary production marketing co-operatives, or of wholesale and retail distribution co-operatives, or as worker-owned primary co-operatives. In many countries, such enterprises have assumed a leading role in seeking manufacturing processes which protect the nutritional value of foodstuffs. Although many of the worker-owned co-operatives operate at a small scale, they have been innovators and industry leaders in these areas.

C. Retail distribution co-operatives [type 2.3.1]

1. In respect to improved nutrition, household safety and healthy living

Consumer-owned wholesale and retail co-operatives, which supply households with foodstuffs and household equipment, occupy substantial shares of the market in many countries. In December 1991, for example, in the then European Community, together with the Nordic Countries, Switzerland and the then Czechoslovakia, a total of 21.6 million households were members (approximately 60-65 million persons). Over half of retail food sales in Switzerland, 34 per cent in Denmark and 30 per cent in Finland were made by consumer-owned retail co-operatives. In Japan in 1994 26 per cent of households were members of the consumer co-operative movement.

As co-operative enterprises which are owned and controlled by the users of the goods and services they supply they have been always concerned to supply them with high quality and affordable products. Indeed, some of the earliest co-operative enterprises, including that set up by the founders of the modern co-operative movement, the Rochdale Pioneers, were established precisely for the purpose of supplying their members with "pure and unadulterated goods". During recent decades in a number of countries this type of co-operative has taken the lead in ensuring that foods supplied to members were safe and nutritionally appropriate, and in providing to their consumer members education and information on nutrition, household safety and preventive health. Consumer co-operative movements perceive these concerns to be part of their overall goal of persuading societies to adjust life-styles radically in order to achieve environmental protection, societal sustainability, and individual health.

Co-operative movements of this type are particularly well developed in Europe and Japan. Most have adopted energetic and innovative programmes, concerning which only a few illustrations can be included. For example, the consumer co-operative movement in Sweden adopted a programme for the environment in May 1990 which viewed environmental, health and ethical matters to be interlinked and essential components. The movement had taken their impact on health into account in developing its own schedule of products for several decades previously: for example, it had been selling new types of detergents for use by persons having allergy problems since the 1960s. 148/ In the United Kingdom the Co-operative Wholesale Society Ltd. led the branch during the mid-1980s towards clearer labelling of nutritional information on

all food products. It has campaigned vigorously for a number of years for members to adopt a "healthy eating" life-style. In 1995 it issued a major report, "The Plate of the Nation", which highlighted problems of diet in the country. They are also a number of smaller worker-owned health food wholesale co-operatives: for example the SUMA co-operative in West Yorkshire, which had in 1995 60 workers, 50 of whom members.149/ The Japanese consumer co-operative movement has concluded agreements with the agricultural co-operative movement to ensure supply of safe foods, which it ensures are properly packaged and labelled. 150/ In western Canada, Federated Co-operatives Ltd., which serves as a central supplier to 330 consumer co-operatives, introduced in 1992 a programme called "Responsible Choices", designed to provide all member households information on the extent to which goods on the market were compatible with human health. 151/

Because of their market shares, consumer co-operatives are able to put pressure on agricultural producers. In Denmark, for example, the market they provide for organic foodstuffs (even though sold at a higher price than non-organic products) has encouraged farmers to respond, so that by 1990 one quarter of milk sold by retail co-operatives originated from farms which did not use industrial fertilizers or chemical pesticides. 152/ Leverage of this nature is increased by the fact that most consumer co-operative movements have their own manufacturing and processing plants, and even their own production units in some cases. For example, in the United Kingdom, the Co-operative Wholesale Society Ltd. runs a 150 acre experimental organic form at Stoughton Grange.153/

2. In respect to distribution of medicines and medical equipment

In the **United Kingdom**, fourteen consumer-owned retail co-operative societies operate pharmacies of their own, some in conjunction with an optical service. These societies have 228 outlets and their pharmacy/optical turnover during 1995 services amounted to 84 million pounds. 154/ In Singapore the co-operative supermarket chain operated by the National Trade Union Council includes a chain of co-operative pharmacies.155/

3. In respect to social care

In **Japan** the consumer-owned retail co-operative movement has begun to provide its own services to elderly members. For example, Co-operative Kanagawa, after a visit in 1990 to the Co-operative Home Care Associates in New York, which is a home-care provider-owned co-operative, sponsored a similar home-care programme. As a result of its success a considerable number of autonomous worker-owned co-operatives were set up to provide home care to elderly members of Co-operative Kanagawa, and the approach was spreading to other parts of Japan.156/.

In **Switzerland** the Migros Co-operative Federation established a department in 1977 whose purpose was to help elderly members maintain and expand their capacity to enjoy an active and healthy life with the maximum degree of self-reliance and continued participation in, and contribution to, their communities. Consequently, programmes were designed to build and maintain all physical, mental and social faculties. They may be considered types of broad preventive programme.

Among programmes of this type were memory training sessions, conducted in a socially supportive environment; holiday camps with specially designed programmes for the development of faculties; and pre-retirement programmes for retiring employees and their dependants. Many programmes were managed through the Migros Clubs and Schools associated with each retail store.157/

The other major Swiss retail co-operative organization, Co-op Suisse, operated similar programmes, although addressed more specifically to the needs of elderly women. These were one part of the programmes of its Women's Guild, founded in 1922, and organized in entirely autonomous local groups throughout the country. The programmes were also broadly preventive, and include short courses on retirement age living, productive and satisfying use

of spare time, maintenance of confidence and self-esteem, physical exercise and sport, health care and widowhood. A solidarity fund was available in cases of emergency, and legal advice, including free legal counsel in special circumstances, was provided. Funding was provided in part by user-fees, in part by subsidies from the parent co-operative organization and from Swiss co-operative insurance enterprises and banks.158/

4. In respect to funeral services

In some countries, such as the **United Kingdom**, the consumer-owned retail co-operative movement has included provision of funeral services as one among the set of services provided to all members. Here, 25 consumer-owned co-operative societies provide funeral services. Their turnover in 1995 amounted to 200 million pounds sterling. A developing aspect of this business is a facility to provide for the expense of a funeral at a fixed rate during the lifetime of the member. The co-operative share of the funeral market in the United Kingdom is about 25 per cent.159/

D. Funeral co-operatives [type 2.3.2]

Forms of mutual savings or insurance against the costs of funeral services have been widespread in many societies: one of the original purposes of the early "friendly societies", the precursors of modern co-operative insurance enterprise, was in fact to meet burial costs. To this purpose has been added in some cases the co-operative ownership of undertaking enterprises and burial plots. By means of co-operative organization costs could be reduced, compared to private for-profit enterprise, and the financial and emotional stress felt particularly by the elderly can be reduced.

Independent funeral co-operatives are well developed in certain areas of **Canada**. In 1993, in provinces other than Quebec, there were 34 funeral co-operatives with a total membership of 105,000. In the Evangeline district of Prince Edward Island in the late 1980s about 800 members provided the voluntary work-force and were the eventual consumers of the services provided. The co-operative was financed in part by member shares, in part by a loan from the savings and credit co-operative, whose membership largely overlapped with that of the funeral co-operative. It was hoped that if similar funeral co-operatives were established in neighbouring communities, common services and training could be jointly arranged. 160/

In Quebec there were in 1995 30 funeral co-operatives with a membership of 130,000 and an annual turn-over of $ CAN 10,000,000. In certain regions of the Province they had over 25 per cent of the local market. Their objectives were to reduce the financial stress and anxiety experienced by elderly persons and their relatives. 161/

In the **United States**, in order to avoid the often high costs of private for-profit funeral services individuals in many communities have set up funeral co-operatives. In 1994 it was estimated, for example, that average costs for funeral and burial were US $ 5,000, whereas the Chicago Memorial Association offered basic funerals for US $ 950 and cremations for less than $ 400.

In addition, user-owned associations known as "memorial societies" do not act as undertakers themselves, but are member-owned nonprofit groups that prenegotiate the prices of services with collaborating funeral providers on behalf of their members through group purchases of funeral and burial services. In 1994 there were 147 such memorial societies in 40 of the States in the United States, with an estimated total membership of 500,000 persons. Only some of these associations organized themselves as formal co-operatives. These associations had established a national tertiary organization, the Continental Association of Funeral and Memorial Societies with headquarters in Wisconsin, within a region of strong co-operative movement development.162/

In **Colombia** over one hundred co-operatives, trade unions, mutual societies and parent's associations have established a secondary funeral co-operative "Coopserfun", which by the late 1980s in Bogota had become the third largest provider of funeral services. It was established because of the monopolistic organization of private for-profit funeral services.163/

E. Co-operative insurance enterprises [type 2.3.3]

1. In respect to general insurance

Co-operative insurance enterprises are in operation in 35 countries. They contribute both indirectly and directly to the health of their members and dependants. 164/ A relatively small number of co-operative insurance enterprises restrict the insurance products they provide to their members to enterprise-related risks, such as transportation, fire, theft, hail and labour accident insurance and other forms of workmen's compensation. A larger number also provide individual-related insurance products such as home and automobile insurance, as well as loan protection and pensions. Although not directly related to health, each of these contributes significantly to a reduction in stress and an increase in personal security, both of which have at least some impact upon individual health. In a number of cases co-operative insurance enterprises have placed considerable emphasis on developing insurance products specially designed to meet the needs of particular section of the population. This has been the case in respect to women.

In Sweden the co-operative insurance enterprise, Folksam, with which half the population of the country has at least one policy, has since 1985 developed and marketed insurance products specifically designed to meet the particular needs of women. This was a response to observations that women were less financially secure, and consequently had a lower standard of living than men, particularly when they become sick and old. Moreover, it became evident that many women were unaware of their lack of financial security until confronted with it when they divorced, became ill or old. They were unaware of their legal rights, and how to improve their financial security.

Since the 1960s Folksam had been a pioneer in bringing about equality between women and men employees: in 1978 it adopted the first full equality programme in the Swedish labour market. In 1992 it was awarded first prize for furthering equality between women and men in the workplace by the Swedish Equal Opportunities Ombudsman and the largest Swedish business magazine, "Veckans affarer". Later, when developing insurance products specifically for women, this internal emphasis was found to be of central importance in terms both of public perceptions and practical experience of the requirements of women in respect to insurance, found to differ significantly from those of men, for whom most products had been developed.

Folksam had published books by and for women aimed at increasing their knowledge of finance, law, security and health. In 1985 Folksam decided to make a conscious effort to focus on women as a specific target group for insurance sales. This was considered important not only on ethical grounds, but also in order to enhance Folksam's image and expand its business prospects. A woman was appointed as manager of the "women's market". A marketing strategy was developed by seeking to answer the question "If you want to focus on women's needs, what will you change in the products you offer, how will you market them, and what kind of information/education will you need for this?".

An important goal was to raise women's awareness of their financial situation and degree of security - in particular, women had to realize their need for improved insurance cover. In addition to normal marketing programmes, seminars and lectures were held at places of work or community centres. Their purpose was to identify women's needs for financial security; stimulate participants knowledge of relevant legislation and negotiated agreements; motivate participants to use their rights and opportunities; stimulate them to increase financial security by using co-operative insurance

and banking services; and urge participants to inform and motivate women colleagues, union members and daughters. Such meetings were considered essential also as a means of obtaining first hand and up-to-date information on women's needs.

Sales teams consisting only of specialist female staff, and advertising materials developed by and for women, were considered essential in order to reassure prospective members and policy-holders. In 1988 and 1990 Folksam was a major sponsor of the "Women Can Trade and Idea Fair", and in 1992, although a minor sponsor, it had one of the largest exhibitions, at which female employees gave lectures and seminars on women's financial rights and health problems.

A number of adjustments were made in existing insurance products, the better to respond to women's needs. In 1989 Folksam introduced a collective pension insurance product "Members' Pension" which, because of its flexible structure and low cost, was considered particularly suited to women's needs. By the end of 1992 86,467 women, compared to 53,298 men had taken out this insurance. During this period the premium income from women was 242 million Swedish crowns, compared to that of 148 million from men.

These efforts paid off in commercial terms. In 1985 Folksam's market share of newly-issued individual pension insurance policies was 12.4 for men, 14.1 for women. By 1991, its sales, together with those of a wholly owned subsidiary, "Sparliv", had increased to 28.5 per cent of new policies issued to men, and to 43.2 per cent of those issued to women.165/

More directly concerned with health are the insurance products provided by a substantial proportion of co-operative insurance enterprises which comprise individual and group life insurance; personal, school and traffic accident insurance; and disability insurance. Although these are more concerned with the rehabilitation of persons directly affected, and the protection of dependants, they contribute indirectly to improved health and directly to the ability of members to provide social care to themselves or their dependents.

2. In respect to health insurance

An increasing number of co-operative insurance enterprises provide health insurance: there were at 19 in 1995, in 15 countries: Belgium, Canada (3), Colombia, Denmark, Ecuador, Germany, Italy, Japan, Malaysia, Peru, Republic of Korea (2), Singapore, Spain, the United Kingdom and the United States (and separately in Puerto Rico). They vary in respect to the nature of their membership base and their organizational relations with the co-operative structures in association with which they have developed. The following types of co-operative insurance enterprises provide health insurance:

- specialist insurance department of the national level (tertiary) organization established by consumer-owned retail co-operatives (Japanese Consumers' Co-operative Union: JCCU): this, uniquely, complements health services offered by consumer-owned co-operatives also within JCCU;

- specialist insurance departments of the national level (tertiary) organizations established by nation-wide systems of primary production co-operatives (the National Agricultural Co-operative Federation and the National Federation of Fisheries Co-operatives in the Republic of Korea);

- some of the co-operative insurance enterprises established at national level by groups of savings and credit co-operatives ("credit unions"), or by national federations of this type of financial co-operative, providing insurance products to their members (several of this type of co-operative insurance enterprise exist in Latin America - Coopseguros del Ecuador Ltda.; Segurosperu; and Co-operativa de Seguros de Vida de Puerto Rico; as well as in Canada - the CUMIS Group Ltd.);

- specialist insurance enterprises established by regional co-operative groups: as has been done by the Mondragón Co-operative Group, in Spain (Seguros Lagun Aro, S.A. and Seguros Lagun Aro Vida, S.A.);

- some of the co-operative insurance enterprises established at national level by groups of co-operatives operating in diverse sections of the economy, whether individually or through their national federations (the Co-operators Group Ltd., in Canada; Seguros la Equidad Organismo Cooperativo in Colombia; and the Malaysian Co-operative Insurance Society Ltd.);

- autonomous co-operative insurance enterprises established by tertiary level organizations of both rural and urban based co-operatives (R+V Versicherung, which developed from the Raiffeisen and Volksbank systems, in Germany; Desjardins-Laurentian Life Group Inc., which developed from the Mouvement des caisses Desjardins,in Canada; and the Co-operative Insurance Society, Ltd., which developed from the consumer co-operative movement, in the United Kingdom);

- co-operative insurance enterprises specializing in providing services only to employees of co-operatives throughout the country (AP Pension in Denmark);

- autonomous co-operative insurance enterprises established by some combination of co-operative and trade union movements (P & V Assurances S.C., in Belgium; Compagnia Assicuratrice Unipol S.P.A., in Italy; and NTUC INCOME Insurance Co-operative Ltd., in Singapore);

- autonomous co-operative insurance enterprises established by components of trade union movements alone (Amalgamated Life Insurance Company, whose members are a number of separate "union jointly trusteed funds" established by members of clothing workers' trade unions, in the United States of America).

The countries within which these enterprises function fall into several clearly defined groups, a situation which will be examined below as it suggests certain functional relationships between societal conditions and this type of co-operative activity. The groups are: Latin America (Colombia, Ecuador and Peru, with which may be associated Puerto Rico); South-east Asia (Malaysia and Singapore); East Asia (Japan and Republic of Korea); North America: Canada and the United States (continental section); and Europe (Belgium, Denmark, Germany, Italy, Spain and United Kingdom).

There are in addition to these purely co-operative insurance enterprises, a number of "mutuals" whose organizational structure is similar to that of co-operatives, and whose members are drawn from a professional or other occupational group, provide health insurance among a range of individual-related products. Examples are the Wiener Stadtische Allgemeine Versicherung Aktiengesellschaft in Austria; the Sociedad de Seguros de Vida del Magisterio Nacional in Costa Rica; the Tapiola Insurance Group in Finland; and Nationwide Insurance Enterprise in the United States of America (whose members were originally farmers and which has strong links with agricultural co-operatives).

Health insurance was also offered by three enterprises defined as mutuals but having significant associations with the co-operative movement in respect to origins or current ownership and alliances: these were located in the Netherlands. Two mutual organizations also provided health insurance. They were located in Austria and Indonesia. In France the system of mutual organizations (la Mutualité) had an integral partnership function with the national social security and health insurance system (see Chapter II, section J).166/ In Europe an estimated 100,000,000 persons have health insurance provided by such mutual enterprises.

The quantitative dimension of health insurance provision by co-operative enterprises is not known in full. For those enterprises for which information

is available, NTUC INCOME in Singapore had 18.9 per cent of the health insurance market, but percentages were much smaller elsewhere: Compagnia Assicuratrice UNIPOL in Italy (2.9); the Co-operators Group Ltd. in Canada (2.0 - 3.0); Seguros la Equidad Organismo Cooperativo in Colombia (1.8); P&V Assurances S.C. in Belgium (1.0); Segurosperu (0.2); and R+V Versicherung in Germany (0.1).

While NTUC INCOME had the highest market share, this involved only 723 policies (it is not known if these are group or individual). Unipol (Unisalute) had a market share of only 2.9 per cent, but this was made up of 24,998 policies in 1994. The very early phase of development in health insurance provision is shown by the fact that the Belgian co-operative insurance provider P&V managed 4,000 health insurance policies (1 per cent of the market) compared to 460,000 individual life policies (4.5 per cent of the market).

These relatively low proportions reflect in part the recent date of entry into the market of most of these enterprises, as well as the existence of national health and social security coverage which they are able only to complement but not replace.

One of the 19 co-operative insurance enterprises which at present offer health insurance was established in 1867, and three others in the early decades of this century (1907, 1919 and 1922), but four others were founded between 1943 and 1954, the greater proportion between 1959 and 1970 (seven enterprises) and three subsequently (1983, 1989 and 1994). Their health insurance products were introduced much more recently in each of the cases for which information is available: four enterprises did so after 1988 (1988, 1989 and 1995), and three others did so at unknown dates during the 1980s.

In some countries co-operative insurance enterprises are closely integrated with broad sectoral co-operative organizations. For example, in Japan, early in 1996 there were 2,836 multifunctional agricultural co-operatives: they provided credit, purchasing, extension and marketing services to the 8,840,000 agricultural producers who were their members. They also provided welfare, health and insurance services for members and their dependants (the total population in farm households was 17,290,000 in 1990, of which 5,650,000 were employed in agriculture).

Agricultural co-operatives, which exist largely at the level of municipalities, have organized federations at the prefectural (regional or sub-regional) level in respect of each of the distinct types of function undertaken by agricultural co-operatives. The specialist prefectural federations in turn have organized national federations, again, by distinct types of function.

Hence, there are prefectural federations responsible for providing insurance to members of all of the agricultural co-operatives operating within the prefecture. These are known as Kyosairen. They have established a national federation responsible for insurance, known as Zenkyoren (the National Mutual Insurance Federation of Agricultural Co-operatives). Zenkyoren is engaged in the development of new insurance products, risk pooling and fund management, and providing guidance to prefectural federations.

There exists also a parallel system of prefectural level "welfare federations", responsible for all the health and welfare services provided to all members of agricultural co-operatives operating within the prefecture. They are known as Koseiren. They have also established a national federation, the National Welfare Federation of Agricultural Co-operatives, known as Zenkoren.167/

The fact that some of these enterprises have not yet moved into the health insurance market reflects the still substantial provision by national health insurance: for example, in Denmark the co-operative insurance enterprises which provides insurance to employees of co-operatives (AP Pension) does

include health insurance already in its products, but the analogous enterprise in Sweden (KP Pension & Forsakring) does not. Among seven co-operative general insurance enterprises set up jointly by the co-operative and trade union movements in European Welfare States, two provide health insurance (P & V Assurances S.C. in Belgium and Compagnia Assicuratrice Unipol S.P.A. in Italy), but the others do not (Forsikrings-Aktieselskabet ALKA in Denmark, Vatryggingafelag Islands in Iceland, the Samvirke Group in Norway, the Folksam Group in Sweden and COOP Versicherung in Switzerland).

There is clearly a very considerable potential for expansion of the involvement of certain types of co-operative insurance enterprises in the provision of health insurance. Entry into this market, or expansion of life-insurance types of product to health insurance, cannot be expected from those enterprises specializing in enterprise-related products. However, where large national co-operative movements, involving high proportions of individuals within certain occupational groups, such as agriculture, already have specialist insurance departments or subsidiary enterprises, it would seem that engagement in health insurance would be both feasible and appropriate. An example might be the National Mutual Insurance Federation of Fishery Co-operatives (Kyosuiren) in Japan.

Particularly where co-operative insurance enterprises have been set up specifically to provide individual-related life insurance products, the addition of health insurance would be a logical next step. Examples might include the Co-operative Insurance System of the Philippines; the co-operative insurance enterprises established by savings and credit co-operative ("credit unions") in countries with poorly developed national health insurance systems, such as those in Barbados, Bolivia and Guatemala; those enterprises set up by diverse groups of co-operatives, again in countries with poorly developed national health insurance systems, such as the Mayor Seguros Cooperativa de Seguros in Argentina, Asseguradora Solidaria de Colombia, Cooperativa Nacional de Seguros in Dominican Republic, Syneteristiki Insurance Company in Greece, Koperasi Asuransi Indonesia, Co-operative Insurance Services Ltd. in Kenya, World-Wide Insurance Company in Nigeria and Uganda Co-operative Insurance Ltd.

With further retrenchment in national social security and health insurance systems in countries with welfare state structures, the co-operative insurance enterprises which are very well developed in many of them, could be expected to expand their health insurance products, particularly if adjusted to certain sections of the population most at risk, such as women, self-employed persons, long-term unemployed persons and the elderly. In this way they could complement the basic provision by the public sector which can be expected to remain.

An example of the contribution that co-operatively organized insurance enterprises are capable of making to health and social care in contemporary societal conditions is provided by Unipol Assicurazioni in Italy, which announced early in 1995 that it was to set-up a new health insurance company, Unisalute. Unipol was building a network of agreements with preferred managed health care providers and discussing the venture with other entities within the social economy. Its primary targets were employed workers interested in supplementing the public health and social security system by taking out group health policies through collective bargaining at the enterprise level through the mediation of trade unions. Unipol believed that only by organizing aggregate demand in this way could insured worker's interests be safeguarded from exploitation by health service providers.168/

In Italy, the national health system has covered almost all medical requirements for all citizens since 1978 when a major reform was undertaken. Nevertheless, the service now provided is reported to be in many ways not satisfactory. In the public health sector expenses have increased rapidly, exceeding receipts by the equivalent of over 10 billion US dollars in 1994. As a result, services are running down in many regions and there is lack of investment in research. Consequently, many persons find it necessary to use private services in order, for example, to avoid the long waiting lists normal for users of public facilities. They have to pay themselves for doing so: in

1993 it was estimated that such payments totalled the equivalent of about US $ 20 billion. Moreover, few were able to recoup these expenditures through private health insurance. Because of the nominal comprehensive coverage of the public system, the private health insurance sector remains largely underdeveloped, and restricts its market targets to upper income sections of the population. Consequently, only highly expensive products are available.

In response to this situation a further reform in the health system began in 1993. Among other things it offered new opportunities for the development of private initiatives. Health care funds were introduced to offer citizens services supplementary to those of the public system. These funds can be set up either through agreements between employers and employees, or through voluntary agreements among employees. They can be self-managing, or run by insurance enterprises, or by mutuals dealing exclusively with health matters. The latter option was scarcely developed: in 1995 there were only a few small mutuals in the country.

In this new situation the Unipol co-operative insurance group created an enterprise called Unisalute, which was to become fully operational late in 1995. Its function was to provide quality health insurance policies at fair prices, primarily to persons associated with certain types of partner organizations, as well as their dependants. These would include about 2,500,000 members of consumer co-operatives; 6,000,000 members of employee trade unions, who held group insurance policies resulting from bargaining between their unions and employers; a little less than 1,000,000 members of self-employed persons' trade unions (principally farmers, shopkeepers and craftsmen); account holders in cooperative or other social economy banks, such as the Savings Bank of Bologna, which together operated 450 branches throughout Italy (through the "bank assurance" system); and policy holders in mutual insurance enterprises, such as Reale Mutua, which are partners of Unipol. This potential market amounted to about 10,000,000 persons.

As a complement to its sale of health insurance, Unisalute would set up a network of contracted providers of health care services, including doctors' practices, clinics, specialist centres and nursing homes. One would be responsible for health care management: it would undertake agreements with providers, control the quality and cost of services and suggest the best solutions for complicated cases. Unisalute would recommend to its policy holders preferential use of the network of contracted providers. If this were done it would pay for the services provided without cost to policy holders. In addition to reimbursing its policy holders, or making direct payments to contracted providers, Unisalute would help them identify the most appropriate provider and would undertake appropriate negotiations with them on behalf of policy-holders. A second component of the service provided by Unisalute to its policy-holders will comprise a customer service department offering assistance to both clients and to service providers. A 24-hour help line would guarantee emergency medical attention and advice. Finally Unisalute was to undertake health information and prevention campaigns - an area neglected by the national health system.

Such an engagement in the health and social care sector would constitute a re-establishment of the role of co-operative insurance in the countries now welfare states. The experience of the **United Kingdom** prior to the establishment of the welfare state in 1948 is testimony of their potential. Here health insurance was provided predominantly by "friendly societies". These could be traced back to the seventeenth century. Some developed under the patronage of the upper classes, but, particularly during the course of the industrial revolution, the majority were established by workers to meet their needs. They were self-governing and democratically organized associations not greatly different from co-operatives. It has been estimated that at least one quarter of male workers (representing a similar proportion of the total population) were members of such societies by 1830.

From the 1830s the community-based and self-governing working class societies came to be complemented by larger organizations, with affiliated branches, two of which developed to national dimensions. They were able to offer safer investments and more generous benefits. Members were drawn from

workers in the more regular types of employment, able to plan for regular commitments. By the 1870s there were about two million members, about 30 per cent of adult males. The poorer workers could afford only to join "burial clubs" which provided them only a minimal death benefit. However, during the mid-nineteenth century there developed from these societies large commercial enterprises, known as "industrial assurance" societies, in which there was no control by policy-holders.

Toward the end of the nineteenth pressure grew for the state to provide comprehensive sickness benefits and old age pensions. When the former was introduced in 1911 friendly societies, both those which were community-based and member-controlled and those which were investor-owned and profit-oriented commercial enterprises, continued to have a role: they were made responsible for collecting contributions from employees, which were then topped up with state funding. This benefitted the commercial enterprises more than the smaller member-owned friendly societies, but these did at least continue to function. When in 1948 the Government introduced the comprehensive safety net of national insurance, they dispensed with the services of the friendly societies and set up a totally state funded and administered system of social security and health benefits and services.169/

3. In respect to preventive health

Co-operative insurance enterprises emphasize prevention as the best way to reduce costs of insurance to their members. To be successful in prevention, they consider it necessary to achieve the fully informed participation of all members, and to support member participation in the broadest possible community and societal activities which will result, directly or indirectly, in reduction of risk. They devote considerable resources to prevention of domestic accidents, particularly those involving children, and to sport, leisure and traffic accidents affecting in particular young persons.

Most co-operative insurance enterprises are engaged in preventive health, including research into the courses of risk and loss. This is the case, for example, in Japan, where the co-operative insurance organizations at regional and national levels (Kyosairen/Zenkyoren) have attempted to reduce risks by promoting traffic safety and by health management. In the immediate post-war period these co-operative insurance institutions undertook mobile health counselling programmes, financial assistance for health examinations and for improving rural housing and village environments. They also supported the establishment of welfare federations, Koseiren. More recently, Kyosairen/Zenkyoren have emphasized a preventive approach to health by the elderly. Recreation, sports, health examinations are promoted. A telephone health counselling service has been set up.170/

Since the mid-sixties Folksam, the Swedish co-operative insurance society, has made an internationally recognized contribution to auto safety for the benefit of all auto users and insurers. This has included traffic safety research and research on personal accidents and design of cars, published in regular reports on the interior safety level of cars. Other research has been undertaken in collaboration with universities and other interested parties: experimentation with the promotion of orthopaedic rehabilitation; evaluation of ambulance systems to enhance the training and education of personnel, as well as the ambulances; neck and shoulder pains, both world-related and as a result of road accidents; asthma and allergy problems; heart attacks and vascular disorders; experimentation with models of rehabilitation services to be offered to members of trade unions insured by Folksam.

These activities are initiated and administered by Folksam's Scientific Council. They have often resulted in practical measures being undertaken to promote health and prevent accidents and losses. In collaboration with other social economy organisations, Folksam has established a Social Council to promote information on loss prevention health and related issues including homelessness; alcohol and drug abuse, the situations of the handicapped; immigrants in the welfare state; the situation of children and young people; problems of working life; early retirement; equality and men's and women's

roles; consequences of the changes of the welfare state; pollution and environmental conservation; cancer; good working conditions; injuries in sports activities and their prevention; mental health; suicide; the use of seat belts, etc.

Books and other publications offer member policy-holders and others a wide variety of information concerning health and rehabilitation matters, social welfare policy, economy and legal matters, school issues, traffic safety, etc.

These activities have been undertaken as an expression of the wider perspective concerning the basic aim of an insurance enterprise, natural for a co-operative. A co-operative insurer is entrusted by its policyholders, who are its members and owners, to look after their interests in a comprehensive sense, e.g. to prevent losses, to limit their effects, and to rehabilitate injured policyholders. To do this efficiently, it is necessary to engage in research directly or to promote it in various ways. A similar perspective is needed by all kinds of co-operative in the health and social care sectors. 171/

4. In respect to social care

A number of co-operative insurance enterprises are engaged directly in the provision of social care services, as an extension of their broad concern with preventive and comprehensive approaches to meeting the needs of their members. This has been the case, for example, in Japan with the insurance enterprise owned by the national system of agricultural co-operatives.

Revision of the Agricultural Co-operative Association Law in 1992 made it possible for the movement to undertake programmes related to the welfare of the elderly. The prefectural federations responsible for providing insurance services to agricultural co-operatives, Kyosairen, together with the national apex organization, Zenkyoren, established in 1992 a group responsible for examining the health and welfare of elderly persons. This step was taken in response to the findings of research undertaken by the Agricultural Co-operative Insurance Research Institute (Nokyo Kyosai Sogo Kenkyujo), the research organ of the Kyosairen, concerning projections of elderly persons requiring nursing care in rural areas. These showed that in rural areas, not only was the rate of increase of the elderly population much higher than the national average (already among the highest in the world), but elderly persons faced severe difficulties in obtaining care, owing to the out-migration of younger persons and the problems of access in rural areas.

A national level Council to Promote the Welfare of the Elderly was set up. Education and training materials and support for the establishment of local mutual help groups have been developed. By 1995 10,100 persons had been trained as home helpers, providing assistance in household work, and 957 persons trained to provide nursing care. 75 mutual-aid groups within individual agricultural co-operatives were established in 1993. The programme in progress during 1995 was designed to train 38,200 home helpers and 26,200 home nursing care givers, as well as to set up 1,000 mutual aid groups. It is planned to extend services to the operation of special nursing homes for the elderly.

In order to expand home nursing care for the elderly and for persons with disabilities in rural areas, Kyosairen/Zenkyoren provide subsidies and scholarships to promote increase in numbers of trained personnel and assist in the establishment of rehabilitation facilities. Special occupational insurance, both against accident and liability, has been introduced to cover volunteers engaged in providing home care services to the elderly, and drawn from women's and youth sections of agricultural co-operatives. Since 1973 they have operated two rehabilitation centres, one for persons with disabilities, one for persons recovering from traffic accidents.172/

In Belgium, the co-operative insurance group P&V, which was founded in 1907 as a result of initiatives taken by the Belgian Worker's Party in order to

H. Environment management, sanitation and cleaning co-operatives [type 2.3.6]

Innovations in cleaning procedures, and use of more appropriate cleaning materials, in work-places, hotels, places of recreation and public assembly have been introduced by co-operative enterprises, with improvement in the health impact of the built environment. For example, the Finnish co-operative EKA Group has introduced within the hotels operated by its Restel subsidiary improved forms of room cleaning. There is considerable scope for contributions by worker-owned and labour-contracting co-operatives in this area: in many countries they are beginning to have a significant market share of "environmental services": for example the Premier Environmental Services Co-operative Society Ltd., in Singapore. The labour-contracting co-operative formed by poor women cleaners, members of the Self Employed Women's Association in Ahmedebad, India, have improved the condition of the poorest group of women cleaners and refuse collectors. In India during the 1920s to 1940s there were over 1,000 "Anti-malaria" co-operatives which filled cesspools, cleared vegetation and drained ponds.184/

I. Co-operatives whose business goals might include provision of operational support to health and social care co-operatives [type 3]

1. Financial co-operatives [type 3.1]

(a) Cooperative banks

Health co-operatives in India, Sri Lanka and the United States are known to have received loans on favourable terms from co-operative banks. In the United States the National Co-operative Bank's Development Corporation has provided funding to user-owned health co-operatives, as well as to the semi-co-operative Government sponsored community health centre system. The only case of a health co-operative system developing its own financial capability, is Unimed in Brazil, with its Unicred and Unimed Aseguradora subsidiaries.

(b) Savings and credit cooperatives ("credit unions")

In Quebec, **Canada**, the Mouvement des caisses Desjardins has supported a number of health and social care co-operatives during their take off phases.

(c) Insurance cooperatives

In Quebec, **Canada**, a number of mutual insurance enterprises have supported the take off phases of health and social care-cooperatives. These enterprises are particularly interested in health insurance, in the context of the current crisis in public finance, and the rationalization of public spending in health and related fields. Currently they provide a complementary health insurance programme to the population of the Province.

The close involvement of these enterprises in the development of health co-operatives is illustrated by the history of one of them, "SSQ", which itself began operations as a health co-operative in 1945, prior to the establishment of the welfare state system. It provided affordable and high quality health services to low income residents in one of the poorest neighbourhoods of Quebec City, Sainte Saveur. It was initiated by a doctor, Jacques Tremblay. Achieving considerable success, it expanded its services to the whole City, and thereafter widely throughout the Province of Quebec. When a national health service was established in 1960 "SSQ" concentrated its activities in the group insurance field.185/

2. Co-operative research and development institutions [type 3.2]

(a) At the national level

At the International Co-operative Health and Social Care Forum, held at Manchester, United Kingdom on 18 September 1995 in the context of the Centennial Congress of the International Co-operative Alliance, several participants reported ongoing research. From this and other sources it is known that research on health co-operatives is in progress in Argentina, Canada, Costa Rica, Italy, Japan, Spain, Sweden, the United States and the United Kingdom.

In **Argentina** research is being undertaken at the Gabinete de Estudio y Promocion del Cooperativismo Sanitario at Buenos Aires. 186/

At the Department of Co-operatives ("chaire de coopération Guy-Bernier") in the University of Quebec at Montreal, **Canada**, exploratory research on the development of health co-operatives in eleven countries (Brazil, Canada, Costa Rica, India, Japan, Malaysia, Panama, Spain, Sri Lanka, Sweden and the United States) has been undertaken by Professor Yvan Comeau of Laval University and Professor Jean-Pierre Girard of Sherbrooke University. The purpose has been to stimulate discussion concerning the reorganization of the health delivery system in Canada. The 11 country study, "les coopératives de santé dans le monde: une pratique preventive et educative de la santé" was published by the University in April 1996. As part of this research the Department undertook a field study in 1995 of the development of health co-operatives in **Costa Rica**. This was undertaken with the collaboration of Jorge Barrantes, a Costa Rican student at the University of Quebec at Montreal. 187/ Previously, the Canadian Co-operative Association sponsored research on co-operative community health clinics. 188/

In **Italy** in 1993 the Centro Studi in the Consorzio Nazionale della Cooperazione di Solidarietà Sociale "Gino Matarelli" undertook a survey of 660 of the estimated 2,000 "social co-operatives". 189/

In **Japan** research is in progress in the School of Social Sciences of Ritsumeikan University: a graduate student, Keiko Kawaguchi, reported to the Forum on alternative management strategies for health co-operatives. 190/ The Japanese National Welfare Federation of Agricultural Co-operatives, the apex organization of the user-owned health co-operative movement associated with the system of multi-functional agricultural co-operatives, set up in 1952 an Association of Rural Medicine which has made significant contributions to the study of the impact of substances used in agricultural production on the health of rural populations. 191/

The work of the Espriu Foundation in **Spain** is devoted entirely to this area of co-operative enterprise. 192/ Professor Isabel Vidal of the "Centre d'Iniciatives de l'Economie Social" in the University of Barcelona, is responsible for research on social co-operatives in Europe. The provider-owned health co-operative CES Clinicas in Madrid works closely with the School of Co-operative Studies of the University Complutense of Madrid 193/

In **Sweden**, with adoption in 1991 of policies to decentralize responsibilities from central to local government authorities and to promote privatization to some extent, national level co-operative organizations (the Cooperative Institute, the Union of Housing Co-operatives (HSB: Riksforbund) and the co-operative Folksam Insurance Group, developed the "Medikoop" model for consumer-owned co-operative health centres, designed not to replace but to complement the public system. 194/

In the **United States**, at the University of North Carolina, a rural health research programme has included an examination of health co-operatives. 195/

In **Sweden** the Co-operative Research Institute (KOOPI), the Agency for Co-operative Development at Goteborg (Kooperativ Konsult) and the Department of Business Administration at Stockholm University are each carrying out research on co-operative and other "third sector" developments in both health and social care within the context of changing relationships between the state, the market and civil society. 196/ At the latter institution research projects

include one on provider-owned social care co-operatives within the context of the changing circumstances of the welfare state in Sweden.197/

Co-operative insurance enterprises do not have to rely upon data from other sources: the data they possess on loss (claims against policies for life, disability, accident, unemployment, pension, property etcetera) are among the most sensitive and current types of information, available to them for immediate analysis, providing that they maintain appropriate data management and analytic resources. Analysis of this data constitutes a unique opportunity to quickly monitor negative trends, give advance warning of potential problems and initiate research to produce corrective measures and wherever possible longer-term preventive measures.

The major co-operative insurer, Folksam, has a Social Council, which acts as a "think tank" in respect to risk, loss prevention and rehabilitation, and social, medical and economic questions. Its functions include undertaking research, organizing seminars, publishing studies and information material, organizing lobbying campaigns, shaping public opinion, participating in national policy development and maintaining relations with partners. The Council was set up in 1971 by combining Councils for Social Information, Women and Youth, set up during the 1960s. It is composed of representatives of Folksam itself, other co-operative movements, trade unions and other people's organizations. During 1996 the Council was to look more deeply into the implications of "downsizing" social welfare and of increased unemployment in Sweden. In 1992 it had begun a research project on early retirement in collaboration with the Department of Labour and Organizational Psychology of the university of Stockholm. In 1995 a two year research project began on gender aspects of working activities within the Folksam Group itself.198/

In the **United Kingdom**, the Government's Department of Health has funded a study undertaken by the Centre for Research in Social Policy at the Department of Social Sciences, Loughborough University. An early draft has been approved already by the Department, and the final report submitted to it in late 1995. The study, on "The potential contribution of the co-operative movement and community well-being centres to "Health of the Nation" activities", comprised a literature review, identifying the scale, scope and defining characteristics of health-related co-operative and community schemes and centres; a review of the evaluation processes used in these schemes and centres; and an assessment of the potential contribution to the national "Health of the Nation" policy of the United Kingdom Co-operative Council, Community Well-being Centres and other co-operative groups.199/

The Co-ops Research Unit at the Open University at Milton Keynes examines opportunities for co-operative developments in the health and social care sector as broad changes in the welfare state and in society occur.200/ The Industrial Common Ownership Movement Limited (ICOM), which represents worker-owned co-operatives of all kinds, is concerned with the development of provider-owned co-operatives in these sectors.201/

Research is carried out not only by specialized co-operative research and development institutions but by many of the larger user- and provider-owned health co-operatives, such as the Group Health Co-operative of Puget Sound, and Unimed in Brazil. They examine not only organizational and operational matters, but also programme development and delivery, preventive health as well as environmental factors relevant to health and social well-being. In some cases they undertake policy-oriented research in support of lobbying. Co-operative insurance enterprises undertake similar research.

(b) At the regional level

Research is also being undertaken at the regional level in Europe. In collaboration with the Italian Consorzio Nazionale della Cooperazione di Solidarietà Sociale "Gino Mattarelli", the research network, Euroforcoop, of the European Committee of Workers' Co-operatives (Comité Européen des Coopératives de Production et de Travail Associé: CECOP) undertook during the

period from September 1995 to December 1996 the first part of a review of national experience in respect to the organization and operation of social cooperatives. This covered the situation in nine countries of the European Union (Belgium, Denmark, France, Germany, Italy, Portugal, Spain, Sweden and the United Kingdom). It revealed that changes in the social care sector required new forms of organization capable of synthesizing the advantages of private enterprise with recognition of the interests of the community. Findings were presented at a conference held at Brussels in 1995. A second phase of the review would be to enlarge the research network to remaining member countries of the European Union, extend the scope of the study to a more detailed examination of social cooperatives as new forms of organization in the sector, and diffuse results by a means of a series of seminars and an electronic bulletin board. 202/

In February 1996 CECOP organized at Barcelona, Spain, in collaboration with the Federation des Coopératives de Travail Associé de Catalogne (FCTAC), and with the support of the European Union and the Department of Employment of the Generalitat de Catalunya, a conference in the series "Journées européenes de la coopération sociale" on "social welfare in Europe and new opportunities for the creation of employment in the area of social services". 203/ The "Centre d'Iniciatives de l'Economie Social" of the University of Barcelona, under the direction of Professor Isabel Vidal, also recently organized a conference on this topic, on the basis of which a publication was issued.204/

ICA's Regional Office for the Americas, whose headquarters are in Costa Rica, recently initiated a review of the actual and potential development of health co-operatives in central America. The results are not yet available.205/

(c) At the global level

The ICA Committee on Co-operative Research, which originated in a "research officers' group" in the early 1950s, organizes a global network of researchers by means of which knowledge is improved and new models disseminated. The Committee holds an annual seminar. In recent years it has devoted increasing attention to the establishment and operation of co-operatives in the health and social care sectors. Publication of its proceedings has been hampered by financial constraints.206/

3. Co-operative media enterprises and activities [type 3.3]

The co-operative principles included within the "Statement on the co-operative identity" adopted by the ICA's Centennial Congress, held at Manchester, United Kingdom in September 1995 - and intended to function as guidelines by which co-operatives throughout the world put their values into practice - include as the fifth principle "education, training and information". This principle states that co-operatives provide education and training for their members, elected representatives, managers, and employees so they can contribute effectively to the development of their co-operatives. They inform the general public - particularly young people and opinion leaders - about the nature and benefits of co-operation. For this reason individual co-operative enterprises and business groups, co-operative organizations at secondary and tertiary levels, and organizations of the international co-operative movement, have all paid particular attention to the dissemination of information concerning co-operatives, including potential and opportunity for co-operative forms of organization in new sectors. They also disseminate widely information on health and social care. This has been done by means of all forms of information diffusion, from simple newsletters to the Internet. Some co-operative organizations operate, as a subsidiary or affiliated enterprise, a newspaper or radio or television station. In Singapore, for example, the national trade union movement has supported the establishment of a radio station organized as a cooperative whose owners and members are individual trade unions.207/

In addition, within the media sector, a considerable number of enterprises of all types are organized as co-operatives. They include worker-owned co-

operatives whose members are journalists (such as Inter-Press) or broadcasters, as well as entire newspapers, radio and television broadcasting stations. In some cases co-operative organizations combine to set up media enterprises - for example in the United States the National Rural Telecommunications cooperative, established in 1986 and owned by almost 800 rural electricity and telephone cooperatives, broadcasts a package of television programmes to over 90,000 rural households.208/

Information on healthy living, appropriate nutrition, reduction in environmental hazards and preventive health is already widely diffused through the co-operative media. For example, in 1993 the Union Nacional de Cooperativas de Consumidores y Usuarios in Spain issued a "Guide to Ecological Living".209/ Closer attention to the potential for closer and more direct engagement by co-operative enterprises of many types, but including health and social care co-operatives and co-operative insurance enterprises is already evident, and is likely to expand rapidly in the near future.

The Swedish co-operative insurer, the Folksam Group, set up in 1971, a "Social Council", one of whose functions was to publish and distribute material on current societal trends and their implications for members and the communities in which they live and work, as well as background information needed to inform public opinion and ensure an effective participation in national policy debate and formulation. Material is published at low cost and distributed both to individuals and organizations. 210/

Some of the co-operative research organizations contribute to the publication of material on co-operative forms of provision of health and social welfare services. For example, the Studies Centre (Centro Studi) of the Italian Consorzio Nazionale della Cooperazione di Solidarietà Sociale "Gino Matarelli" publishes its own "CGM" Editions.211/

While the co-operative media is a valuable supplementary source of information for many co-operators and co-operative employees who are within the middle-income and more secure lower-income strata, it is often the only source of information for many members of co-operatives, and for entire communities in which these co-operatives exist. The potential of co-operative media can be appreciated when it is recalled that individual members of co-operatives total about 800,000,000 persons throughout the world, which implies, if only their immediate family is included (and estimated at an additional three persons), a consumer population of about 3,200,000,000 - over half the world's population.

Moreover, members of co-operative enterprises, because their values and principles include concern for the community in which they work and live, are particularly receptive to ideas and information on best practices within the co-operative movement, and in affiliated organizations. Information diffused through the co-operative media is likely to meet with closer scrutiny than that diffused through more general channels. In this regard it is important to keep in mind that for most individuals, their own health and well-being, and that of their dependants, is a matter of central importance: and one not adequately addressed either by governmental public information channels, or by the for-profit media.

4. Training and education co-operatives [type 3.4]

One of the co-operative principles adopted in September 1995, on education, training and information, states that "co-operatives provide education and training for their members, elected representatives, managers and employees so they can contribute effectively to the development of their co-operatives." Although the rigorous training required by many professional and paraprofessional personnel who are worker-members of, or employed by, co-operative enterprises engaged in the health and social care sectors has hitherto been the responsibility of non-co-operative educational institutions, there are some indications that co-operative institutions may be beginning to provide such training. This may be particularly appropriate in areas which

the co-operative enterprises emphasize, particularly in "healthy-living" and broad preventive health programmes.

In **Portugal** an educational co-operative, the "Higher Polytechnic and University Education Cooperative" (Cooperativa de Ensino Superior Politecnico e Universitario (CESPU)), has established two Higher Institutes of Health Sciences, one in the north, one in the south of the country. These provide degree courses, and also post-graduate and continuing education courses in health sciences. 212/

In the **United States**, a number of the larger user-owned health co-operatives, which employ several hundred health professionals in an increasingly wide range of specialities, have already entered into agreements with local medical and social care teaching institutions whereby students and trainees may undertake residencies. In **Spain** the provider-owned health co-operative CES Clinicas gives particular attention to training in order to assure quality services to clients.

A much broader contribution is made by many co-operative enterprises engaged in the health and social care sectors to provide training (and not merely information) to members, their dependents and other members of the community.

Provision of training to own staff has not been limited to health co-operatives: in some cases provider-owned social care co-operatives have given considerable emphasis to training. For example, in the **United States of America** the Co-operative Home Care Associates of New York believes that training is the foundation of its high-quality performance, particularly as most of the worker-members had low formal educational levels. Consequently, the co-operative provides new worker-members with initial training, financed by public and foundation funds. Emphasis is on problem-solving skills and co-operative team building. Training is provided in English and Spanish. It is provided by the Home Care Associates Training Institute, which has 15 full- and part-time staff. The core of the training is a four-week training course for new home-care aides, followed by four months of on-the-job training that includes site visits from field supervisors who provide advice and support. All teachers were formerly worker-members. Four times a year worker-members meet for in=service training sessions in order to keep up-to-date with rapidly changing methods of providing care to clients. 213/

V. SUMMARY OF AVAILABLE DATA ON HEALTH CO-OPERATIVES AND SUMMARY OF HISTORICAL DEVELOPMENT

A. Configurations of co-operative engagement in the health and social care sectors by type of societal condition

Table 1 indicates the presence, in each of the countries affected, of the main types of co-operatively organized enterprise (user-owned and provider-owned health co-operatives; co-operative insurance enterprises offering health insurance; co-operative pharmacies). This table shows a considerable degree of geographical clustering of affected countries. There appear to be strong correlations between type of co-operative engagements, overall societal type and organizational configuration in respect to the health and social care sectors. The following groups of country can be identified:

(a) "welfare states" in the market economies of Europe, with which may be included Canada and Israel;

(b) Japan;

(c) United States;

(d) Latin American countries;

(e) developing countries in Asia (India, Sri Lanka, Malaysia, Singapore, Philippines, Republic of Korea);

(f) least developed countries in Africa, Asia and the Caribbean (Benin, Niger, United Republic of Tanzania, Haiti);

(g) countries with transitional economies.

B. Estimated population using health co-operatives

Table 2 sets out what is known, or can be reasonably estimated, concerning the total population regularly served by both user-owned and provider-owned health co-operatives. The many qualifications are set out in the notes to this table. The reader should consider these statistics to be only a reasonable estimate of the order of magnitude involved, and not firm data.

C. Information on the operational characteristics of health co-operatives

The third table in this series sets out what is known of certain basic operational characteristics of user-owned and provider-owned health co-operatives. The numerous qualifications are set out in the notes to the table.

D. Summary of historical evolution of co-operative engagement in health and social care sectors

As a complement to the previous analysis of development, it may be useful to bear in mind the general course of historical evolution - principally to be able to answer the question of whether health co-operatives and health insurance provided by co-operative insurers are on the upward trajectory or not.

In the nineteenth century co-operative and mutual involvement consisted primarily of forms of social security, with some provision of health and

social care, primarily by the predominant consumer co-operative movement. These developments were restricted to western, northern and central Europe.

In the first decades of the twentieth century early involvement of the public sector in social security in some European countries involved partnerships with co-operative and mutual insurance enterprises. Retail co-operative contributions to improved nutrition and housing co-operative contributions to improved sanitation were of major significance, given their broad dimensions. Engagement in health service delivery was limited: forms of social care were more widely developed (by the consumer co-operative movement).

During the 1920s and 1930s engagement in health service delivery expanded in several parts of the world. In Japan both agricultural and consumer co-operative movements engaged in health service delivery; in the United States farmers' organizations played an important part in early experiments in user-owned co-operatives and in Canada agricultural co-operative movements supported community-based health services; in Israel joint trade union and co-operative enterprise-based health services were an integral part of Jewish settlement in Palestine; in eastern Europe rural user-owned and community-based health co-operative systems appeared and expanded significantly in Yugoslavia, and following this model, in Poland; in India (partly following the Yugoslav model), Sri Lanka and in China a variety of rural community-based experiments in co-operative health service delivery were undertaken.

During the same period government-co-operative/mutual partnerships continued to grow as, in some European countries elements of a welfare state were established step-by-step. In the United States there was an analogous partnership as part of the New Deal support for rural co-operative development. Only in Spain was there a proto-co-operative provider-owned movement having very specific characteristics. In the USSR and Mongolia any tendency to similar co-operative engagement (if it existed: but co-operatives had been strong) ended with the establishment of the particular socialist forms of enterprise-based service provision.

Hence, at the beginning of the Second World War there were significant foci of co-operative activity in health and social care in a number of different parts of Asia, Europe and North America. They were user-owned, either as health co-operatives or as consumer-owned retail and housing movements, and their largely associated co-operative insurance enterprises (the mutuals being similarly user-owned.

War-time and immediate post-war conditions profoundly affected the continued expansion of co-operative engagement, at least in direct service delivery and insurance. In eastern and central Europe and China socialist systems blocked their further development, previous movements in China, Poland and Yugoslavia being fully replaced by the public sector. In some countries of western Europe establishment of full welfare states of the "Beveridgean model" also absorbed almost all previous co-operative enterprise and precluded further expansion. Limitation for this reason affected other countries during the 1950s and 1960s as the public sector expanded (as in Canada). Throughout the developing countries with colonial or semi-colonial experience a form of "colonial welfare" and centrally planned public sector monopoly also precluded any incipient co-operative engagement either in delivery or services. Indeed early autonomous co-operative movements were themselves "co-opted" as parastatal structures.

The only countries in which expansion occurred was the United States, where urban-based user-owned health co-operatives were able to develop, although simultaneously rural experiments declined, and Japan, where in the immediate post-war conditions the agricultural and consumer movements became stronger and increased their commitment to health and social care. In Israel the trade union/co-operative system became the de facto national system. However, on balance, the late 1940s and 1950s might be characterised as a period when previous expansion in co-operative movement contribution was stalled, possibly even declined globally.

In the late 1960s a new element appeared, the provider-owned health service delivery co-operatives in Latin America. They expanded during the 1970s, although affected by political upheavals in some countries, and experienced successive phases of relationship with public sector national social security systems as these were installed. In the United States favourable economic conditions encouraged further expansion of opportunities for user-owned health delivery and health insurance co-operatives to benefit from further development of enterprise-based health insurance and public sector programmes of support for the poor and the elderly.

During the 1980s concern first of consumer-owned retail co-operative movements then of agricultural co-operative movements, joined by housing co-operatives, for environmental pollution and improved nutrition and healthy living, led to important contributions to broad preventive health emphases, particularly in Japan and western Europe.

Toward the end of the 1980s and increasingly in the next decade housing and insurance co-operatives in some countries, together with user-owned health co-operatives, joined other movements to call for adjustments in public sector provision, clearly becoming inadequate in a number of welfare state and other developed countries. In some cases public authorities agreed to open opportunities for co-operative partnerships, as in Italy. With further adjustment and retrenchment in public sectors, opportunities for co-operative enterprise increased, although in some countries they experienced "stop-go" cycles as governments changed and with them perceptions of the value of the co-operative alternative. Crisis in the mixed public/private structures in the United States also offered chances for further co-operative contributions.

In many developing countries during this most recent period severe retrenchment in public sectors has offered increasing and substantial opportunities for co-operative organization of health and social care - but these opportunities have been difficult to take as the co-operative movement itself had been weakened during previous periods of too close partnership with the public sector. As part of restructuring, deregulation and privatization, co-operative insurance enterprises have found new opportunities, including provision of health insurance. However, where provider-owned health co-operative systems were already well-developed the new situation has also offered major opportunities.

In the transitional economies, although opportunities for genuine co-operative engagement appear to be very large, practical constraints remain substantial and have so far precluded significant development. However, the opportunities remain, and it is merely a matter of resolving the difficulties.

In the 1980s and 1990s, therefore, there has been an expansion in co-operative contribution to health and social welfare. It has been more varied in nature than it had been prior to public sector predominance, and, moreover, must operate in conditions of strong private for-profit sector competition and widespread dislocation of labour markets.

Table 1 Countries in which the principal types of co-operative enterprises are active in the health sector, 1995

Country	Health co-operatives			Co-operative health insurance	Co-operative pharmacies	
	user-owned	provider-owned			user-owned	provider-owned
		primary	secondary			
	1	2	3	4	5	6
Argentina	-	x	-	-	-	-
Belgium	-	-	-	x	x	-
Benin	-	x	-	-	-	-
Bolivia	x	x	-	-	-	-
Brazil	x	-	x	-	-	-
Canada	x	-	-	x	-	-
Chile	-	-	x	-	-	-
Colombia	-	-	x	x	-	-
Costa Rica	(joint-provider)	x	-	-	-	-
Czech Republic	-	-	-	-	x	-
Denmark	-	-	-	x	-	-
Ecuador	-	-	-	x	-	-
Finland	-	-	-	(m)	x	-
France	(m)	-	-	(m)	(m)	-
Germany	-	x	-	x	x	-
Haiti	-	-	-	-	x	-
India	x	-	x	-	-	-
Ireland	-	-	-	-	x	-

Country	Health co-operatives			Co-operative health insurance	Co-operative pharmacies	
	user-owned	provider-owned			user-owned	provider-owned
		primary	secondary			
Israel	x					
Italy	-	x	-	x	x	-
Japan	x	-	-	x	-	-
Korea, Republic of	?	-	-	x	-	-
Malaysia	-	-	x	x	-	-
Mongolia	-	x	-	-	-	-
Myanmar	?	-	-	-	-	-
Niger	-	-	-	-	x	-
Poland	-	x	-	-	-	-
Netherlands	-	-	-	(m)	x	-
Panama	x	-	-	-	-	-
Paraguay	-	-	x	-	-	-
Peru	-	-	-	x	-	-
Philippines	x	x	-	-	-	-
Portugal	-	x	-	-	-	x-
Senegal	x	-	-	-	-	-
Singapore	x	-	-	x	x	-
South Africa	x	-	-	-	-	-
Spain	(joint-provider)	-	x	x	-	-
Sri Lanka	x	-	-	-	-	-
Sweden	x	x	-	-	-	-
Switzerland	-	-	-	(m)	x	-

Country	Health co-operatives			Co-operative health insurance	Co-operative pharmacies	
	user-owned	provider-owned			user-owned	provider-owned
		primary	secondary			
United Kingdom	-	-	x	x	x	-
United Republic of Tanzania	x	-	-	-	-	-
United States & Puerto Rico	x	x	x	x	-	x

It is believed that health co-operatives exist also in Australia, but no further information is available. The notation (m) indicates that mutual organizations are important providers.

TABLE 2 POPULATION SERVED BY HEALTH CO-OPERATIVES
CIRCA 1994

Region and country	Type of Co-op [user-owned: u] *[provider-owned: p]*	Date of information	Members		Users		Total users
			Reported	With associated population	Reported	With associated population	
Benin	P	94	na	na	na	x	x
South Africa	U	95	na	na	na	na	x
United Republic of Tanzania	U	95	na	na	na	na	x
Subtotal (Africa)							x
Australia							
India[1]	U	95	(125,000)	(750,000)	+	+	(750,000)+
Japan:							
consumer[2]	U	95	1,810,000	(7,240,000)	--	--	(7,240,000)
agricultural[3]	U	93	8,500,000	(22,500,000)	--	--	(22,500,000)
Malaysia[4]	P	95	na	na	na	na	[2,500,000]
Mongolia	P	95	na	na	na	na	x
Myanmar	na	na	na	na	na	na	x
Philippines	U	92	na	na	na	na	x
Republic of Korea	na	95	na	na	na	na	x
Singapore[5]	U	95	na	na	na	na	[1,200,000]
Sri Lanka[6]	U	92	(22,500)	(90,000)	+	+	(+90,000)
Subtotal (Asia)							**(+30,580,000)**

Region and country	Type of Co-op	Date of information	Members		Others		
			Reported	With associated population	Reported	With associated population	
Israel[7]	U	95	...	3,500,000	...	...	3,500,000
Subtotal (Western Asia)							3,500,000
Argentina	P	95	na	na	na	na	x
Bolivia[8]	U	85	440	(2,000)	na	na	x
Bolivia[8]	P	77	na	na	na	15,000	X
Brazil[5]	U	95	na	na	na	na	x
Brazil[9]	P	95	--	--	8,000,000	--	8,000,000
Chile[10]	P	92	--	--	134,500	538,000	538,000
Colombia[10]	P	94	--	--	144,000	576,000	576,000
Costa Rica	P	95	--	--	na	na	x
Panama[10]	U	92	300	1,200	--	--	1,200
Paraguay	P	95	--	--	na	na	x
Subtotal (Latin America)							**+9,115,200**

Region and country	Type of Co-op	Date of information	Members		Others		
			Reported	With associated population	Reported	With associated population	
Canada[11]	U	95	na	na	na	na	(1,000,000)
United States[12]	U	94	na	na	na	na	(4,000,000)
United States[12]	P	94	--	--	na	na	x
Subtotal (North America)							**(+5,000,000)**
Germany	P	95	na	na	na	na	x
Italy[13]	P	92	--	--	(25,000)	--	(25,000)
Poland	P	96	na	na	na	na	x
Portugal	P	96	na	na	na	na	x
Spain[14]	P	92	--	--	(1,000,000)	(4,000,000)	(4,000,000)
Sweden	U	94	na	na	na	na	x
Sweden	P	94	na	na	na	na	x
United Kingdom	P	94	na	na	na	na	x
Subtotal (Europe)							**(4,025,000)**
Developing regions	U						**841,200+**
Developing regions	P						**9,114,000+**
Developed regions[15]	U						**38,240,000+**
Developed regions[15]	P						**4,025,000+**
Total	U						**39,081,200+**
Total	P						**12,140,200+**
All							**52,220,000+**

Notes: Figures in ( ) indicate estimates based upon firm information and calculated on the basis of known factors. Those in [ ] - Malaysia and Singapore - are "guesstimates": they are not included in regional or global totals. Figures underlined refer to membership of broader organisations (co-operative or trade union), all of whom are eligible for health co-operative services.

Information can be considered indicative only. The year to which it refers varies. That for recent years other than 1994 is included in the various totals without adjustment for possible change to 1994. The total for Spain, 800,000, dating from 1988, is included but up-dated to 1,000,000 on the basis of recent unconfirmed reports that there has been considerable expansion since 1988. Information for years prior to 1988 are not included in the totals, although shown against the relevant countries.

Information is not available for some countries. Where it is presumed that the numbers involved are small, the notation "x" is included in the total. Where it can be presumed that the numbers involved are significant (at least 100,000 persons), the notation "X" is included in the total. No "guesstimate" for these countries has been attempted, and nothing has been included in the regional and global totals. For some countries totals indicated can only be termed "Guesstimates". They are also not included in the totals: they are intended only to be indicative of possible dimensions.

Some statistics are provided for "members", sometimes without sufficient explanation of whether the total includes or excludes dependants of "members". This happens also in respect to non-member "policy-holders" or "enrolees": it is sometimes not certain whether the numbers quoted refer only to the persons in whose name the policy has been issued, or the total of dependants covered by the policy. The following notes explain and qualify the information set out in the table: where this is an estimate based upon reasonable suppositions, it is provided in parenthesis, but used nevertheless in the calculation of the totals.

[1] Information is very limited for India. In 1995, Shushrusha Citizens' Co-operative Hospital in Bombay had a membership of 7,624. There were 14 other user-owned health co-operatives in Maharashtra State: their membership is likely to be less than that of Shushrusha, the oldest in India. An estimate of 15 x 5,000 members (=75,000) can be proposed. Indira Gandhi Co-operative Hospital in Cochin, Kerala had 3,000 "shareholders", presumed to be members, in 1992. There were 25 other co-operative hospitals and 62 clinics in 1995. The former are likely to have been smaller than that in Cochin, the oldest in the State. An estimate of 25 x 1,000 members (=25,000) can be proposed. Health co-operatives are also reported in Karnataka and Goa, but there is no information on membership: it is presumed that co-operatives are fewer and membership is smaller than is the case in Maharashtra and Kerala, precisely because no information has been reported. Thus a "guesstimate" of 75,000 (Maharashtra) plus 25,000 (Kerala) (= 100,000), plus 25,000 for Karnataka and Goa would give a total for India of 125,000 members. Information from Shushrusha and Indira Gandhi co-operatives suggests that "members" and "shareholders" are likely to be household-heads. Applying an average household size of 6 (eligible dependants are limited to parents, siblings and children), a total of 750,000 individuals is taken as an estimate, and included in the regional and global totals.

To these could be added non-members to whom various community outreach programmes were provided free or at cost: they had no formal contractual status and were served only occasionally and partially. No estimate of their numbers is attempted. In very general terms it could be said that it is unlikely that more than one million persons are served by health co-operatives in India.

[2] The total number of members at the end of March 1995 was 1,810,000. These are identified specifically as households. Given that most are likely to be urban residents, it seems appropriate to apply an average household size of four persons (i.e. including in some cases dependant resident parents), then a total of 7,240,000 persons can be calculated.

[3] The number of members is not available. This may be because health co-operatives within the agricultural co-operative movement are not so much autonomous co-operative enterprises with their own membership, as is the case of those in the consumer movement. Rather they are facilities available by reason of membership in the agricultural multifunctional co-operative and specifically provided by the "welfare federation" or member service department of the secondary level federation of these co-operatives. Almost all rural households are in fact members of such co-operatives, and hence can make use of these health co-operatives. However, as of March 1992 these enterprises were present in only 34 of the 48 prefectures. This may express the fact

that they were not available in predominantly urban prefectures, or not in remote prefectures with limited agricultural sectors. Nevertheless, it is known that total membership of the Central Union of Agricultural Co-operatives was 8.5 million, presumed to be households. Applying an average household size of three (to reflect the demographically aged character of rural populations and the impact of out-migration) this would give an individual total of 25.5 million persons. A reasonable estimate of the numbers of individuals for whom the services of the health co-operatives were available would be, therefore, between 20 and 25 million, with 22.5 million being taken as the estimate used in the regional and global totals.

[4] The provider-owned co-operative network, KDM, is now part of the more comprehensive KOHISAT, which includes KDM, the national co-operative insurance enterprise MCIS, co-operative banks and consumer co-operatives. Members of all these co-operative organizations are eligible for the services provided by the KDM system. The total membership in all types of co-operative in Peninsular Malaysian in 1984, the latest year for which information was available, was 2,292,000: with dependents, calculated at 4 per membership this would suggest a total of 10,000,000. It can be presumed that not all members would have access to KDM facilities. In 1988 KDM itself estimated that only about half a million members of co-operatives would use the network out of a potential total of three million in the Malaysian co-operative movement. Consequently, a "guesstimate" of 500,000 members will be used provisionally: with family members, estimated at an additional four, the number of users would be 2,500,000. This is an indicative total only, and is not included in regional or global totals.

[5] Individuals, together with their dependants, who are members of any trade union which forms part of the National Trade Union Council, are automatically a member of the various dental and health care co-operatives sponsored by the Council. In 1991 total membership of all co-operatives was 513,000, of which 233,000 in insurance and 183,600 in consumer co-operatives (with the likelihood of some overlap between these two categories). A "guesstimate" of 400,000 members will be used provisionally, suggesting total usage of 1,200,000, if average household size is taken to be three.

[6] The only health co-operative for which membership was known had a membership of 3,000 members in 1970: estimates for 1992 indicate memberships of between 1,500 and 3,000 for each health co-operative. There were 10 health co-operatives operating in 1992, suggesting a total membership of between 15,000 and 30,000 (22,500 is taken as the average). Applying an average household size of 4, this would suggest between 60,000 and 120,000 (90,000 as an average) persons served by these co-operatives (90,000). The numbers actually served are likely to be larger, because very recently a number of the co-operatives decided to open membership to all members of co-operative enterprises operating in the same districts: these are likely to be numerous as agricultural, savings and credit and consumer co-operatives are well developed in those regions of the country where health co-operatives operate. However, there is no way of estimating the numbers involved.

[7] In Israel in 1995 the co-operative health insurance and services covered more than 70 per cent of the population, and would be equivalent therefore to at least 3.5 million of the total of over 5 million.

[8] Information is not included in the totals as it is likely to be out of date.

[9] The members of Usimed user-owned health co-operatives were former contract-holders with the Unimed provider-owned health co-operative system, and it may be presumed that they are included within the total of 8,000,000 "users" reported by Unimed. These are described as "health scheme users" which leaves unsettled the question of whether they represent policy holders alone, i.e. excluding their covered dependents, or policy holders together

with their dependants. If the latter is the case, given that most users were from lower middle and upper lower income households, average household size could be taken to be five - suggesting a user population of about 40,000,000. Unimed included 30 per cent of the country's doctors - 73,000. As the total population was 151 million, application of the same proportion, that is 30 per cent, would indicate 45 million persons which accords with the estimate based on household members. On this basis it could be assumed that the 8 million refers to "policy holders" and that the user-population totals 40 million. However, in earlier literature Unimed stated that the population served (8 million) was "equivalent to that of the population of Sweden", which suggests that "users" are in fact all individuals served, both policy holders and their dependents. This is the total retained provisionally as the total of users.

[10] In Chile, Colombia and Panama totals are presumed to be households represented by a member, to which a factor of four has been applied to estimate total users.

[11] In 1992 in Canada the 20 health co-operatives which responded to the annual survey of all Canadian co-operative enterprises reported an aggregate membership of 300,000. With dependents this would suggest a total user population of 900,000. There were 37 co-operatives in operation in 1995. While it is not possible to estimate their membership, it might be assumed that these were newer and smaller co-operatives less likely to respond to the annual enquiry, and it is reasonable to allow an additional user population of 100,000, making a national total of 1,000,000.

[12] The 1994 information provided by the National Cooperative Business Association refers to "United States residents" and presumably means therefore individual persons, not households. It identified one million users. However, the term "member" is usually applied to the person with whom a "health plan" has been accepted. Dependants are clearly defined separately from the "member". For example, the Family Health Plan Cooperative Health Maintenance Organization of Milwaukee defines dependants as including spouse, unmarried children of the member or the spouse, legally adopted children and children under legal guardianship, foster children and even children of a dependant child. Consequently, the total number of users could reasonably be estimated at membership multiplied by a factor of four. In contrast Group Health Co-operative of Puget Sound stated specifically in its 1994 Annual Report that it served more than 510,000 "residents" of Washington and North Idaho - presumed to be members and "enrolees" (through enterprise-based health plans) and their eligible dependants. This is one of the largest user-owned health co-operative in the United States, but there are 12 others, of which Family Health Plan at Milwaukee is of the smaller type - yet it serves 100,000 members (x 4 = 400,000). Consequently, it may be presumed, at least provisionally, that the estimate of 1,000,000 by the National Co-operative Business Association refers to "members and enrolees" excluding dependants, so that a total of between 3.5 and 4.5 million persons are likely to use these health co-operatives. An estimate of 4,000,000 is used. That this might be a correct assumption is suggested by the fact that the predecessor of the National Cooperative Business Association, the Co-operative League of the United States (CLUSA) reported in 1982 a total "enrolment" in co-operative health maintenance organizations of 706,278: this term suggests that dependents were excluded. A growth to one million "members/enrolees" in 12 years is feasible. No information is available concerning users of provider-owned co-operatives.

[13] In 1992 users of 660 "social co-operatives" surveyed totalled 42,000 (64 per enterprise). The total number of such co-operatives was about 2,000. The total of users could be estimated at 128,000. However, only 13 percent were health co-operatives, suggesting a total of 16,640. Membership of such co-operatives was likely to be larger than social care co-operatives such as

residential centres and "sheltered" workshops, so a total of 25,000 is estimated provisionally.

[14] In Spain a total of 800,000 "policyholders" was reported for 1988: with their dependents this suggests a total of 3,200,000, applying an average household size of four. Subsequent, but unconfirmed reports indicated that by the early 1990s the total of policy holders had risen to 1,000,000 -- and hence of total users to about 4,000,000.

[15] The category "Developed regions" includes North America, Europe, Australia, Israel and Japan.

TABLE 3: BASIC STATISTICS ON HEALTH CO-OPERATIVES

Health Co-operatives	Date Established[1]	Number of Co-operatives (1995)	Members[2]	Enroled Other Users	Hospital Beds	Clinic Beds	Doctors [members, staff or employed]	Date to which information refers
User-owned health co-operatives								
Health co-operatives, Bolivia	?	8	440	?	?	?	?	1985
Usimed health co-operatives, Brazil	1993	6	?	?	-	-	-	1995
Tignish Co-operative Health Centre, Prince Edward Island, Canada	1974(?)	1	1,700	?	none	?	?[3]	1994
New Ross Health Co-operative Nova Scotia, Canada	1987	1	(2,500)	?	none	?	?	1994
Community Health Services Association members, Saskatchewan, Canada[4]	1962	9	10,000+	(25,000)	none	?	?	1995
Other co-operative community health clinics, Canada[4]	Early 1960s	28	?	?	-	?	-	1995
Shushrusha Citizens' Co-operative Hospital, Bombay, India[5]	1969	1	7,000	?	150	20	?	1992
Indira Gandhi Co-operative Hospital, Cochin, Kerala, India	1971	1	?[6]	?[7]	?	?	?	1992
Other "hospital co-operatives" in Kerala, India	1949	?[8]	?	?	?	?	?	1992
Other health co-operatives in Maharashtra, India	?	14	?	?	?	?	?	1995
Other health co-operatives in Goa and Karnataka, India	?	?	?	?	?	?	?	1995
Israel	1926	?	(3,500,000)	-	?	?	8,000	1995

Health Co-operatives	Date Established[1]	Number of Co-operatives (1995)	Members	Enroled Other Users	Hospital Beds	Clinic Beds	Doctors [members, staff or employed]	Date to which information refers
"Medical Co-operatives" members of Japanese Consumers' Co-operative Union, Japan	?[9]	118	7,240,000	none	13,028	?	1,605	1995
National Welfare Federation of Agricultural Co-operatives members, Japan	1919	191	22,500,000	none	37,841	?	3,570[10]	1993
COOPASI, Veraguas, Panama	1990	1	300	?[11]	none[12]	none	none[12]	1992
NATCCO co-operative, Quezon City, Philippines	1992	1	?	?	?	?	?	1992
Employment related trade union sponsored Senegal	1975	40 (1980)	?	?	none	none	none	1980
Dental co-operative, NTUC, Singapore	1971	1	?	?	na	na	none	1995
Health care co-operative, NTUC, Singapore	1992	1	?	?	?	?	?	1995
South Africa								
Galle District Co-operative Hospital, Sri Lanka	1962	1	2,000+	?[13]	75	none	none[14]	1992
Gampaha Co-operative Hospital, Gampaha, Sri Lanka	1962	1	1,167	?[15]	?	?	?	1992
Other "hospital co-operatives" in Sri Lanka	1932	8	?	?	?	?	?	1995
Associated with small industrial co-operatives United Republic of Tanzania	1995	5	?	?	?	?	?	1995
"Interested parties partnership" co-operatives of various types, Sweden (Medikoop model)	1992-3	?	?	?	?	?	?	1995

Health Co-operatives	Date Established[1]	Number of Co-operatives (1995)	Members	Enroled Other Users	Hospital Beds	Clinic Beds	Doctors [members, staff or employed]	Date to which informatio n refers
Consumer-controlled co-operative health maintenance organizations in the United States:			?	[4,000,000]				1995
Family Health Plan Cooperative, Milwaukee, Wisconsin	1979	1	100,000+	?	-	-	?	1995
Group Health Co-operative of Puget Sound, Seattle, Washington	1945	1	82,000	396,000	505	189	1,007	1993
Group Health Association of Metropolitan Washington D.C.	1932	1	?	?	?	?	?	-
Health Partners, Minneapolis-St. Paul	1957	1	650,000	?	?	?	550	1995
Group Health Co-operative of Eau Claire, Wisconsin[16]	1972	1	20,000	?	none	?	?	1991
Group Health Co-operative, Madison, Wisconsin	1976	1	40,000	?	?	?	?	1995
Health Insurance Plan of Greater New York	?	1	?	?	?	?	?	?
Group Health Plan of North East Minnesota, Virginia, Minnesota	?	1	?	?	?	?	?	?
United Seniors Health Co-operative, Washington D.C.	1984	1	8,800	none	none	none	none	1995

Health Co-operatives	Date Established[1]	Number of Co-operatives (1995)	Members	Enroled Other Users	Hospital Beds	Clinic Beds	Doctors [members, staff or employed]	Date to which informatio n refers
<u>**Provider-owned health co-operatives**</u>								
Argentina (COOPRES)	1993	1	?	10,000	?	?	?	1996
Co-operative clinics, Benin	1991	10	?	?	none	?	?	1994
Health co-operatives, Bolivia	pre-1977	?	?	15,000	?	?	20[17]	1977
Members of Unimed do Brasil, Brazil	1967	304	na	8,000,000	1,176	?	73,000	1995
Cooperativa de Servicios de Proteccion Medica Particular (PROMEPART)/Institucion de Salud Previsional (ISAPRE), Santiago de Chile, Chile	1968	?	134,540 (538,000)	?	?	?	?	1992
Cooperativa Medica del Valle y de Professiones de Colombia (COMEVA): Prepagada COOMEVA/EPS, Colombia	1964 (1973/95)	?	144,000 (576,000)	?	?[18]	?	?	1995
Health co-operatives "Femec" and "Unimec", Colombia	?	?	?	?	?	?	?	1995
Coopesalud, Coopesain and Medicoop Costa Rica	1988	3	?	210,000	none	?	95	1995
Health co-operatives, Germany	?	3	?	?	?	?	?	1995
India (SEWA)	late 1980s	1	34	?	none	?	none	1989
Social (health) co-operatives, Italy	?	?	?	?	?	?	?	1994
Members of Malaysian Doctors' Co-operative, [KDM], Malaysia	1988	472	?	?	none	?	?	1995
Enerel Dental Clinic, Ulan Bator, Mongolia	1994?	1	?	?	?	?	?	1995
Unimed de Paraguay	?	?	?	?	?	?	?	1995
Health co-operative, Poland	1945	?	?	?	?	?	?	1996
Lisbon and Oporto, Portugal	?	3	?	?	?	?	?	1996

Health Co-operatives	Date Established[1]	Number of Co-operatives (1995)	Members	Enroled Other Users	Hospital Beds	Clinic Beds	Doctors [members, staff or employed]	Date to which information refers
Medical Mission Group Hospital and Health Services Cooperative, Mindanao, Philippines	1982	1	?	50,000	60	?	?	1992
Autogestio Sanitaria, Barcelona, Catalonia, Spain	1974	?	na	194,549	?	?	4,021	1988
Lavinia, Spain (excluding members in Catalonia)	1976	?	na	600,000 800,000+ (1992)	none	?	15,375	1988
CES.S.COOP/SANICOOP, Madrid, Spain[19]	1980	?	?	?	none	?	100(?)	1992
Cooperatives of general practitioners, United Kingdom	?	30	?	?	none	none	?	1993
Provider-owned (doctors, dentists) USA	1982	1	?	50,000	60	?	?	1992
Joint user and provider-owned health co-operatives								
Costa Rica	1993	1	none	27,000	none	?	54	1995
Spain	1989	1	?	194,549	?	none	4,021	1988

Notes

1/ The date refers to the beginning of operation, and not to any earlier date of registration, wherever this is known.

2/ For details see Notes to Table 1

3/ Medical staff include an unstated number of full and part time physicians, a public health nurse, pharmacist, dentist and two dental hygienists (The Atlantic Co-operator, vol.60, No.2, 1994, pgs.1 and 10).

4/ The Centres locaux des services communautaires in Quebec - of which there were 160 in 1989 - were run by community boards and employed salaried (not fee-for-service) health professional staff. However, at least for the purposes of this paper, they have not been considered co-operatives, because users are not directly members with full rights of ownership and control. In contrast, the Community Health Services Associations in Saskatchewan are described as "community-based and democratically controlled by the community in which they operate" and as "some of the oldest and most successful community-based health centres in Canada ... organized on a co-operative basis" (L. E. Apland, "The co-operative sector and health care in Canada", Canadian Co-operative Association, Ottawa, Canada, January 1990, quoted in Medical Co-op Committee of Japanese Consumers' Co-operative Union "Medical Co-ops' Report" No 17 Medical Co-operatives in the World, 1992, p. 131).

5/ In the Proceedings of the International Health-Medical Co-op Forum held in October 1992 the Dean of the co-operative is reported to have described it as a "consumer-governed" organization, and later referred to it as "an organization of citizens and doctors and local people interested in social work and health care". It is presumed that the doctors who are members became so as representatives of the community. They may also be consultants who provide services to members, but this is a distinct function, and does not imply that the co-operative is either provider-owned or jointly-owned.

6/ In 1992 it was reported that 50 per cent of shares were held by the State Government of Kerala, and 50 per cent by the public. The total number of shareholders was 7,000. It is not clear if these are individuals, that is user-members and health professional staff members, although this could be presumed to be the case.

7/ A number of large enterprises in Cochin have enroled their employees with the hospital co-operative - it is not certain if these are included in the total of 7,000 members. The co-operative also serves members of the public within the local community.

8/ In 1992 it was stated that there were six other "hospital co-operatives" in Kerala. In 1995, it was reported that there were "87 health co-operative units", which comprised 25 hospitals and 62 clinics. Possibly, these were grouped within a smaller number of co-operatives.

9/ In a report entitled "Materials of Medical Co-op Committee of Japanese Consumers' Cooperative Union", distributed at the COPAC Open Forum held at the World Summit for Social Development in March 1994, it was stated that "Full-fledged medical business activities carried out by co-operatives are said to have originated with an industrial co-op (now known as agricultural co-ops) established in the farming region of Shimane Prefecture in 1919. The co-ops medical business spread rapidly during the 1930s, especially in agricultural areas. ... Influenced by these developments, co-operatives in urban areas began to establish medical societies." However, no date was given for the foundation of the first health co-operative within the consumer co-operative movement.

10/ This included part-time doctors.

11/ In 1992 the co-operative was negotiating a contract with 5,000 member strong co-operative of teachers operating in the same province, whereby all would be able to use the co-operative's services.

12/ The health co-operative had in 1992 no facilities of its own and no staff doctors. The health professional members provide services to user-members, including out-patient services in their clinics, at agreed fees. An offer had been made to the co-operative to purchase the only private hospital in the area.

13/ Shortly before 1992 the co-operative had decided to establish an "associated member" category and make this available to members of all other co-operatives in the district.

14/ Doctors from the government hospital and the medical faculty of the local university provide consultants to the co-operative.

15/ The co-operative also serves members of the public within the local community.

16/ Kushner (1991) includes this enterprise in a list of "examples of active primary health care co-operatives or co-operatives that include primary health care". However, she notes that, although initially established as a pure model health co-operatives that sold voting shares, this failed to raise adequate capital, so the group soon evolved into a prepaid, non-profit health maintenance organization. Nevertheless, all prepaid members are entitled to vote in annual elections for the consumer-run board of directors, on which only consumer members can serve.

17/ A report transmitted by the Universidad Catolica Boliviana to the United Nations in 1977 noted that there were in 1976 18 doctors and 2 dentists attending 15,000 persons. In a Co-operative Information Note prepared for COPAC by the Co-operative Studies Department of this University in April 1984 it was stated that there were 8 provider-owned health co-operatives with 444 members. It was noted that other co-operatives, including credit unions, also had health programmes.

18/ In 1973 the co-operative opened its own twelve story modern hospital, but the number of beds is not known.

19/ This is the only known case of a private for profit health sector enterprise (in dentistry) being converted into a worker-owned co-operative by its professional employees. A number of other primary co-operatives were established in the Madrid region, and at some time between 1985 and 1990 a secondary co-operative, SANICOOP, was established.

VI. TRENDS IN THE DEVELOPMENT OF INSTITUTIONS CAPABLE OF SUPPORTING COMPREHENSIVE APPROACHES TO ENGAGEMENT BY THE CO-OPERATIVE MOVEMENT IN THE HEALTH AND SOCIAL CARE SECTOR

In order to realize the very substantial potential of those health and social care co-operatives operating at the primary level (i.e. those directly engaged in providing services to individuals) for contributing to improved health and social well-being for large sections of the population in most countries, effective secondary and tertiary level organizations are needed. Their function, as is the case in all areas of co-operative organization, would be to provide operational support to health and social care co-operatives, and to harmonize and coordinate the widely dispersed but potentially mutually supportive activities of co-operative enterprises in all relevant sectors.

The purpose of this chapter is to review the current state of development of such co-operative institutions, as a prerequisite for suggesting actions within a comprehensive co-operative strategy for health and social welfare. Unless otherwise stated information is derived from the sources referred to in the notes to Chapters II, III and IV.

A. Development of secondary and tertiary organizations by co-operatives providing health services to individuals (health co-operatives)

1. User-owned health co-operatives

(a) Secondary organizations

Those user-owned primary health co-operatives established from an independent community-base and operated as fully independent primary enterprises, rather than within an established co-operative movement, such as those in Japan, have no links to a sponsoring or supporting association which may already have its own secondary and tertiary structures. Consequently, they are free to collaborate with other health co-operatives in order to set up secondary co-operatives for the purpose of taking advantage of economies of scale: with functions such as group purchasing, use of common facilities and services etcetera. However, this requires organizational energy and favourable conditions, not always available, and is likely to be worth-while only where the primary co-operatives are located within reasonable distance of each other and, in some countries, within the same administrative or juridical authority.

In fact, however, there appears to be little development of secondary co-operatives formed by association between fully independent primary user-owned health co-operatives. Only in Saskatchewan, Canada, has a regional level Federation of Health Co-operatives been established. A number of factors may be relevant. One of the most significant may be the fact that the primary co-operatives are in fact not located sufficiently close to each other to render collaboration at the operational level advantageous. This may have been the determining factor for the mutually isolated co-operative community health centres in the Maritime Provinces of Canada, and for many of the health co-operatives in the United States. However, in the case of the co-operative health centres in Saskatchewan, and the health co-operatives in the Wisconsin-Minnesota area of the United States, it might have been thought that geographical proximity was sufficient to render operational collaboration

through secondary co-operatives useful. Presumably, therefore, in these areas some other constraining factors have been at work.

The primary user-owned health co-operatives in Sri Lanka have never formed a secondary co-operative, although the numbers existing and their locational proximity, particularly those within close proximity to Colombo, in a country with well-developed infrastructure, might have rendered such an organization useful. It is possible that the close association of primary health co-operatives with other types of co-operatives, each with well developed secondary and tertiary structures, has diminished the need for their own secondary formations. The associated co-operative networks may provide most forms of needed support, such as inputs which could be obtained as part of wholesale supplies to general consumer co-operatives.

The health co-operatives of this type in India have not established secondary organizations, possibly because of their small number and locational separation, although the conditions for such development would appear appropriate in Kerala. The health co-operative in Panama appears to be the only organization of its type in the country.

It is uncertain whether the user-owned health co-operatives which have developed within the Japanese consumer co-operative movement have established their own secondary formations, such as input purchasing or common service providing co-operatives, as a means of operational collaboration. They are likely to have developed structures parallel to those of the general retail consumer co-operative movement which has a strong regional structure. The health co-operatives which have been established by agricultural co-operatives in Japan are in fact operating at a regional level, as an expression of the process whereby the agricultural co-operatives themselves have combined at prefectural level. Each is a secondary co-operative, responsible for providing specialized services to member primary agricultural co-operatives, and their individual members.

Among those user-owned primary health co-operatives which have been sponsored or supported by non-community associations, most are relatively new and some even only at an experimental phase (for example, those in Sweden established according to the Medikoop model sponsored by tertiary housing and insurance co-operatives, and Usimed, sponsored by Unimed do Brasil). Given this sponsorship, the need for secondary and tertiary formations might be reduced.

(b) Tertiary organizations

Tertiary formations - that is national level representative and servicing organizations - have been established only by the two separate Japanese health co-operative movements. Those which developed in the context of the consumer movement have established their own Medical Co-op Committee, which is affiliated with the consumer co-operative movement's apex organization: the Japanese Consumers' Co-operative Union (JCCU). The individual health co-operatives are members, in the same way as the consumer-owned retail co-operatives are members, of the JCCU. Similarly, the health co-operatives set up by the "welfare federations" which primary agricultural co-operatives have established at the prefectural level, have themselves combined to set up a tertiary organization in the form of the National Welfare Federation of Agricultural Co-operatives (ZENKYOREN), which is one of a number of apex organizations within the National Federation of Agricultural Co-operative Associations (ZEN-NOH).214/

There are no tertiary co-operative organizations of user-owned health co-operatives in other countries. In the United States 24 health co-operatives formed in August 1946 the Co-operative Health Federation of America. After a number of changes in name it became the Group Health Association of America,

and most recently the American Association of Health Plans, representing Health Maintenance Organizations, among which health co-operatives are a minority.215/

However, in Canada, Sweden and the United States, national apex co-operative organizations have included concern for the development of health co-operatives in their activities. During the last several decades, the Canadian Co-operative Association and the Conseil Canadien de la Cooperation have similarly promoted health co-operatives as major elements of reformed health and social care sectors before federal and provincial bodies examining health sector reform. In Sweden the Folksam Insurance Group and HSB: Riksforbund (the Union of Housing Co-operatives) have developed the "Medikoop" model as a basis for consideration by local government authorities as part of the process of the taking over by community-based health co-operatives of services formerly provided by the public sector. In the United States the National Co-operative Business Association supports all forms of co-operative organization in the health and social care sectors.

2. Joint user- and provider-owned health co-operatives

The only tertiary organization known to exist is the "National Consortium of Social Solidarity Co-operation" (Consorzio Nazionale della Cooperazione di Solidarietà Sociale Gino Mattarelli"), whose 2000 members include co-operatives which are jointly owned, as well as those predominantly provider owned.

3. Provider-owned health co-operatives.

(a) Secondary organizations

This type of health co-operative is a secondary co-operative established by independent health professionals, many already organized in group practices. In Brazil they have formed what may be considered further secondary formations - co-operative business groupings at sub-regional and regional levels: i.e., for each State. At the beginning of 1994 provider-owned health co-operatives were grouped into 17 State-level alliances.

In Spain, the structure is somewhat complex, as an organizational base was established prior to co-operatives becoming politically acceptable. Members subsequently set up true co-operatives when conditions became favourable. In Catalonia, which might be considered the core of the health co-operative movement in Spain, the original provider-owned primary health co-operative (Autogestio Sanitaria) diversified to include an associated jointly-owned hospital co-operative (SCIAS), a family health care/preventive oriented subsidiary, a secondary "management" and common service co-operative (ELAIA) and a secondary training, research and development co-operative (which eventually became the Espriu Foundation). In the Madrid region the primary co-operatives of the "CES Clinicas S. Coop" group has established a secondary organization, SANITAS.

(b) Tertiary organizations

In Brazil, on the base constituted by its 304 member primary health co-operatives, and its 17 State-level alliances, the national tertiary co-operative, Unimed do Brasil (the National Confederation of Health-care Co-operatives) has been able to establish a substantial cluster of specialist organizations, known as the Unimed Multicooperative Business Complex or "Co-operative Businesses and Enterprises Complex Unimed do Brasil" whose function is to support the effective operation and expansion of member primary co-operatives. The Complex consists of a number of wholly owned subsidiaries, covering almost all of the financial, managerial and operational needs of the networks of primary co-operatives. For legal reasons relevant to the

financial management of co-operative enterprises, and to facilitate operations on the financial market, the Unimed System established in 1990 a holding company, Unimed Participations (Unimed Participaç_es), whose shareholders include both individual Unimed health co-operatives and the secondary level state associations. This company oversees the operations of a number of specialist enterprises wholly owned by Unimed: Unimed Systems, Unimed Insurance, Unimed Brokerage, Unimed Products and Hospital Services, Unicred and the Unimed Centre of Studies Foundation.

Unimed Insurance (Unimed Aseguradora), also established in 1990, provides health, group life, and disability insurance, as well as a private pension plan, both to doctors who are members of Unimed health co-operatives, as well as to other health professionals. It also provides reinsurance for the operational risks of the health co-operatives themselves, including their obligations to enterprises with whom they have group contracts for health service provision. In 1994 the enterprise insured 2,500,000 clients.

The Unimed Complex has developed its own financial management system: Unicred (Confederaçao Nacional das Cooperativas de Economia e Credito Mutuo dos Medicos Ltda). This is a national confederation of 60 Unicred co-operatives located in all parts of the country. It began in 1989 and after slow expansion up to 1992 increased rapidly in 1993 and then expanded steadily. Its development was inspired in part by the Caja Laboral del Complejo Cooperativo, part of the Mondragón Group of Cooperatives in Spain. Payments made to member doctors for services provided within their primary health co-operatives, as well as payments for services provided by Unimed hospitals, laboratories, clinics and other services, are made into Unicreds. Members of Unimed also use Unicreds as normal savings and credit co-operatives for their own personal and professional financial transactions. The large funds which accumulate within the individual Unicreds are invested in the commercial banking system through their National Confederation, and the income received is used to provide below-market interest rates for financing health co-operative and other Unimed developments, as well as providing personal credit services to members, funding study grants and paying dividends and interest on the personal loans made by members to their co-operative.

In order to research, develop, implement and coordinate products and services in the area of information technology and exchange the Unimed Complex has established a specialist enterprise, Unimed Systems. Among a range of products which this has developed has been Siamed/Siamed Plus, an integrated computerized system for management of member health co-operatives, and for the exchange of administrative and clinical data, necessary for the operation of the network of primary co-operatives as an integrated system, including the operations of the tertiary level Unimed Complex itself. It has also developed software known as Sisvida for the management of life, accident and temporary disability insurance, and specialized software for health insurance administration used by Unimed insurance. Unimed Systems has in turn established Unired, a satellite data communication network which makes possible the exchange of administrative and clinical data between all member health co-operatives throughout Brasil. Its further connection with Internet has proved to be an affordable facility for health professionals of major significance for their professional development.

The Unimed Complex has also established its own Unimed Products and Hospital Services (Unimed Produtos e Serviçios Hospitalarios), also known as Unimed Hospitals Enterprise, in May 1995. Its function is to unite all Unimed facilities within a single integrated network in order to solve common problems and make up for deficiencies in human resources. It provides logistic and managerial support for Unimed's own hospitals, laboratories and rapid treatment units throughout the country. It acts as a bulk purchasing organization for domestic and imported products, and plans to begin production of its own generic drugs. It provides technical and managerial advisory

services and is developing an integrated technology and information network as well as the standardization of equipment and materials for hospitals, clinics and other facilities. By this means it is intended to reduce costs for member primary co-operatives as well as prices to users. Major emphasis is given to efficient hospital management: Unimed has contributed significantly to improvement in an area where national standards have been recognized to be inadequate, leading to wasted resources and high costs.

In February 1995 the Unimed Centre of Studies Foundation (Fundaçao Centro de Estudos Unimed) was officially established in Belo Horizonte, although it had already engaged in some activities during the previous two years. Its principal purpose is to provide training, particularly in co-operative management and administration but also in general business methods, for directors, managers and technical staff of the Unimed Multico-operative Business Complex; to diffuse information on the administration of co-operative health services; to carry out scientific and technical research; to promote and organize related events; and to carry out exchange programmes within Brazil - including with two of the major universities - and abroad, including programmes with a number of international foundations. The Foundation is financed from the Unimed Complex's central funds, as well as from independent donations made by public and private partners.

In **Malaysia**, the Malaysian Doctors' Co-operative (KDM), recently established, may be considered to be at an early phase in the development of a tertiary level co-operative.

In **Spain**, the provider-owned health co-operative movement established a national level tertiary co-operative (Lavinia), which complements the national-level association of health professionals who were members of what might be described as pre-co-operative organizations (igualatorios) (ASISA). This national organization does not seem to have established specialized subsidiary institutions supportive of operational, managerial and financial expansion, as has occurred in Brazil.

In **Italy** a "National Consortium of Social Solidarity Co-operation" (Consorzio Nazionale della Cooperazione di Solidarietà Sociale "Gino Mattarelli") has about 2000 members. It operates a Studies Centre (Centro Studi) which is known to have undertaken a comprehensive survey of 660 "social co-operatives" as of December 1992. The Consortium works to strengthen local development centres - which might take the form of consortia of social co-operatives - able to disseminate an entrepreneurial culture among social co-operatives, increase self-regulation and pursue common interests.

4. Collaboration between user-owned, jointly-owned and provider-owned health co-operatives at primary, secondary and tertiary levels

Within both user-owned and provider-owned health co-operatives the normal processes of internal development include adjustment and diversification which tend to bring each toward an intermediary, joint or mixed status. Thus, the natural tendency in user-owned health co-operatives is toward establishing their own facilities and hiring permanent professional staff, interested in co-operative forms of organization in the health sector and in the preventive orientation of such co-operatives. They are usually represented on the Board of Directors and in some cases are full members. Special institutional arrangements exist in the larger user-owned health co-operatives to ensure a mutually respectful and beneficial relationship between the non-medical professional representatives of the user-owners, and professional staff. Of particular interest has been the development of such relationships in the Group Health Co-operative of Puget Sound.

The type of primary health co-operative defined as mixed provider/user-owned may originate from such a process, although more frequently it is likely to originate in the interest of provider-owners in achieving the full participation of users. In still purely provider-owned health co-operatives, such an interest is also evident. This is the case in the complex of health co-operatives in Catalonia, Spain. Unimed do Brasil has established an associated system of user-owned co-operatives (USIMED).

These tendencies might be expected to favour collaboration between different types of health co-operative at local, regional and national levels. There are few examples of this at present, largely because of the fact that in few countries do both types of health co-operative exist within the same region: in most cases there are either user-owned or provider-owned types but not both. Malaysia appears to be the only country where consideration has been given to establishing a single national health care co-operative (KOSIHAT) (essentially a tertiary formation) which would include the network of provider-owned health co-operatives, co-operatives outside the health sector whose members would become the user-members, and the national co-operative insurance enterprise.

The only country in which there is more than one national level tertiary organization of a single type of health co-operatives - in this case, user-owned - is Japan. The Medical Co-op Committee of the Japanese Consumers' Co-operative Union and the National Welfare Federation of Agricultural Co-operatives do not have formal institutional arrangements for regular collaboration at the national level. However, they collaborate for specific purposes, as in the organization of the International Health Medical Co-op Forum held in the context of the ICA's 30th Congress in October 1992.

B. Development of relevant secondary and tertiary institutions by other types of co-operative concerned with health and social care

1. Co-operatives providing social care to individuals (social care co-operatives)

In Italy the Consorzio Nazionale della Cooperazione di Solidarietà Sociale "Gino Mattarelli" (known also as Consorzio Gino Mattarelli, CGM) represents and supports over 2,000 health and social care co-operatives, of which the majority are engaged solely in social care. This comprises a secondary organization operating at the local and regional level, and a national level organization.

In **Portugal** the National Federation of Education and Rehabilitation Cooperatives for Children with Disabilities (FENACERCI), founded in 1985, played an extremely important role in the development of the CERCI Movement. It represented in February 1996 47 such co-operatives, located in all parts of the country, and serving directly or indirectly 5,000 persons with mental or multiple disabilities. Its principal objective was to secure recognition of the rights of persons with disabilities, as well as of their interests and those of their families. It provided its members with a wide range of services, including legal assistance, technical advice, technical and educational documentation, training and publicity. 216/.

In the United Kingdom a group of co-operative and community business development workers and members of the Co-operative Research Unit of the Open University and ICOM recently formed a Social Co-operatives Network to support this type of enterprise.217/.

2. Co-operative pharmacies

In Belgium, a tertiary organization, the Office des Pharmacies Cooperatives de Belgique (OPHACO) exists, and is a member of ICA. At the regional international level, primary pharmacy co-operatives have established the European Union of Social Pharmacies, whose objectives include promotion of co-operative pharmacies in the countries where they existed and elsewhere and of public health education through information campaigns.

In the United Kingdom the co-operatives owned by user-owned retail co-operative pharmacies are secondary level organizations. In the United States the co-operatively organized networks of non-co-operative pharmacies are secondary level organizations. They have not combined to form higher level secondary or tertiary organizations.

3. Health and social care sector support co-operatives

Those established by groups of hospitals, including both public and others, are secondary level networks. No tertiary organizations are known to have been established. Primary user-owned health co-operatives are not known to have established such institutions, nor joined those established by the non-co-operative sector. Opportunities for reducing costs by development of a system in this form have not been taken. This may be a result of the small numbers and geographical separation of those health co-operatives which are operationally small: but which would benefit most from such an arrangement. Nevertheless, even where there are a number of health co-operatives within the same geographical region - as, for example, in Saskatchewan - there do not appear to exist such support co-operatives. Conversely, the larger health co-operatives (such as the Group Health Co-operative of Puget Sound) may be large enough to command their own preferential bulk supply.

In contrast, provider-owned health co-operatives have tended to establish regional then national tertiary organizations, and then expand and diversify vertically by setting up their own support subsidiaries: this has been the case of Usimed do Brasil.

4. Insurance co-operatives

Within the co-operative insurance sector, given that health insurance is a significant and distinct insurance product, specialist institutional arrangements at national level for harmonizing this component of their activities might have been expected, but none seems to exist. This might reflect the fact that in many countries there is only one co-operative insurance enterprise, at least for specific sectors, such as agriculture. Health insurance is likely to be dealt with in one branch of such an enterprise. As provision of financial support to health co-operatives, or to other co-operatives in respect to their activities having an impact upon health, is likely to be perceived as not different in an operational sense from collaboration with any other type of co-operative enterprise, no separate organizational arrangements have been made.

Members of the International Co-operative and Mutual Insurance Federation (ICMIF) have set up complementary regional associations: the Africa Association of the ICMIF (AFRA); the Asia and Oceania Association of the ICMIF (AOA); the Americas Association of Co-operative and Mutual Insurance Societies (AAC/MIS); and the Association of European Co-operative and Mutual Insurers (ACME). In addition, a number of operational regional groupings have been set up by co-operative enterprises. In Europe Unipol, P&V, Folksam and the French mutual organization MACIF set up EURESA in 1990 as a holding company whose function was to support the creation and development of insurance enterprises in the social economy, and as a joint venture intended to promote close collaboration between the member enterprises. Three of these enterprises provide health insurance.218/

5. <u>Savings and credit co-operatives and co-operative banks</u>

Savings and credit co-operatives in most countries have established their own secondary and tertiary organizations. In many countries co-operative banks have begun at the primary level, then established secondary operational groups at sub-regional and regional levels, and then national level organizations. These serve as holding enterprises for the entire co-operative system, rather than as representative organizations.

6. <u>Producer, supply and marketing co-operatives in primary production</u>

Producer and supply and marketing co-operatives in primary production have their own well developed secondary and tertiary structures at national and international levels. They have given increasing attention to those aspects of their activities relevant to health, including the effect upon health of environmental pollution, the production of healthier foodstuffs and questions of occupational health of members and employees. However, these issues have been examined within their existing institutions and no separate organizational arrangements have been made.

At the international level the International Co-operative Agricultural Organisation and the International Co-operative Fisheries Organisation, both specialized bodies of ICA, promote food production and closer links between producer- and consumer-owned co-operatives.

7. <u>Consumer-owned wholesale and retail co-operatives</u>

In most countries where they operate this type of co-operative enterprise has a well-developed secondary and tertiary structure. In some instances this constitutes a single business structure, in other cases an organization representative of distinct primary and secondary level enterprises. These apex organizations have given strong support to involvement by this type of co-operative in securing from producers and processors supplies of safe and nutritionally appropriate, as well as engagement in the education of their members in healthy living.

At the international level, the International Consumer Cooperatives Organisation, a specialized body of ICA, actively promotes these national developments. The basic philosophy of this Organization, as determined in 1969, and reaffirmed in 1988, stipulates that the consumer has a right to a reasonable standard of nutrition, clothing and housing; adequate standards of safety and a healthy environment; unadulterated merchandise at fair prices with reasonable variety and choice; access to information on goods and to education on consumer topics; and an influence in the economy through democratic participation.

In a set of Consumer Cooperatives Guidelines adopted by the Organisation in March 1995 the responsibility of wholesale and retail co-operative enterprises to their member-users (who are also their member-owners) includes product and assortment quality, responding to the requirement for safety and health protection) as well as competitive prices, elaborated by means of a policy aimed at protecting purchasing power. With respect to responsibility toward the environment, the Guidelines stipulate that consumer-owned co-operatives should take action in the market in order to counteract the over-abundance produced by industrial societies, and to build a relationship with nature by using resources without destroying them, so as to set up an "ecocompatible form of development". <u>219</u>/

8. <u>Housing co-operatives</u>

In most countries where they exist, housing co-operatives have combined to establish tertiary organizations at the national level. At the international level the International Co-operative Housing Organisation is a specialized body of ICA.

Most national apex organizations promote and support efforts by their member co-operatives to extend the provision of shelter to a broader supply of services, including in most cases social care and "healthy living", and in an increasing number of instances preventive, family-oriented and community-based health services.

In a statement on housing co-operatives and the co-operative identity, adopted by the International Co-operative Housing Organisation in January 1996, the principles of housing co-operatives were set out. They include a commitment to service: they should strive to meet their members' needs for affordable, good quality housing, security of tenure, and safe, secure neighbourhoods. They should work to create environments where members give and receive support beyond their shelter needs and treat each other with respect and tolerance. While existing for the purpose of meeting their members' needs, housing co-operatives, being part of a larger community, and should contribute to improving the quality of life in their immediate neighbourhoods.220/

9. Co-operative enterprises providing health and social care benefits to members, employees and their dependents

It appears that in none of the numerous secondary or tertiary organizations formed by those co-operatives in each of a number of sectors, and which independently provide health and social care benefits, has there been established any specialist institutional arrangement for promoting and developing such provision - although undoubtedly the issue has been examined by many of them as one part of their concerns. Nor have any such secondary or tertiary organizations entered into any special arrangements with analogous organizations of health co-operatives. Only in a few cases have such arrangements been made at the local or sub-regional levels. In general, co-operative enterprises seek health and social care insurers as well as service providers according to their ability to satisfy their needs. They do not make significant distinctions between co-operative and non-cooperatively organized enterprises. Conversely, health co-operatives seek individual users without significant distinction between co-operators and others, and seek enterprise sponsored "enrolees" without significant distinction between co-operative and non-cooperative enterprises. Thus, there have been few deliberate attempts to emphasize the systematic development of arrangements within the co-operative movement.

C. Collaboration at the national level between all components of the co-operative movement having direct or indirect impact upon health and social well-being

1. The role of national co-operative apex organizations

In the **United States of America** the National Cooperative Business Association, as part of its mission to develop, advance and protect co-operative business enterprises, focused during 1995 on serving as an advocate for advancing the cooperative model in addressing social and economic needs. In this context, it expanded its support for cooperatives in the health sector in the belief that cooperatives of this type would help people throughout the country to save on health care. During 1994 the Association participated in the national debate on health care reform. In representations made before specialized committees of the federal legislative the Association argued

against the establishment of State-owned and operated agencies, with boards of directors appointed by state officials, but inappropriately termed "consumer purchasing cooperatives". The Association argued for recognition of the unique qualities of member-owned cooperatives in this as in other sectors. For those lobbying purposes the Association formed a National Coalition for Health Care Cooperatives.221/

2. Specialized co-operative organizations concerned with health and social care

There are no known cases where, at the national level, a tertiary co-operative organization has been established for the specific purpose of harmonizing the development of the three distinct types of co-operative directly and solely engaged in the health sector (health co-operatives, co-operative pharmacies and health sector support co-operatives), for the purposes of encouraging closer collaboration, including combined operations and use of each other's services.

3. Development of collaborative arrangements between co-operative organizations of different types

In a number of cases user-owned health co-operatives have reached agreements with other co-operative organizations whereby all their members have automatic access to the health co-operative's services. This was the case in **Panama**, in respect to a 5,000 member strong co-operative of educators; and in **Sri Lanka**, where many user-owned health co-operatives were set up specifically to provide services to members of co-operative enterprises. In **Japan**, health co-operatives within the agricultural co-operative movement, although originally distinct primary level enterprises, have become one among the set of secondary level co-operatives acting at the regional (prefectural) level and offering specialist services to these multi-functional co-operatives. In Japan also the links between the user-owned health co-operatives associated with the consumer co-operative movement and consumer co-operatives are close because of common membership, and organizational links at the regional (prefectural) and national levels.

A few cases are known of collaboration between co-operative insurance enterprises which offer health insurance products to their own policy-holding members and their dependants and health co-operatives. In **Malaysia**, the Co-operative Insurance Society Ltd. (MCIS) has participated in the development of the comprehensive co-operative health care system, KOHISAT, which includes also the provider-owned health co-operative operating at the secondary level (KDM), and agricultural and other co-operative movements on behalf of their members, who constitute the users of the system. The Government's agency responsible for co-operatives has actively supported the development of this national system. In **Colombia**, the co-operative insurance enterprise Seguros La Equidad has taken the lead in establishing a new enterprise, Saludcoop, which links itself with provider-owned health co-operatives, and other co-operatives and trade unions representing their members who will constitute the users of the co-operative health system. 222/ In **Brazil**, the Unimed system has developed its own health insurance subsidiary, Unimed Aseguradora.

The new health insurance company based on managed care (Unisalute), set up in **Italy** in 1995 by Unipol Assicurazioni, aimed at a comprehensive co-operative movement approach. Unisalute's mission would be that of supplementing the services that the public system was unable to provide, because of lack of equipment or outdated organization, through a network of contracted health-care service providers (clinics, diagnostic centres, individual doctors, and dentists). Over the last few years there had been a progressive cut-back in the number and quality of services offered to citizens free of charge by the Italian Health System. In these circumstances Unisalute had been contacting all the social groups that had a stake in the social

economy. The Unipol Group had always striven to ensure, as far as possible, the participation in its companies of representative trade unions, co-operatives and savings banks, as well as important Italian and international economic and social institutions. Contacts were in progress with co-operative banks, savings banks, other Italian and European mutual insurance companies, and with international information technology suppliers.223/

In **Belgium** the pharmacy group "Multipharma", which employs 1,380 persons, is an integral member of the co-operative insurance group P&V, owned by co-operatives, mutual organizations and trade unions.

In **Sweden** housing co-operatives are interested in health matters, and it has been from a housing/community development base (with support also from a national level co-operative insurance enterprise) that the Medikoop project and the cooperativization of local public health services has developed. This is still a localized experiment, and appears to have lost its initial momentum, but has a potential for national level collaboration between housing, insurance and health co-operative organizations.

As provider-owned health co-operatives are a form of worker co-operative, the possibility exists of support from the relevant regional or national apex general organization of worker co-operatives. However, the only known case is in **Spain**, and involves the membership and active participation of the Madrid based CES.S COOP in the regional Workers' Co-operatives Union (UCMTA). In the **United Kingdom** the Industrial Common Ownership Movement (ICOM) constitutes the tertiary organization for worker-owned co-operatives.

4. Support from general co-operative development organizations

In **Sweden** a network of co-operative development centres was established in the early 1990s, at least one of which, that at Gotaborg, has been particularly interested in promoting health and social care co-operatives. 225/

In the **United Kingdom**, since the early 1980s a network of local co-operative development agencies has strongly supported social employment co-operatives, thereby assisting disadvantaged and excluded persons to integrate with the economy.226/

D. Development of strategic alliances with other stakeholders

1. With trade unions

Co-operative organizations involved in health and social care developed in many cases as a result of broad movements in which, for example, trade unions and mutual organizations were also involved. Operational collaboration still exists in a number of countries. For example, in the United States the Amalgamated Life Insurance Company provides health care utilisation management and cost containment services to a number of trade unions and employers.

2. With other not-for-profit organizations

Co-operatives are beginning to form operational alliances also with other non-profit organizations in the health and social care sectors. For example, Amalgamated Life Insurance Company in the United States has expanded from its trade union base by alliances with the Oxford Health Plan whereby its group life products are sold with that Plan's group health product, thereby giving access to a highly developed distribution system for group insurance. 227/

3. With voluntary organizations and individual volunteers

In Italy social care and social training co-operatives have made innovative contributions to the formulation of partnerships between co-operatives, individual volunteers and voluntary organizations. In some cases volunteers complement the activities of paid employees, expanding the available labour force. In other cases they perform entrepreneurial or managerial functions, either in the absence of salaried employees, or as a means to transfer experience gained in other sectors because the persons concerned, or the communities in which they live, perceive social co-operatives to be an important means whereby broad objectives for social care may be achieved, and deserve therefore additional support. Volunteers may also act as representatives of the local community, or of clients and their associations, on the directorates of such co-operatives. Finally, they may act to represent the co-operative itself before local, regional or national authorities, or with other stakeholders.

Volunteers - or, more specifically, individuals in the community with a commitment to improving social care - have been instrumental in the establishment of many social care co-operatives. Many have applied entrepreneurial experience gained elsewhere to the task of setting up such co-operatives as a means to deal with a social problem with which they are engaged. The community-based values, solidarity, and engagement with the disadvantaged made available by these volunteers have served to strengthen the intrinsic qualities of co-operative enterprise. Their continued presence as voluntary advisers and supporters has been a significant resource. 228/

4. With local communities

Co-operative enterprises, by principle, are active elements of the communities in which they operate - their members and their dependants live there, and have numerous other functions which form part of the totality of activity of members of the community. In many ways they contribute to the "social health" of the community in ways which most public sector, private for-profit and even other not-for-profit enterprises are unable to do.

To a certain extent health and social care co-operatives are an expression of forms of community organization over and above such relationships. In Italy in particular, the rapidly expanding social care co-operative sector is perceived as a new means whereby the community as a living entity is able to organize to deal effectively with problems which other institutional structures have been unable to resolve. They are acknowledged to constitute organizational structures for advancing the common good.

E. Development of comprehensive national strategies for engagement by the co-operative movement in the health and social well-being sector

This global review, although focusing upon co-operative enterprises directly engaged in the health and social care sectors, including co-operative insurance enterprises, has included consideration of the contributions of other co-operatively organized sectors, notably those in agricultural and fisheries production, wholesale and retail distribution, and housing and community development. In later chapters it will examine the nature of a comprehensive and coordinated engagement by all relevant sectors of the co-operative movement in trying to improve health and social care.

As far as is known, only in a few countries have there been moves toward such a comprehensive and strategic approach. However, in a number of countries partial or exploratory steps have been taken. In Japan, the consumer-owned health co-operative movement has lobbied for a substantial revision of national health policies. In Sweden housing and insurance co-operatives have explored with local government authorities the possibility of a community-based comprehensive health and social care service. In the United

Kingdom, where a Co-operative Party is represented in the national legislature, a member of the party, Mr. Alf Morris, M.P. who was also President of the 1995 Co-operative Congress, launched an initiative, in collaboration with the Co-operative Bank, at the co-operative national Congress that attempts should be made to develop a comprehensive co-operative health and social care system involving service delivery co-operatives and co-operative insurers. In response to this initiative a number of suggestions have been made. He called for the co-operative movement to establish a "self-help, not-for-profit, co-operative caring sector". 229/

F. Development of institutional collaboration and strategy formulation within the international co-operative movement

1. Institutional collaboration

(a) Existing institutional structures

The fact that provider-owned health co-operatives are a type of worker-owned co-operative enterprise is reflected in the inclusion of relevant specialized departments within some regional, national and international representative organizations of this type of co-operative. For example, the European Committee of Workers' Co-operatives (Comité européen des coopératives de production et de travail associé: CECOP), which in 1992 represented about 50,000 co-operatives in 12 European countries with 1,000,000 individual members, has a Department of Social Cooperatives. Where worker-owned (provider-owned) health co-operatives are numerous within a country, the national or regional apex organization may have a unit or department responsible for health co-operatives, as is the case in Catalonia, Spain.230/ A Confederation of European Firms, Employment Initiatives and Co-operatives for Psychically Disabled (CEFEC Confederation) began activities in 1987. 231/

The International Organization of Industrial, Artisanal and Service Producers' Co-operatives, a specialized organization of the ICA, does not have a special component responsible for provider-owned health and social care co-operatives. Organizations representing consumer co-operatives, and those representing housing co-operatives, at international levels have made no special institutional arrangements for supporting or representing user-owned health or social care co-operatives.

(b) Initial regional and global meetings

The first formal interregional or global exchanges of experience and views were organized by the Japanese health co-operative movement. From November 1991 to January 1992 a group from the Medical Co-op Committee of JCCU undertook the first international study tour in the health co-operative sector. It visited eight countries (India, Sri Lanka and Malaysia; Sweden, Italy and Spain; Canada and the United States).

Partly on the basis of contacts made during this study tour, and jointly with the National Welfare Federation of Agricultural Co-ops, the Medical Co-op Committee organized the first global meeting, entitled International Health - Medical Co-operative Forum, at the time of the ICA's Thirtieth Congress in Tokyo in 1992. At the ICA Centennial Congress held in Manchester, United Kingdom in September 1995, a second global meeting was held, organized by the ICA Secretariat, entitled International Co-operative Health and Social Care Forum.

Following the First International Co-operative Health Forum held in 1992, the Medical Co-op committee of the Japanese Consumers' Co-operative Union (JCCU) actively promoted international contacts within Asia. In October 1993 it sent study groups to four Asian countries. In collaboration with the

National Co-operative Council in Sri Lanka, it organized the First Asian Co-operative Health Meeting, held in Colombo in April 1994. Forty-one participants from four Asian countries and from the ICA Regional Office for Asia and the Pacific attended, and 15 reports were presented. Participants appealed to all health cooperatives in Asia to promote actively the exchange of experience and to develop solidarity within the health co-operative movement. It was agreed that the Medical Co-op Committee of JCCU would continue to promote exchanges and other collaboration among health co-operatives in the region, and that a Second Asian Co-operative Health Meeting would be held in India in 1996.

In March 1995 a delegation of the Medical Co-op Committee of JCCU participated in the Open Forum on Cooperatives and the World Social Summit for Social Development, held at Copenhagen, and organized by the Committee for the Promotion and Advancement of Co-operatives (COPAC). In June 1995, a first Interamerican Forum on Co-operative Health Care and Related Services was held at Sao Paulo, Brazil, organized by Unimed do Brasil. Its purpose was to delineate guidelines for establishment of an ICA specialized body. 232/

(c) Establishment of the International Health Co-operative Organization (IHCO)

In 1994, Dr. José Espriu who had led the process of health co-operative development in Spain, proposed, in an article published in ICA's Review of International Co-operation, that ICA establish a specialized body for the health and social care co-operative sector. This was discussed at the International Forum held in September 1995 and a number of proposals made. Subsequent developments have been concerned with health, but not social care, co-operatives.

An ICA Health Steering Committee led by Dr. Shoji Kato, Chairman of the Medical Co-op Committee of JCCU, held its first meeting at ICA Headquarters on 29 and 30 January 1996. The Committee examined two drafts of the rules of a new ICA Specialized Organization for health sector cooperatives, one prepared by the Medical Co-op Committee of JCCU, representative of user-owned health co-operatives, and one by Unimed do Brasil, representative of provider-owned health co-operatives. A common text of the draft rules was largely completed.

The Steering Committee agreed that the new specialized organization was to be named the International Health Co-operative Organisation (IHCO). It was to function as a forum for consumer and producer health co-operatives which sought to provide high-quality, cost-effective community health care based on freedom of choice, integration of services, and ethical working conditions. Its objectives were: (a) to provide a forum for discussion and exchange of information on issues of relevance to its member organizations; (b) to provide information to United Nations bodies, national governments, the media and the public about the nature and role of health co-operatives; (c) to promote the development of health co-operatives; and (d) to collaborate with other Specialized Organizations of the ICA.

Membership of the Organization was to be open to those co-operative organizations affiliated directly or indirectly to ICA which had as their main or partial objective the provision of health care to their members or the provision of self-employment for health professionals. Educational and research institutions which promoted health co-operatives or related services and which were direct or indirect members of ICA were also eligible for membership. Associate membership status was available for co-operatives which were non-members of ICA but whose activities were devoted to the provision of health services. Both members and associate members would normally be national or regional organizations (i.e. not individual primary or secondary level co-operative enterprises)., except in countries where those structures did not exist.

The Committee decided to accept the offer of the Fundacion Espriu to host a second meeting, which would be held in Barcelona, Spain in April 1996. This considered action plans at global and regional levels as well as the structure of the Secretariat. 233/

There has been no similar global development in respect to co-operatives which function in the area of social care alone.

(d) Developments within the International Co-operative and Mutual Insurance Federation (ICMIF)

The Federation, whose members comprise 170 co-operative and mutual insurance enterprises, held as part of its 1995 Annual Conference a seminar on opportunities for co-operative and mutual insurers in the provision of social welfare, particularly retirement pensions and health care.234/

The Federation established in 1995 an Insurance Intelligence Group, made up of representatives of member organizations in various markets, and responsible for monitoring developments and identifying issues and topics which appeared to require further research and development by members. At a meeting of this Group held in January 1996 it was decided that within its work programme there should be included a priority research project entitled "Social security and health care: tailor made insurance products to fill the gap in social security". A project report would be transmitted to the ICMIF Conference to be held in 1997 in Puerto Rico. In February 1996 the Chief Executive Officer of the Federation and interested members of the Insurance Intelligence Group reviewed the first draft of the present global review and made substantial comments. 235/

2. Formulation of comprehensive strategies by the international co-operative movement

Discussion at the recent international meetings has been concerned with health co-operatives alone. Co-operative insurance enterprises have been more interested in alliances with other co-operative organizations. While considerations in both areas have been relevant to the formulation of comprehensive international and national strategies, and have included proposals which could form important components of such strategies, none has been formulated as yet in a comprehensive and formal manner as a result of this debate. Moreover, discussion has been concerned primarily with health co-operatives themselves, with some extension to the role of co-operative insurance enterprises, but with only occasional mention of the involvement of co-operatives in other sectors, including producer-owned agricultural and fisheries marketing and consumer-owned retail co-operative movements.

3. Technical assistance within the co-operative movement

(a) Movement-to-movement assistance by health, social care and insurance co-operatives

Support by the international co-operative movement for the development of an enhanced impact by the co-operative movement on health and social well-being, whether in the form of financial, material or organizational assistance, would appear to be clearly beneficial. Recent study tours and regional and global meetings have certainly made possible for the first time the identification of "best practices" in specific societal conditions. At the same time the diversity of co-operative forms of response to those conditions has become apparent. However, these exchanges of experience have not yet developed into regular programmes of technical assistance. There is no evidence of the better developed health co-operatives, except those in Brazil, providing regular programmes of assistance to health co-operatives elsewhere, although *ad hoc* assistance has sometimes been provided, for

example, by the Japanese movement, which has provided hospital equipment to a health co-operative in Sri Lanka.

Moreover, some exchange of experience at the regional level is known to have promoted an interest in health cooperatives. For example, in Latin America, the provider-owned co-operative COOPASI in Panama benefitted from information about a similar co-operative in Colombia, as well as from the support of the Gabinete de Estudios y Promocion del Cooperativisimo Sanitario in Spain. Unimed do Brasil has reported interest in its experience among other Latin American countries. Its International Department, in addition to developing operational agreements with doctors in Argentina and Uruguay to provide services to Unimed clients, has promoted partnerships with co-operative health organizations in the "Merconorte" countries (Bolivia, Chile, Colombia, Ecuador, Peru and Venezuela). In some cases it has invested capital in co-operatives elsewhere. It has encouraged and supported the establishment of the Femec health co-operative in Colombia, and works in partnership with it and another health co-operative enterprise, Unimec. Certain of Unimed's specialist seminars have been attended by representatives from Argentina, Chile and Paraguay. In June 1995 the Department organized, in collaboration with the ICA, the First Interamerican Forum on Co-operative Health Care and Related Services, held in Guarulhos, in the State of Sao Paolo.

The Saskatchewan health co-operative movement is known to have studied United States experience. From November 1990 to February 1991 specialists from the Swedish Co-operative Institute, the co-operative insurance Folksam Group and the Union of Housing Co-operatives (HSB-Riksforbund), then engaged in development of the model for consumer-owned co-operative health care centres "Medikoop", undertook a study tour of Canadian health co-operatives. In Asia health co-operatives in India and Sri Lanka have been encouraged by visits made to them by the Medical Co-op Committee of JCCU. This Committee has also played an important role in making first external contacts with health cooperatives in Myanmar, Mongolia, Republic of Korea and Philippines, bringing them into the growing international movement.

Although technical assistance in the form of financial or staff transfers has not become frequent, study tours have taken place with positive results. For example, the provider-owned Co-operative Home Care Associates of New York was studied in the early 1990s by a group of co-operative leaders from the Kanagawa consumers' co-operative in Japan who, upon their return sponsored a similar co-operative home care programme which resulted in the establishment of a considerable number of worker-owned home health and social care to elderly members. 236/ The Canadian co-operative movement has supported the ACOGIPRI co-operative engaged in the rehabilitation of persons with disabilities, in El Salvador.237/

Transitional economies have received considerable assistance from co-operative organizations in the developed market economies and some has been in the health sector. For example, in 1991 the Belgian co-operative pharmacy organization Office des Pharmacies Co-operatives de Belgique (OPHACO) and the national co-operative organization (FEBECOOP) reached an agreement with the national co-operative organization of the then Czechoslovakia to set up a co-operative pharmacy in Prague in order to provide consumers with reliable and reasonably priced products. If the pilot project succeeded it was to be taken up elsewhere in the country and in other transitional economies: by 1995 two such enterprises already operated, and others were being planned. In 1992 OPHACO organized a two-month programme of training in pharmacy management in the Czech Republic, financed by the EEC PHARE programme. It has been reported that interested parties in Latvia have examined the Unimed model.

Informal contacts have taken place between the co-operative insurance enterprises offering health insurance in Latin America (those in Colombia, Ecuador and Puerto Rico). 238/

(b) Assistance by international co-operative organizations to health and social care and insurance co-operatives

The ICA organized the International Co-operative Health and Social Care Forum held at Manchester in September 1995, and has supported the work of the Steering Group engaged in exploring the possibility of setting up an ICA specialized body for the health and social care sectors. During 1995 and 1996 it collaborated closely with the United Nations in the preparation of the present global review.

The Regional Office for Central America and the Caribbean (now the Regional Office for the Americas) of ICA has administered a project on "Co-operatives and Health Service Provision" in partnership with the International Research and Development Centre IRDC (Canada), the International Centre for Health Care Research and Counselling (Costa Rica) and participating organizations in the project countries. The project involves the preparation of a study on the health care system in 10 countries: Belize, Costa Rica, Dominican Republic, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama and Puerto Rico. The experience of co-operatives in the provision of health care is to be studied, and co-operatives interested in providing health care identified. Alternatives to the present system of health care provision are to be defined and strategies for their implementation elaborated. The goal of the project is to demonstrate to both governmental health care authorities and co-operators that co-operatives can provide adequate health care services and should be considered alternatives to present health care systems.239/

The ICA Regional Office for West Africa began late in 1995 to provide training in co-operative management to the recently established provider-owned health co-operatives in Benin. Here international co-operative organizations (ICA through its Regional Office for West Africa), a developed country non-governmental organization (Wereldsolidarieteit in Belgium), ILO, UNDP and the World Bank have joined with national co-operative organizations and other social economy organizations (Benin Credit Mutuel, Fédération Générale des Travailleurs) and the Government to support the development of a proto-type system of provider-owned health co-operatives operating at the primary level.240/

The Confederacion Latinoamericana de Cooperativas y Mutuales de Trabajadores (COLACOT) is collaborating with the ILO in support of primary health co-operative development in Bolivia.241/

The contributions of all types of co-operative enterprise to the alleviation or prevention of poverty is in itself probably the most significant means whereby the movement can make an impact upon health and social well-being. The health and social care objective, while acknowledged, is considered but one of the indirect benefits of improvement in the overall material and social well-being of the affected community. In some cases, however, the formation of co-operatives which will reduce poverty and protect members and their communities from economic risk, has been designed specifically as a means to improve health. For example, ICA supported this development: in northern Zambia, in collaboration with WHO. The purpose is to investigate whether or not the setting up of co-operative enterprises might be an effective means whereby migratory women fish traders will be better able to protect themselves from HIV transmission.

Technical assistance between those co-operative insurance enterprises providing health insurance products is already substantial. It could be made available to others in their regions of operation, or by means of existing working relationships. For example, in Asia the Malaysian Co-operative Insurance Company, NTUC INCOME of Singapore and the two organizations (of agricultural producers and of fishery enterprises) in the Republic of Korea, might be able to assist others in the region. The Desjardins-Laurentian Life

Group Inc., in Canada, would be able to assist Francophone enterprises. The Co-operators Group and the CUMIS Group in Canada, the Co-operative Insurance Society Ltd. in the United Kingdom, Amalgamated Life Insurance Company, CUNA Mutual Insurance Group and the Nationwide Insurance Enterprise in the United States, as well as Lagun Aro and Unipol in Spain and Italy would also appear to be in a position to assist.

The recent establishment of the ICMIF Insurance Intelligence Group, which has identified social security and health insurance as a priority area for information exchange, is an important step toward a full programme of technical assistance in the health insurance area.

F. Positions of governments

1. Policy statements

At a celebratory event held in January 1995 at the Royal Norwegian Society for Rural Development the Norwegian Minister of Finance, Mr. Sigbjorn Johnsen, told participants that he considered that the co-operative form of organization of enterprise was not out-dated, but could develop further through new roles in local communities and in health care (as well as in transportation). 242/

In the United Kingdom, the United Kingdom Co-operative Council has persuaded the Government's Department of Health to fund a study of "The Potential Contribution of the Co-operative Movement and Community Well-being Centres to "Health of the Nation" Activities". The Chairman and the Chief Executive of the Co-operative Council formed part of the Steering Group set up by the Department to supervise the study. This expression of interest has been considered by the Co-operative Council to be of major significance for the future of the engagement by the cooperative movement in the health sector. 243/

In Quebec, Canada, the Provincial Government has for the first time authorized the establishment of a user-owned health co-operative intended to provide employment for health professionals (Sainte-Etienne de gres). This was considered by specialists in Quebec to be a significant shift in policy. 244/

In 1995 the International Labour Organization reported that governments of many central and eastern European countries consider that social service provision by mutual enterprises or associations are a significant means of replacement for the social security nets which disappeared in the process of transition from socialist regimes. 245/

2. Supportive activities and development of partnerships

In Costa Rica the Government has in recent years sponsored several experiments in health service delivery featuring contractual arrangements between the Social Security Bureau (responsible for hospital and medical care - the Ministry of Health being responsible for health promotion and disease prevention) and provider-owned co-operatives. A first attempt was that involving the formation of a co-operative form of operation of the Integrated Clinic located at Pavas. More recently the Social Security Bureau made an contractual arrangement with a provider-owned co-operative, COOPESAIN, serving Tibas, a community of about 50,000 inhabitants adjacent to San José. Members included a full range of professional, technical and administrative personnel, many previously employed in the public sector. The co-operative opened in January 1990. 246/

In Japan in 1951 the Government designated the National Welfare Federation of Agricultural Co-operatives, the apex organization of the user-owned health co-operative movement associated with the system of multi-functional agricultural co-operatives, as one of a number of organizations responsible for implementing public health programmes in rural areas.

In Sri Lanka user-owned health co-operatives were acknowledged as partners with the public sector system. They received Government subsidies in order to provide free services to members of all co-operatives in their district. In many cases the doctors with whom they had contracts were primarily employed in the public sector.

In the United States during the 1930s and early 1940s the Federal Government introduced a rural health programme as part of the programme to combat rural poverty undertaken by the Farm Security Administration. Agricultural supply and marketing co-operatives were promoted, as well as genuine health co-operatives, in addition to community-based health associations which were not fully co-operative in organization.

G. Position of intergovernmental organizations

The United Nations General Assembly, and recent international conferences held under its auspices, including the World Summit for Social Development, the Fourth World Conference on Women: Action for Equality, Development and Peace, as well as the three sessions of the preparatory committee for the United Nations Conference on Human Settlements (Habitat II), have identified the international co-operative movement as a distinct partner in the task of carrying out a participatory and community-based approach to contemporary societal problems (see Preface). Pursuant to the decisions reached by them the United Nations Department for Policy Coordination and Sustainable Development has supported further engagement by the co-operative movement in health and social care by preparing the present report in close collaboration with ICA.247/

As part of "an Inter-regional Programme as Follow-up of the World Summit for Social Development" the Cooperative Branch of the **International Labour Organization** has begun a pilot phase, to last during 1996-1997, of a Programme on the "Promotion of Social Services through Social Economy". This would concentrate on implementing technical cooperation activities complementary to, and synergetic with, the activities of other organizations promoting mutual social service systems. Through case studies, pilot activities and feed back from programme partners, the programme would gain the field experience necessary to build a theoretical foundation for the promotion of mutual aid groups. The Cooperative Branch would have a number of functions: an observatory of organizations involved in non-traditional social service systems; focal point for the network of such organizations; technical service centre to produce and disseminate information and training material on and for mutual aid groups, and to provide advisory services in this field; initiator of pilot activities in collaboration with ongoing ILO projects and programme partners; technical backstopping unit for such projects; and policy and legal advisor to Governments of the countries in which the programme was to operate.

ILO would collaborate closely with a Belgian non-governmental organization, World Solidarity (Wereldsolidariteit - WSM), with which it has worked for many years in this area. WSM and the Belgian Government would fund the Programme, at least during its pilot phase. The Programme would include in its pilot phase support to health co-operatives in Benin, and to primary health care organized through cooperatives and mutual groups in Bolivia (including COLACOT, CRISOL and the Confederation of Workers).

ILO already supports the engagement by co-operative enterprises and organizations in the health and social care sectors. As part of the Programme to Support Self-Reliance of Indigenous and Tribal Communities through Co-operatives and other Self-help Organizations (INDISCO) its Cooperative Branch supports provision of basic health services and promotion of mutual aid for indigenous and tribal peoples through pilot projects in India and the Philippines. As part of a programme of co-operative development in Haiti it supports the organization of community pharmacies and mutual insurance. In Niger it supports the establishment of ten village pharmacies managed by local co-operatives. As part of a small industrial co-operatives project in the United Republic of Tanzania it supports health protection for informal sector workers through five co-operatives and associations formed by them. Within its PRODERE programme in Latin America it supports the development of funeral co-operatives, as well as local primary health care systems, in ten countries.

Together with WSM, its Belgian partner, the ILO has programmes of support for health service mutual assistance organizations in a number of Francophone countries in Africa: Benin, Burkina Faso, Chad, Cote d'Ivoire, Mali, Senegal, Togo and Zaire. A similar programme of support for health service mutual organizations in Latin America includes as a third partner COLACOT (Confederacion Latinoamericana de Cooperativas y Mutuales de Trabajadores, whose headquarters are in Colombia). 248/

The **World Health Organization** (WHO) has adopted objectives which coincide very closely with those characteristic of co-operatives in the health and social care sectors: broad emphasis upon healthy living, preventive programmes, and participation by individuals and communities. In May 1977 the World Federation of Public Health Associations, a non-governmental organization, accepted an invitation from the World Health Organization and UNICEF to develop a position paper representing views of non-governmental organizations concerning primary health care for presentation at the International Conference on Primary Health Care to be held in September 1978 in Alma-Ata, Kazakhstan. The World Federation presented a position paper which synthesized the positions of large numbers of interested organizations, consulted by it during 1977 and 1978. In this paper it stated that "Ample opportunities for a self-sustaining style of health care can be realized by relating the health care system to other community development programmes, such as fishing and farming co-operatives, credit unions and insurance schemes."

WHO was engaged in 1992 in two relevant lines of action within its programme of technical and economic support to countries and communities in greatest need, including the least developed countries. Both were designed to strengthen enterprise at the local level. One approach included experiments in the more effective utilization of health personnel through innovative local non-governmental organizations, especially co-operatives. The second approach was to identify those cooperatives (as one type of local developmental organization) having an appropriate managerial capacity and to ascertain their interest in including some health components within their current activities. In respect to the first approach, WHO has joined with UNDP and the World Bank in support of the establishment by recently graduated but unemployed health professionals of provider-owned community health co-operatives in Benin. In respect to the second approach, WHO considered that co-operatives of all types were a potentially useful organizational form for the promotion of health and for the extension of health services, at a minimum to their own members and their families. As employment and income generating enterprises they had the potential for financing and managing their own health care development. Therefore, it considered the question worth exploring of what cooperatives could do for the development of their own health services. In addition co-operatives could be used as entry points or springboards for participatory and self-reliant health development in the areas in which they operated - particularly in communities still without adequate health services.

On this basis WHO has collaborated with ICA in exploring the possibility of reducing risk of HIV infection among women engaged in fish processing and marketing in Zambia by means of supporting their economic empowerment through co-operatives. A representative of WHO, responsible for this project, participated in the International Health and Social Care Forum held at Manchester in September 1995.249/

The United Nations Development Programme (UNDP) and the World Bank have joined with WHO in supporting provider-owned health co-operative development in Benin. The United Nations Educational Scientific and Cultural Organization (UNESCO) has supported the ACOGIPRI co-operative, engaged in rehabilitation of young persons with disabilities, in El Salvador.250/

VII. DETERMINANTS OF THE EXTENT TO WHICH CO-OPERATIVE ENTERPRISE ENGAGES DIRECTLY IN THE HEALTH AND SOCIAL CARE SECTORS

A. Accumulated relevance of principal determinants

The distribution by country of the principal types of co-operative enterprise directly engaged in health care, shown in Table 1 reveals an uneven presence in a relatively small number of countries. Certain geographical clusters are apparent and they seem to relate rather generally to broad types of societal condition. Engagement in social care is not included, as the review of this area was intended to be illustrative and not comprehensive.

Indeed, examination in Chapters II, III and IV of the evolution of co-operatively organized enterprise in the health and social care sectors has suggested that certain societal environments appear to have been more conducive than others to their initial appearance and subsequent successful development. In some societies co-operatively organized activity has experienced rapid expansion: elsewhere progress has been slow, and in many countries there is still no such presence. In some countries a variety of types of co-operative enterprise has appeared in the health and social care sector: elsewhere only a restricted number out of the possible types of such enterprises is present.

Moreover, in some of the societies where co-operative enterprises are engaged in health and social care, there is already an energetic collaboration between the different types of co-operative already engaged, and even, in a few countries, initial moves toward establishment of a "co-operative system" of health and social care. Elsewhere, there appear to be few interactions between locationally and operationally isolated co-health and social care operatives.

It is appropriate at this point to attempt to identify the factors which appear to be responsible for this uneven development. In particular, it is necessary to examine how such factors, some favourable, others unfavourable, combine in each type of societal condition to determine whether or not co-operative enterprises are able to operate effectively in the health and social care sector. Only with a better understanding, however partial and tentative this may be, of the relevance of societal environments, as well as of internal operational characteristics, will it be possible to suggest what might be the potential of co-operatives in this sector in each of a number of specific societal circumstances, and what might be the most effective means whereby this potential might be realized.

The following appear to be the most important of the determinants of the extent to which co-operative enterprises have become - and are likely to become in the future - directly engaged in the health and social care sector. They are identified in a sequence whereby an unfavourable condition in each narrows the environment available to successful co-operative engagement already permitted by those preceding:

- the **extent of public sector responsibility** for the provision of insurance coverage for health and social care purposes, and, separately, for the delivery of health and social care services, to all individuals within national society, and the extent to which responsibility is translated into effective provision. This determines the "space" or available market share within which it is possible for co-operatively organized enterprises (as one

among the various types of non-public enterprise) to attempt to set themselves up and operate effectively.

- given that some space is available for engagement by non-public enterprise in health and social care, then the next determinant is that of the **policy position of the government in respect to the appropriateness of co-operatively organized enterprise.** That policy position rests upon the broad perception held by government (understood to include separately the possibly different views held by policy-makers in the legislature and in relevant ministries and public agencies, existing legislation, as well as actual bureaucratic practices) firstly of co-operative enterprise of any type, and secondly of co-operative enterprise applied within the health and social care sector.

This perception may be neutral, unfavourable or favourable. The policy which is adopted on the basis of a favourable perception may vary from a neutral permissiveness to a strong active support. If perceptions are neutral, the most favourable policy position is likely to be neutral also: certainly not strongly active. Indeed, because of insufficient interest, previously existing negative legislation and practices might be allowed to continue. If perceptions are negative, it can be expected that policy positions will also be negative.

Moreover, both perceptions and policies concerning current and possible future engagement by co-operatives in the health and social sector will vary according to whether or not there exists already a significant co-operative presence in these sectors, established prior to adoption of current policies. For example, if such co-operatives are well established, it may not be thought worth-while to translate even unfavourable perceptions into negative policies, or to energetically implement such policies even if adopted. Even if perceptions are generally favourable, if no such co-operatives as yet exist, the political energy required to adopt legislation or to implement supportive actions needed for innovation and experimentation might be insufficient to overcome inertia. However, if already established, their support and expansion as an expression of favourable perceptions is likely to be easier.

- given that not only is space available for co-operative engagement in health and social care, but that governmental policy, legislation and administrative practice are at least neutral, and at best positive, then the next determinant is that of individual **citizen's perceptions of co-operative enterprise as an appropriate means** whereby they can secure that part of either health and social insurance or the delivery of health and social care services not made available to them in fact by the public sector. These perceptions depend to a considerable extent on whether the individuals and communities concerned are familiar with co-operative values and principles, and are perhaps themselves already members of co-operatives operating in other sectors. If they are familiar with co-operative forms of enterprise in other areas of activity, then the application of the same approach to health and social care insurance and service delivery is not likely to be so difficult a step to take. However, even if they are predisposed toward some form of mutual aid, in preference to reliance on public sector, private-for-profit sector or philanthropic sources, they may be more familiar with types of mutual assistance different to some extent from co-operatives - such as "friendly societies" and other types of mutual association, including organizations operated as subsidiaries or affiliates of, for example, trade unions. Thus recognition of the value of mutual aid in these areas need not be expressed as support for co-operative enterprise.

- given that market space is available, official policies are not unfavourable and the individuals and communities concerned are familiar with co-operative forms of enterprise, then the next determinant is that of **the perception held by the co-operative movement itself of engagement by health**

and social care co-operatives in these sectors. This can be considered to be an initial determinant of whether **relevant and sufficient organizational energies** will be made available by other co-operative enterprises and organizations to the group or community, which is already disposed to a co-operative solution, so that they may be able to take the necessary initiatives to set up a co-operative enterprise in health or social care and then to manage such a co-operative during the early phases of its operation. It is not automatically the case that existing co-operative organizations will be interested in providing energetic support to a new area of co-operative enterprise: they may be fully engaged in pursuing their own interests. Of crucial importance is, firstly, whether or not there exist in local co-operative organizations individuals capable of acting as initiators, catalysts and supporters, and secondly, whether or not existing co-operative enterprises and organizations, including both sectoral and general national apex organizations, are interested not only in promoting the concept of health and social co-operatives, but of providing active support, including **making available capital**, particularly during the initial stages of their establishment.

- at the same time that the above determinant becomes relevant to whether or not a potential for organization of health and social care co-operatives is likely in fact to be realized, other determinants become relevant, including the **perceptions and positions taken by other stakeholders** in health and social care. These include **organizations in which the concerned individuals may be part** - such as trade unions, organizations of self-employed persons such as farmers' organizations, other professional associations, consumers' associations, and organizations representing women, young persons, the elderly, persons with disabilities and other interest groups for which the quality and quantity of health and social care insurance and service delivery is particularly significant. If these organizations perceive co-operative enterprises to be a form of organization whereby their needs can be met effectively, they are likely either to support those set up by others in the same communities, or to sponsor their own co-operative enterprises.

- also at the same time that the above two groups of determinants become relevant are the **perceptions and policy positions of health and social care professionals**, other than those employed by or otherwise affiliated with governments and co-operatively organized enterprises themselves: that is health and social care professionals, either self-employed or employed by private enterprises (whether for-profit or non-profit), and their associations, as well as private for-profit enterprises engaged in various aspects of the health and social care sector, such as ownership and hospital management, pharmaceutical manufacture, supply of other goods and services, and insurance. Such perceptions and positions are not likely to be monolithic, given the variety of types of individual, association or enterprise and their own multiple interests. They may be favourable to co-operative engagement by **users**, or neutral or (and more frequently) unfavourable, even actively opposed. In the latter case the significance of their opposition depends upon the extent to which it can be translated into market occupation - which depends on many factors, including the possible preference of co-operators for their own type of enterprise, and the support provided to co-operatives in health and social care by the broader co-operative movement. It depends also on their success in influencing governmental policy. Moreover, in effect, it is the sum of their separate influences, some favourable, other not, especially in respect to their influence on governmental policy and consumer awareness, that determines the likelihood of co-operative success.

- there are likely also to be **perceptions and positions** taken by other stakeholders in society - particularly relevant being those **of employers** (with a probable distinction between those who are small- and medium-scale employers and those who are large-scale employers), given that they may be responsible

for some part of the national system of health and social care insurance (and to a lesser extent, service delivery) in respect to their labour force. They may perceive co-operative enterprise to be an effective partner in discharging their obligations, particularly if such enterprises are able to meet their preference for keeping costs lower than those offered by alternatives.

- finally, if the combination of all the different environmental determinants is, in aggregate, favourable, then a number of **technical and organizational determinants** become relevant, including, for example, the availability of capital, and the availability of technical and managerial personnel familiar with operation of co-operative types of enterprise. Of relevance to whether or not these are significant or not is a factor already having had an influence, that is the extent to which co-operative enterprises and organizations are present in the same community, and are actively supportive of health and social care co-operatives.

B. Detailed aspects of principal determinants

Having emphasized the fact that it is the combination of relevant factors, rather than a single determinant that determines the degree and success of the aggregate environment for co-operative engagement in health and social care, it is now useful to look in greater detail at the nature of each of these determinants.

1. Extent of public sector responsibility and effectiveness of public services

One of the primary determinants is the nature of the real (as opposed to the intended) contribution of the public sector. A basic distinction can be made between national systems which are "Bismarkian" in nature, that is where the public sector contribution consists of provision of social insurance, limiting thereby private sector insurance provision, delivery of services themselves being left to the non-public sector, and those which are "Beveridgean" in nature, that is where the public sector contribution is based upon delivery of services, limiting thereby service provision by the non-public sector, insurance being covered by the public budget.

Where the situation is "Bismarkian" and structured in such a way that it is intended that the public sector be complemented by the private sector, there is some scope for co-operative enterprise engagement in insurance, and full opportunities both for providers to combine to establish their own health and social care co-operatives, and for users either to form their own health and social care co-operative, or to make use of provider-owned co-operatives, or any other source. Where the situation is fully "Beveridgean" the scope for co-operative enterprise in both insurance and service delivery is much more limited.

A further distinction might be made between situations where services are delivered through facilities owned and operated by central or local governments (and by independent practitioners operating almost solely on the basis of contracts with the public system, which is normal in Welfare States), and that delivered through facilities owned and operated by enterprises in the state and parastatal sectors, which was the solution in the former socialist countries.

A further aspect is that of the effectiveness of the public sector, both in its insurance and its service delivery functions. Effectiveness can be measured in terms both of equatability in coverage of all citizens and at each phase in their life cycle, and also of efficiency of actual delivery in respect to each specialist preventive, curative and rehabilitative activities.

The significance of the extent of public sector responsibility for either or both insurance and service delivery can best be made clear by considering firstly the impact of public sector development upon pre-existing co-operative enterprise, whose further expansion it generally constrained, and secondly the impact of adjustment or withdrawal of the public sector, which opened diverse opportunities for co-operative sector expansion.

(a) Nature of initial impact of public sector upon pre-existing co-operative sector engagement and subsequent collaboration

The following appear to be the principal forms of initial impact and subsequent collaboration:

(a) substantial co-operative insurance presence is terminated and fully taken over by a public sector of the "Beveridgean" type (public sector free service delivery, hence insurance unnecessary): co-operative engagement is highly constrained [United Kingdom] or largely constrained [Canada];

(b) substantial mutual insurance presence (with some mutual service delivery) integrated in partnership with predominant but not monopoly public sector of the "Bismarkian" type (insurance, but no service delivery): mutual associations promoted, little space for co-operative engagement [France];

(c) mixed provider-owned health co-operative and mutual insurance situation affected by, but not replaced by, more comprehensive national social security ("Bismarkian"): space for expansion of provider-owned health co-operative networks and co-operative health insurance in alliance with mutual and trade union organizations (multi-provider situation) [Colombia, Brazil];

(d) user-owned health co-operative system forming part of broader co-operative movement affected by substantial but not monopoly national insurance and delivery system, and obliged to adjust to remaining spaces, with some partnership in service delivery: space for continued growth of co-operatively organized systems [Japan];

(e) user-owned health co-operatives not replaced by partial public insurance and delivery systems: rather space for expansion retained, and opportunities made available for innovation through alliances with enterprise-based system [United States];

(f) early experimentation in user-owned, community-based co-operative health service delivery largely constrained by emphasis given to public sector system: space for co-operative expansion limited [most Asian and African countries];

(g) previous user-owned health co-operatives fully replaced by socialist centrally-planned enterprise (and local authority) based service delivery (for which insurance unnecessary) [countries currently with transitional economies].

(h) transformation by full nationalization into the public sector of previous integrated trade union/co-operative system which functioned as a de facto national system [Israel]

(b) Nature of opportunities for co-operative engagement made available by adjustments in or reduction of public sector

The following are the principal types of scenario:

(a) disintegration of enterprise-based socialist system, with only residual retention in some sectors (including some parastatal "co-operative" sectors), but also with considerable uncertainties concerning private sector (including

genuine co-operative) involvement in occupying areas no longer (or never) within the public sector;

(b) adjustment in the "welfare states" (principally in those of the Beveridgean type) with some decentralization and privatization (more in some countries than in others), and some openness to experimentation with co-operative forms of enterprise, although no major dismantling of public sector: opportunities taken by co-operative enterprises in diverse but limited areas - but larger opportunities for greater partnership remain to be explored;

(c) the situation in the United States is complex because the public sector engagement is very considerable but partial and divided between Federal and State jurisdictions, and the balances and relationships between stakeholders are in constant change. In general developments in health and social care sectors, including concern to reduce costs through "health maintenance" approaches, favour further expansion of user-owned health co-operatives;

(d) very substantial retrenchment in public sectors resulting from broad macro-economic changes and by structural adjustment strategies in many developing countries provide significant opportunities for co-operative forms of "privatization", although operational problems are considerable in many of the least developed countries (including weakness of co-operative sector) - less so in the more prosperous economies and where strong co-operative sectors exist [Malaysia, Republic of Korea];

(e) in the Latin American countries a tendency toward more comprehensive public sector involvement in social security is balanced by the more general factors constraining public budgets: in general considerable opportunities for expansion in co-operative insurance, in alliances with provider-owned health co-operatives.

2. Governmental perceptions and policy positions in respect to co-operative enterprise

The perception held by governments (as an expression for the most part of underlying societal attitudes) of the respective roles of public, private for-profit and private not-for-profit (social economy) components is of primary significance within each of the principal societal systems (centrally-planned socialist, Beveridgean, and Bismarkian). Governmental support is most likely to be forthcoming in countries where co-operatives are well-established, and particularly where political leaders may have themselves entered public life through their activities in the co-operative movement. This is particularly the case where that movement is in itself a political force, whether directly or indirectly expressed: in some countries there are Co-operative Parties represented in the legislature. Official support is particularly valuable in those circumstances where other stakeholders in the health and social care sector are opposed to co-operative forms of its organization.

An insufficiency of political commitment in many countries often results not so much from opposition from other interested parties, but rather primarily from a combination of ignorance or prejudice concerning the general nature of the co-operative movement. This appears to be of greater significance than more specific ignorance concerning the potential of co-operative forms of organization for contributing to the adoption of more appropriate strategies for the health and social care sectors.

3. Citizen's perceptions of mutual assistance and co-operative enterprise as an alternative to governmental responsibility

In a few cases the presence of a single individual, or small group of persons (concerned citizens, co-operators, health professionals) drawn from a single community has been sufficient to generate an interest in a co-operatively organized response to health and social conditions and the need for services. More usually, however, it has been necessary that there converge at the same time and in the same place the interests of not one but several different groups, capable of supporting and facilitating the efforts undertaken by each other. Such groups may include, for example, citizen's groups (formal or informal), trade unions, co-operatives in other sectors, farmers and other self-employed persons associations, consumers' organizations, and women's and older persons' organizations.

Among the favourable factors it is possible to discern a core combination which has been described as the existence (or facility for the creation) of mutual trust among a group of persons, which constitutes the basic prerequisite for the voluntary commitment of resources, whether these be of capital, time or prestige. These basic factors include strong community bonds; a commonly held idea (whether political or other); a shared life situation and need; and a common venture.251/

Elsewhere, a high proportion of citizens may perceive that it is not their own but a governmental responsibility to provide health and social care insurance and service delivery. This perception allocates to the public sector a form of society-wide collective responsibility. Over-reliance upon public sector provision of health and social care may result. Thus, although now changing, the view is still widely held in the developed "welfare states", that public authorities have the primary responsibility for achieving health. Perhaps surprisingly, in many developing countries the same perception is pervasive, even though services actually delivered have rarely been adequate. This reflects the predominance during colonial and post-colonial periods of "top-down" national planning in which governments tended to assign the greater part of responsibility, at least for health service delivery, to the public sector.

In most countries, it is accepted that the society-wide collectivity need not be monolithic, and need not be confined to the public sector, and that certain sections of the population may (even should) establish their own separate and community-based forms of collective responsibility and action. Here various forms of social economy are permitted, even encouraged. In certain cases, for a variety of reasons, mutual associations organized by occupationally defined groups - trade unions or other professional associations - are preferred to co-operatives. Elsewhere, co-operatives enterprises may be preferred.

In other societies, both public and social economy responsibilities are considered appropriate only for certain sections of the population. Most citizens are held responsible for their own arrangements as individuals or as market-determined groups of consumers. It is believed appropriate that private for-profit enterprises provide both insurance and services. Within this framework, in some cases, citizen choice of mutual or co-operative solutions is allowed as a right, even encouraged in respect to certain sections of the population (but in preference to public sector involvement in their situation). In other cases, social economy solutions by any section of the population are discouraged, in deference to for-profit enterprise.

The question of effectiveness is only partly correlated with these basic types of perception concerning societal responsibilities. That is, even where the public sector is quite restricted in its intended scope, its services may be delivered efficiently. In contrast, where the public sector predominates, or is a virtual monopoly in provision of either or both insurance and services, it might be that effectiveness is less than satisfactory (for any number of reasons).

4. Perceptions held by the co-operative movement of its engagement in health and social care

The co-operative movement itself has a varied perception of the suitability of applying its own model of organization to health and social care. In some cases initiatives in these areas have been viewed with some restraint. In a number of countries established co-operative movements have not shown much interest in promoting and supporting health and social care co-operatives, an attitude possibly arising from a dislike of mixing what are perceived to be "social" issues with the purely business activities which are considered to be the primary or sole reason for co-operatives to exist.

This approach has been rejected by other elements of the co-operative movement as erroneous because (a) there is no reason why co-operative enterprises should not include distribution of "social" benefits to members as part of their use of surplus; (b) a co-operative in the health or social sector can be just as much a business enterprise organized on co-operative principles as one in agriculture or housing; (c) expansion of the co-operative movement to such areas as health and social care is likely to win new members, improve its image, prove to other stakeholders its relevance, and thereby indirectly benefit all of its parts.

In all cases it needs to be taken into consideration that the existence of numerous and economically viable co-operative enterprises and even secondary groupings in a significant number of economic sectors within a certain region or country does not in itself signify the existence of a coherent and centrally harmonized "co-operative sector" or system, capable either of adopting a policy or of persuading all co-operative enterprises to pursue it. This is so even if most or all of the distinct co-operative entities are members of representative and supportive tertiary organizations. Nevertheless, there may exist what might be described as a certain proto-systemic condition in some regions. There may be strategic alliances between co-operative groups in support of co-operative engagement in health and social care.

5. The availability of capital

Successful establishment of a health or social care co-operative needs time and long-term financial commitment. As in the case of every co-operative enterprise, the autonomy of such a co-operative, and the commitment of members, both of which are essential to successful start-up and subsequent achievement of viability in an often hostile market environment, depend upon raising initial capital from members resident within the community where the co-operative will operate. Moreover, it is essential to secure sufficient and regular prepayments from members and other associates in order to support operating costs. This condition not only contributes to the financial security of the co-operative, and allows for its efficient financial management, but secures member commitment to and preferred use of the co-operative. If prepayments do not cover all expenses, then an additional payment on the basis of fee-for-service is also required.

However, to a greater extent than is the case of co-operative enterprises in some other sectors, user-owned health co-operatives require considerable financial resources at the outset: perhaps not if the co-operative restricts itself to early phases of the developmental dynamic, characterized by delivery of simple services, but certainly if it intends to establish a facility such as clinic or hospital (and it has been shown that those health co-operatives that operate their own hospital have a much better chance of permanent financial viability).

Moreover, the long-term viability of health co-operatives depends upon an effective impact upon members and communities of their emphasis on preventive

health: once their membership has adopted a life-style supportive of health, then the need for curative and rehabilitative intervention, with which are associated high costs, is reduced. However, diffusion of preventive measures, often requiring innovations that are more social than medical, takes time and effort. Responsibility for the costs involved is not easy to assign to individual members, except by setting the level of prepayments significantly higher than the aggregate costs for curative and rehabilitative interventions. These latter are likely to continue to be required until preventive approaches have their effect. For a while, total costs per member are likely to be higher than for purely curative interventions made in for-profit facilities. Repayment to individuals or to the co-operative of health expenses by public social security programmes is likely to include only essential curative and some rehabilitative costs, but not contributions to broad preventive measures which have delayed benefits. Consequently, these must be borne by the membership: although they can be met often through their own labour.

Financial pressures are greatest during the early period of a health co-operative's existence. Once past this period, and with a viable hospital base, then their financial viability has been found to be relatively easy to maintain. The longer they are in operation and the faster they grow, the more likely it is that they can become self-sufficient in respect to capital.

It is necessary to convince the community and its leaders that these forms of organization and operational emphasis are appropriate. It is in this respect that the factor of community familiarity with co-operative enterprises becomes important. Where significant proportions of the local community are members of other types of co-operative, there is greater understanding of the operational dynamics of such enterprises, and an associated willingness to give sufficient time for it to become established.

These considerations are particularly important for health co-operatives set up in rural areas, where higher costs are likely to result from low population densities, the inadequate development of general infrastructure and utilities, and higher costs of distributing supplies.

A further problem arises in that the communities most in need of this type of co-operative are those most likely to have a severe capital shortage: that is, low-income communities in either rural or urban areas. Members of such communities, if they are working, are likely to be employed by small enterprises, or to be self-employed, and therefore not to have enterprise-related health insurance. If unemployed they are certainly unlikely to be able to afford capital shares or prepayment fees. Public support, if any, may not be in the form of financial payments: it might consist of operation of primary health centres with insufficient capacity to meet all needs. Even when financial payments are made, these are not likely to include an amount surplus to immediate costs which could be used by recipients for investment in a health co-operative. In such circumstances it is unlikely that such co-operatives in these communities can be established by means of initial shares contributed by members.

Financial support is frequently provided to such communities by public agencies, for the purpose of improvement in health and social care facilities and programmes. However, if channelled to health co-operatives this may invite an unacceptable degree of external control, which limits community participation and member commitment, and ultimately constrains precisely those organizational features of co-operative enterprises that render them efficient.

Moreover, in these communities the ability of prospective members to raise sufficient capital is often constrained not so much by the absence of sufficient capital, but by that of financial institutions trusted by them to

manage their savings and apply them efficiently. Where these exist, adequate capital can be made available, particularly for investment in such areas of common concern as health and social care. This has been shown to be the case by the ability of savings and credit co-operatives and rural co-operative banks in many countries, and in both the recent past and the present, to mobilize and concentrate capital from poor and apparently capital starved communities. Invested and reinvested in their entrepreneurial development and supportive services, initial capital has accumulated significantly over a period of several decades. This process would ensure that the health and social care co-operatives would have sufficient capital to support continuing expansion.

Of considerable importance, therefore, is the availability of finance and managerial guidance during early phases in enterprise development from other parts of the co-operative sector, and principally from financial co-operatives. This factor also tends to strengthen the significance of the prior existence of a well developed co-operative movement in the regions, if not in the specific localities, where individuals wish to establish or expand a health or social care co-operative. It suggests that in the process of strategy formation attention might well be focused on the need to develop health and social care co-operatives primarily in some kind of association with existing co-operative systems (including, of course, where already existing, successful health and social care co-operatives themselves).

6. Perceptions held by potentially allied organizations

Where co-operative organizations are already well developed, they may be able to provide the support, including capital, required to establish health and social care co-operatives and to operate them during their early periods of development. However, at all times, but particularly where co-operatives are poorly developed, it is possible for support to be provided by other types of organizations of which the group of individuals wishing to establish a health or social care co-operative are already members, or which are strongly developed in the community. These include trade unions, organizations of self-employed persons such as farmers, associations of other professional groups, consumers' movements, and organizations of persons most in need of alternative forms of health and social care insurance and services.

Indeed, many contemporary user-owned health and social care co-operatives, as well as co-operative insurance and co-operative pharmacy enterprises, have developed through alliances between co-operative and such other organizations, notably trade unions.

7. Perceptions held by health and social care professionals

Certain sections of the health profession have been predisposed to the preventive community-based approaches embodied in health co-operatives, not only those set up by providers themselves, but also user-owned health co-operatives.

However, many have been opposed to co-operative organizations, particularly to standard prepayment arrangements. Their professional associations have often energetically constrained the establishment or expansion of health co-operatives. In some cases opposition has been sufficient to persuade legislators to adopt laws which proscribe the forms of collaboration among health professionals which are inherent in the organization even of provider-owned health co-operatives. They have sometimes banned the employment of doctors by user-owned co-operative enterprises.

Hostility to the concept of co-operative enterprise in the health sector has been reinforced, particularly where health co-operatives operate in rural areas and in low-income urban neighbourhoods, by an unwillingness of doctors

and other health professionals to work in these environments: this factor affects all types of health enterprise in such areas. Reasons have included the limitations upon earning, but also the lower standard of facilities, lesser opportunities for professional development, as well as a poorer quality of life for their families. On the other hand rural co-operatives may be able to attract those professionals interested in the conditions characteristic of those areas, and particularly in community-based services.

Conversely, and particularly in the cases of provider-owned health co-operatives, the process of commercialization of medicine (that is, expansion of large-scale enterprises operating networks of for-profit clinics, a form of highly capitalized competition tending toward establishment of monopoly conditions) has caused doctors to reconsider their opposition to co-operative forms of organization in the health sector. These may come to be perceived as a particularly viable form of group practice, with a potential for development of vertical and horizontal organizations alone capable of meeting such competition. In some cases also, health professionals may prefer association in co-operatives to incorporation in public health programmes. Particularly in difficult economic circumstances, public funding and partnerships with co-operatives have established an environment perceived by independent doctors as the only one offering them financial security.

8. Perceptions of employers in the private for-profit sector

Many societies assign responsibility for organizing health and other forms of social security insurance in respect to employed persons and their dependants to the enterprises in which they are employed. Employers are responsible for contributing part of the insurance cost, and for administering the collection of that part contributed by their employees.

In some cases the enterprises act as collecting agents within a national social security system in which contributions and benefits are uniform. Insurance is provided by the public sector. Elsewhere, enterprises are able to act independently, and providing certain criteria are met, they can seek to reduce their share of costs by securing the most attractive terms from insurance enterprises outside the public sector. In many cases enterprises have found that the combined insurance and service delivery activities of health co-operatives, both user-owned and provider-owned, are attractive in that costs in relation to benefits are relatively low, and employee satisfaction high. The ability of such health co-operatives to offer insurance and privileged access "plans" specially designed to meet the particular needs of enterprises, particularly those of small and medium size within the same community as that in which the co-operative functions, has been found to be a particularly valuable feature.

In many cases groups of small- and medium-sized enterprises have themselves set up health insurance purchasing co-operatives, in order to obtain more affordable and appropriate insurance coverage for their employees, including that provided by health co-operatives.

Consequently, enterprises and their associations have been supportive of these forms of operational alliances with health and social care co-operatives, thereby providing the latter with a large clientele, and assuring their financial viability. Moreover, support from the private for-profit sector can be a significant means whereby alliances with trade unions and other organizations can be made more effective, and opposition from health professionals countered.

C. Relevance of determinants in each principal type of societal context

In reality, none of the factors discussed above exists in isolation, either from each other or from the general societal conditions existing in the country or region concerned. Usually they operate simultaneously, forming converged clusters of determinants, some reinforcing, others detracting from the full impact of those simultaneously operating. Because they express underlying societal conditions there is often a high degree of auto-correlation between them. Moreover, to some extent, the process of classification and separate description used above itself falsifies the complexity of real conditions, suggesting the possibility of separate existence which in the real world is not the case.

Finally, it should be borne in mind that factors which are favourable in certain societal conditions may be unfavourable in others. Their relevance is likely to change over time, and to differ in the context of overall societal conditions. Accordingly, at different points in its recent history in each society, there are different combinations of favourable, neutral and unfavourable factors come into being in response to the societal environment, and determine whether or not co-operatives in these sectors are likely to appear at all, and to be successful subsequently.

If it is necessary to consider the entire cluster of factors relevant to engagement in the health and social care sectors of each single type of co-operative enterprise, then it is even more appropriate to consider the total societal environment in which development of entire systems of co-operatives - including health co-operatives, co-operative pharmacies, insurance co-operatives, various forms of support co-operative, and others - are operating. The actual configuration of positive and negative conditions, and the broad trajectory of their development over time, can be assumed to be specific to each society and therefore, broadly similar within each of a number of principal types of society.

Consequently, the remainder of this chapter consists of an examination of the relevance of the complex of favourable and unfavourable factors to engagement by the co-operative movement in health and social care in the context of broad societal conditions. Classification of such conditions can only be approximate, given their complexity, but is worth attempting in order to make the findings of the review as useful as possible to the reader. In fact the distribution of the different types of co-operatives directly engaged in the health and social care sectors, shown in Table 1, is characterized by a number of clusters which suggest the distinct societal types which can constitute a framework for such an examination, as well as the basis for the exploration of future developments.

1. Welfare states in Europe, and in Canada and Israel

(a) Extent of public sector responsibility and effectiveness

In most European societies since at least the Middle Ages groups of individuals have combined in mutual aid organizations whose purpose was to pool resources as a means of insurance against risk of ill health, disability or other misfortune. For operational reasons, and as an expression of solidarity, each organization was usually limited to persons who had the same occupation and residence. There were few attempts to combine to provide health services directly, although this may have occurred more often in the case of social care. These were provided either by private practitioners or by various combinations of philanthropic and local community institutions, including local government authorities. There was very limited central government involvement.

In most of these societies there took place a rapid expansion, adjustment and diversification in types of mutual aid organization in response to the

major societal changes of the nineteenth century. Of central significance to an understanding of the contemporary nature of co-operative engagement in the health and social care sectors is the relationship between the types of mutual aid organization which developed during this period and the public sector structures in health and social care introduced progressively during the twentieth century. A brief comparative review of the experience in France and in the United Kingdom may serve to identify the principal aspects relevant to the present situation.

In France a welfare state of the "Bismarkian" type was adopted, providing a national social security system which included comprehensive (although partial) health insurance coverage, but leaving provision of services outside the public sector, with some exceptions. Because the system of mutual aid organizations, the "mutualité", was already very strongly established, it was able to develop a close partnership with the public sector, acting in effect as a complementary and operationally integrated component of a joint public/mutual system. Such a partnership expressed the historic strength of the mutual approach, based, as was the co-operative movement in other countries, upon trade unions, professional associations and other forms of popular solidarity.

In the United Kingdom user-owned health co-operatives, which had never appeared prior to establishment of the welfare state, never became necessary thereafter, at least until the recent period of retrenchment in the public sector. The substantial contributions of mutuals and co-operatives in health and social insurance which existed already at the beginning of the twentieth century, entered a limited partnership with the public sector for a brief period, but was terminated when their functions were taken over by the welfare state. That the partnership did not continue and develop as it did in France was a most distinctive feature: and the basic explanation for the very limited direct involvement of co-operative enterprises at present.

The United Kingdom's experience exemplifies the effect on co-operative enterprise in the health and social care sectors of a "Beveridgean" approach, characterized by transfer of responsibility for delivery of these services to the public sector. This included very substantial control over the activities of private practitioners, most of whose work came to be linked with the state system. By means of this arrangement users' access to services whenever needed was satisfied. The existence of public services free of direct cost to users, because they were met from the central budget, meant that users did not have to be concerned with the insurance aspect.

In France the "mutual aid association" alternative to the public sector was not terminated as in the United Kingdom, but rather continued as a formal partner. Consequently, to the extent that withdrawal of the public sector occurs, it would appear likely that the space will be occupied by the "mutualité", with the prior agreement of the Government.

In Canada, some of the few user-owned health co-operatives existing before introduction of either provincial or federal systems of health and social care insurance and service delivery were obliged to cease their activities, or transfer to other functions. Others continued in an uneasy relationship with the public sector, but only where the co-operative movement was very strongly developed within local communities, as in Saskatchewan.

With recent decentralization and experimentation with privatization, a characteristic of most welfare states from the mid-1980s, opportunities have appeared for entry or re-entry of co-operative forms of organization. Because the insurance component has been affected less than the service component (i.e. public systems continue to cover private service costs), and because public services are still available to low and lower middle income populations, there has been as yet very limited development of user-owned

health co-operatives (in Sweden, exceptionally), but a greater development of provider-owned health and social care co-operatives, as "niches" appeared. This has been the case in the United Kingdom, Portugal and particularly in Italy, where, however, the "provider" element is strongly mixed with a joint-, multi-owner or "interested parties" approach. This reflects the strength of closely allied co-operative, trade union and community interests.

In many of these countries co-operative insurance enterprises are well established, often having existed prior to the welfare state. In some countries, user-owned insurance took the form of mutual organizations rather than co-operatives, although the distinction appears to be slight in some cases, and more an expression of the specificity of national legislation then of real structural or operational distinctions. In most countries health insurance and other social security functions were transferred into the comprehensive national social security systems when the welfare states were set up, leaving co-operative insurers to concentrate on life, home and enterprise insurance. More recently they have again begun to offer health insurance. This has been of particular interest to the still small sections of the population looking for complementary insurance because of their own special status with respect to the national public system.

Again, probably as an expression of a strong consumer co-operative movement in wholesale and retail sectors, user-owned co-operative pharmacies exist in a number of these countries. They are particularly well developed in Belgium, where one group, Multipharma, is part of the P & V co-operative insurance group. Retail co-operatives include pharmacy departments or subsidiaries. Elsewhere, however, the public sector leaves no space for co-operative enterprise. In Sweden, for example, the entire retail pharmacy branch is run by a state monopoly, Apotekbolaget, and there has never been any public discussion of the option of privatization or co-operativization.252/

In Spain what might be described as a "pre-co-operative" or "proto-co-operative" provider-owned system of health services, unique in Europe, developed prior to the late introduction of the public system of social security/health insurance and health services. It was transformed from this pre-co-operative condition to full co-operative status as a result of legislation adopted within the broader socio-political changes of the mid- and late- 1970s of which introduction of national social security and public health services were a part. Because they were already strongly established and functionally effective, the co-operative system remained in place as one organizational sector of what became a multi-stakeholder system which was essentially "Bismarkian".

The insurance coverage offered by the Mondragón Co-operative Group to its members has proved to be both more effective and more affordable than the national system subsequently introduced. Because of the significance of the parent co-operative movement in the Basque Autonomous Region it has been allowed to co-exist as a complement to the national social security system, from membership of which co-operative members were exempt.

In spite of recent adjustments, in most of these countries public sectors remain predominant in both insurance and service delivery. Expansion of co-operatively organized activity is possible only as partial and selective withdrawal of the public sector occurs. Moreover, it must take place in competition with for-profit private enterprise, and as an alternative to other types of not-for-profit and mutual aid associations. Nevertheless, there appears to be much scope for a planned transfer of certain activities from public to co-operative sectors.

In those types of welfare state where public sector intervention has been largely in the delivery of services (i.e. the "Beveridgean" type) several increasingly unsatisfactory aspects have been identified over the last decade:

certain sections of the population are not covered _de jure_ or _de facto_; the quality of services does not meet the expectations of those covered.

The following are the principal failings in the public system most commonly identified: unnecessarily bureaucratic and inflexible; sub-optimal use of existing resources; routine and apathetic care; failure to recognize variety in local circumstances and needs; narrow focus on biological concepts of health and illness; long waits for service; treatment that is discourteous, impersonal and at times even detrimental to health; and recourse to hospital admission when ambulatory care would be adequate because of inadequate out-patient facilities.

These conditions reflect a number of factors: changes away from the ideological and political environment in which the systems were set up and first developed; pressures on funding from public budgets undergoing reduction; demographic and socio-economic transformations; and the build-up over long periods of no longer appropriate or efficient forms of management and operation.

Of particular interest to a comparison of the relative merits of public and co-operative components is the fact that, although public sector service delivery is basically one controlled by the electorate, and is, therefore, "user-owned", this control is remote because of the intervention of a non-transparent system of management. This reduces the quality and relevance of service delivery.

In contrast to the trend in all other countries in this group, in Israel the long- established predominance of a co-operative and trade union affiliated comprehensive health and social care system of insurance and service delivery was ended in 1995 with full nationalization.

(b) Governmental perceptions and policy positions concerning the appropriateness of a co-operatively organized component of the health and social care sector

Governments at national, regional and local levels in the majority of countries with welfare state structures are keenly interested in the introduction of alternative, cost-effective, health care delivery models. Their position arises mainly from the continued rise in costs of health care services, itself in part due to demographic changes, combined with response to a general societal perception that a reduction in public sector responsibilities is in itself desirable.

In the last decade it has become clear that most governments recognize the central relevance of community-based primary health services, in which there is high citizen participation, to their goals of achieving improved health and social well-being. This recognition has been expressed in international declarations, strategies and guidelines. It has been supported by the programmes of the relevant international organizations, notably by WHO and UNICEF. As a result, its significance has been further acknowledged by Governments.

One expression of this new emphasis has been change in legislation. In Italy, for example, new legislation (Law 381 of 1991) legally sanctioned a new concept of partnership between the public sector and co-operative enterprises engaged in health and social care ("social co-operatives"). It granted full legal recognition to areas of co-operative enterprise previously not covered by legislation. Article 1 stated that:

> "Social co-operatives have as their purpose the pursuit of the general community interest in promoting human concerns and in the social integration of citizens".

The Law recognized the particular characteristic of co-operative enterprises, that is their entrepreneurial approach to the task of providing social services in a manner which satisfies the aspirations and goals of the individuals concerned and the communities in which they live. It recognizes that co-operatives are able to provide required services in an effective manner because they use methods appropriate to enterprises which must be viable within the market (including careful organization, innovation and efficient use of resources), while at the same time enabling full participation of concerned individuals and representatives of the community in their direction and management.

The fact that social co-operatives pursue as their basic objectives the optimization of social utility, rather than the maximization of profit, and that they use effectively economic efficiency and viability as a means to ensure their effective provision of social services, rather than as an end in itself, are recognized by this legislation as justification for treating co operatives in the health and social areas as appropriate partners of the public sector, indeed as probably more efficient means for carrying out the responsibilities of government than public sector agencies themselves.

In effect, Law 381 promoted further progress toward a mixed system of welfare in which local authorities and social co-operatives collaborate for the general benefit of the community. Local authorities, having a duty to practice equality, democracy and transparency, are legally obliged and authorized to support co-operatives, investing them with a public function.

Moreover, the new legislation sanctioned the full engagement by volunteers in the operation of social co-operatives (provided that their number did not exceed one half of the total membership). They would be able not only to complement the work of paid employees, but to help in entrepreneurial and managerial functions and represent the interests of clients and the local community within the directorates of the co-operatives.253/

In the United Kingdom, in response to the increasing fiscal burden of providing health and social care services from a smaller tax base but to an ageing population, the 1990 Health Services and Care in the Community Act was adopted, as a result of which there has been large-scale privatization and, within a smaller public sector, radical change in the role and structure of services. For example, direct responsibility for funding residential care services was transferred from the national government's Department of Social Security to the Social Services Departments of local authorities. The latter have assumed responsibility for purchasing care services on behalf of clients, as well as assessing needs, arranging for provision of care, and monitoring the quality of its delivery.

In these conditions private for-profit enterprises and voluntary organizations have both expanded their shares of the market. There have been opportunities also for an expansion of co-operative enterprises, both provider and user-owned. In some cases voluntary organizations need to have an organizational structure permitting them to operate as enterprises, an opportunity for co-operative formation. There is some scope for conversion of public sector institutions. There is much scope for co-operative forms of organization among social care providers: of whom there were an estimated 6.8 million, including relatives and friends. As many of these providers worked in informal status, scope for their organization in worker-co-operatives was particularly great.

Provider-owned social care co-operatives are considered in the United Kingdom to be "socially efficient" - they are not bureaucratic; responsive to diverse needs; because of the personal nature of services provided, and the democratic co-operative structures, they are open to user participation and community views; able to deliver quality services by committed staff,

including involved volunteers. It is believed that it is highly beneficial to involve and empower users and their representative associations both when identifying need or market niches, and when establishing the participative and accountability structures of a social co-operative. It is suggested that users should have a right to participate in the management structure and to influence the ways in which care is delivered and quality is maintained.

In general, social co-operatives had a number of basic advantages: a strong ethical base, commitment to democratic practices, equal opportunity and strong links with the local community. In order to benefit fully from these, however, it was necessary to make efforts to increase the familiarity of policy-makers with the co-operative model.

Although existing worker-owned co-operatives were committed to user involvement, consultation and quality control, the relevant structures were not yet well established, and there was need for further progress before the ideals of social work professionals were fulfilled. Nevertheless, it was felt that worker co-operatives with strong experience of participation and participative structures were better positioned to move further in this direction than were many other types of providers. It was felt also that the presence of social care co-operatives increased user choice and had a salutary effect upon the market.

In contrast social employment co-operatives might never be able to provide fully independent opportunities for persons with disabilities, except over a lengthy period. They might need some external support. In the United Kingdom some adjustment of the system of benefits provided by the state to individuals, and the use of volunteers, as was the practice in Italy, might facilitate the viable operation of such co-operatives.254/

In the United Kingdom the Government has shown some interest in community-based and user-participative forms of organization of health and social care, including co-operative enterprises, but this has been expressed so far only in the commissioning of research at the suggestion of the United Kingdom Co-operative Council.

In Sweden policies in these areas have shifted with recent governmental changes. When the government was formed by conservative parties it supported rather strongly transfer from the public sector to co-operatives as one component of privatization. But when a socialist government resumed office, its caution with respect to privatization had the effect of curtailing support for transfers from public institutions to co-operatives, and for the establishment of new co-operatives to meet changing consumer requirements.

In other countries acknowledgement of the importance of community-based and citizen-participatory systems has not automatically brought about recognition either by governments of the fact that co-operative health services may be one of the most effective means of organizing them. In Canada, for example, the national apex co-operative organization has been active for more than a decade in accumulating evidence and in providing arguments to Provincial and Federal authorities concerning the effectiveness of health co-operatives. While some official acknowledgement of the relevance of such approaches has been forthcoming, recognition of the potential inherent in a wider expansion of health co-operatives and establishment of a full partnership with a restructured public sector has been slow to appear.

It has been reported in some cases that not only lack of interest but even hostility has been apparent in governmental positions. For example, a 1990 review of the effectiveness of co-operative and other consumer sponsored health care delivery systems in Canada noted that these had been strongly recommended by virtually all the official commissions of inquiry into adjustment of the health sector held during the previous decades, while many

independent analyses had also recommended their rapid growth to a full partnership status. Nevertheless, provincial governments, responsible for health policy, had not adopted strongly supportive policies, and expansion had not occurred on any wide scale. Cases were cited of apparent prejudice against co-operative alternatives. For example, a 1983 Canadian study, which had shown that costs for users of the two largest community health clinics in Saskatchewan were 17 per cent lower than for users of private practices, was not released by the Provincial Government for six years in spite of numerous requests for publication made in the Provincial Legislature. 255/.

The 1990 review also pointed out that the success of co-operative and other consumer-controlled and community-based health organizations in providing health and social services to relatively disadvantaged members of the community had the paradoxical effect of reducing governmental support for their expansion as organizations capable of meeting the needs of better advantaged lower income as well as middle income sections of the population. This was because they had gained a reputation as "poor persons' welfare" institutions, and hence associated with a certain position in the political spectrum. It would appear essential for both Government and the co-operative movement to devote appropriate attention to counter this image - which is perhaps a particularly intense form of the general perception of co-operatives as organizations of and for the poor, or, at least, the working-class.

In other countries, antipathy to health co-operatives appears to have been an expression of a wider opposition to co-operatives of any type, which had ideological roots. In Spain before 1974, for example, restrictive legislation seriously impeded the establishment and expansion of health co-operatives.

Excessive governmental intervention in health co-operatives where these already exist has been identified as a restrictive factor in some countries. Where public sector provision of health insurance and health services is widespread (i.e. where welfare state conditions exist), but where a limited role is permitted to the private sector, including health co-operatives, the responsibilities of government for setting standards and guidelines and regulating activities in the non-public sector sometimes extend to a perception by responsible officials, if not by policy-makers, that it is their function to intervene directly in the management of health co-operatives, which are treated in much the same way as facilities within the public sector. Even in conditions of diminution in the role of the public sector, the government departments responsible for health have shown some reluctance to relinquish control of health co-operatives.256/

There have been an increasing number of cases where governmental authorities responsible for health have adopted policies of promoting and supporting community-based primary health facilities. However, they have not envisaged these as being autonomous and co-operatively organized enterprises. For example, in Prince Edward Island, Canada, the Tignish Co-operative Health Centre rejected the option of participating in a provincial government programme designed to promote community health centres because this would have required appointment of the directors and manager by the provincial government, an arrangement inconsistent with its character as a co-operative.

In Quebec a less intrusive position appears to have been adopted by the provincial health authorities in respect to the network of community-based clinics (Centres locaux des services communautaires: CLSC). These had integrated existing independent community clinics at the time of their establishment and they are allowed considerable autonomy. Their originality is perceived to lie in the organizational compromise they afford between state control, the preference of health sector workers for autonomy, and the desire of individual citizens to exercise community responsibility. In practice control is divided among these principal actors. Health providers do not have the same degree of control as they would have in worker-owned

enterprises, while users do not have the same degree of control as in user-owned enterprises. The recent approval by the provincial government of the establishment of a new user-owned health co-operative at Sainte-Etienne des grès is considered by specialists as evidence of recognition that, in addition to the community-based clinics, autonomous co-operative enterprises can play a role.

Experience in Sweden has shown that transfer from public to co-operative sectors does not automatically result in improvement, and in seizure of opportunities for innovation, because public authorities are reluctant to dispense with considerable supervision.

Throughout the 1940s, 1950s and 1960s Governments built up, a childcare service capable of meeting demands for an equal and comprehensive service for all. The solution to societal problems was large-scale and centralised. The social environment was relatively stable, and above all else, the future was considered predictable. In the 1990s the level of funds allocated to the public sector has been falling rather than rising. Economic growth was at or near a standstill, and turbulence had reduced the stability and predictability of Swedish society, involved in a continuous process of seeking discernible and reliable lines along which development could be realistically managed. If no successful alternative models emerged, the situation would result in a "cheese-paring" style of rationalisation as part of an ongoing and organisationally confused process of change.

Thus, a series of new models was emerging in the childcare sector. Performance units, outside contractors, including co-operatives, and internal contractors had created both competition and multiplicity. In some instances, staff and contractors had been approached and offered the running of their activities. In others, tenders had been solicited from child-care units and contracts had been developed. All these measures had been carried out within the framework of centralised resources and control systems. Thus, the child-care apparatus was in the mid-1990s basically a professional bureaucracy, and its organisation was being approached by recreating what existed rather than finding genuinely new approaches to governance. Demands for rationalisation were placed on co-operative units instead of identifying natural and different alternatives. In this way, costs were certainly pared back, but it was questionable whether the services provided were any better.

When a new organisational structure was introduced, it would have been sensible to begin by looking at the strategic exterior of the organisation and then methodically identifying the specifics of operation. In child-care, the process had often been done vice-versa. The first step had involved alternative forms of operation that were unrelated to the strategic requirements for differentiated service. This lack of a clearly articulated direction had impeded opportunities for shaping and implementing appropriate new organisations.

In child-care co-operatives the drive for decentralisation and multiplicity had been coupled in practice with unchanged forms of management. Steps had been taken in the direction of diversified forms of child-care provision, but these had been introduced as a homogenous concept rather than emphasizing the differences between the child-care system and contract situations. The homogenous models for introducing such organisations into municipalities suffered from the very fact that they were homogenous, at a time when rapid change to a great variety of functions was being sought. Contractual relations were instead built up over long periods of time and were dynamic. Furthermore, the demand for efficiency and cost rationalisation was being focused upon individual units instead of following a natural progression, thus creating a system that retained its hierarchical aspects.

Child-care co-operatives had become obliged to grant rights of inspection and to submit specific reports to the responsible civil servant at the expense of evaluations based on assessment of results. As was previously the case, however, co-ordination took place at central planning level, regardless of whether the units were operated under co-operative, private or municipal direction. Contracting our activities but then continuing to govern in the traditional, cost-oriented manner meant that contracts became long-winded and that the potential for rationalising by utilising each partner's unique capabilities was lost.

The prerequisite points of departure for organising child-care co-operatives were in gaining insight into what the market demanded and analyzing ways of concentrating in-house activities that would enable units to link up and contract outside activities. Clearly, these approaches had seldom, if ever, been explored. For example, knowledge of how to establish new relationships, formulate new concepts and link with new partners had not been built up during the development phases and had not been evaluated in subsequent attempts at reorganization.

In the processes of change representatives for, and investments in, the existing child-care organisations often became obstacles to the very process of rejuvenation they sought. They tended to defend the know-how and security of the well-established and familiar systems, rather than tackling the new and unfamiliar. Organisations tended to cling tenaciously to outlooks and strategies that had formed in response to the social values and requirements of a particular period. Thus, organisations were always, to a certain extent, a historical product manifesting institutionalised values. They were, therefore, more suited to meeting demands that had existed previously than those that were anticipated.257/

(c) Citizens' perceptions of the appropriateness of co-operative enterprise in the health and social care sector

Individual citizens (and broadly based citizens' movements such as those of women, consumers, and others ..) have shown a growing interest in "healthy living", adjustment in the relationships between society and the natural and built environments, and a desire for greater participation in policy processes, and acceptance of new forms of community and individual responsibility.

In this context, interest in co-operative forms of enterprise has to some extent grown in some countries. It has not been very strong where mutual organizations are already established and in many cases already enjoy formal partnerships with the public sector. Where they have left space for co-operative formation, local and regional circumstances appear to be of considerable significance, as well as the incidence of certain types of co-operative, likely to be most supportive of new co-operatives in health and social care in the particular circumstances of societal organization of these countries. This relationship will be explored more fully in the next section.

(d) Perceptions held by co-operative movements and readiness to promote and support co-operative enterprises in the health and social care sector

Where regions with a long and substantial experience of the co-operative movement exist within countries where there has been a crisis in the welfare state, there appears to be a greater tendency among citizens to select a co-operative solution. For example, in Italy the formation of "social co-operatives", which began during the late 1970s and expanded rapidly during throughout the 1980s, occurred within the context of a crisis in provision of

public sector health and social welfare. However, these initiatives were grounded in the existing co-operative movement which had retained substantial solidarist and communitarian principles.

The views of local and regional co-operative organizations, and hence of national organizations, have been supportive of a co-operative engagement in health and social care, possibly because reliance upon community-based regional solutions involving trade unions and political movements is strong and long-established, whereas the welfare state is of relatively recent introduction.

The individuals who pioneered "social co-operatives" were familiar with - often directly experienced in - the co-operative movement. They extended the co-operative form of organization to embrace the entire area of activity which was the concern of social policy, taking the position that the purpose of a co-operative enterprise need not be restricted to satisfaction of the needs of its members alone, but could be extended to provide benefits to others in the communities in which they operated. By this means citizens could organize themselves to establish new forms of institution better able to respond closely to the real needs of local communities, and in particular to those of disadvantaged persons within those communities. They wished to activate preventive and promotional services, meet specific needs, and adopt forms of democratic management instead of what they perceived to be the hierarchical organizations imbued with a bureaucratic mentality prevailing at the time in the area of provision of social services.

Concerned elements of the co-operative movement have identified health and social care co-operatives as one significant means whereby the original functions and concerns of the movement might be continued with new relevance within societal conditions which are largely - although not completely - different. In the past co-operatives were the entrepreneurial form chosen by weaker segments of the population as the most effective means for their economic and social empowerment. Members looked to co-operatives for the solution of primary needs such as food, housing and employment.

Since the Second World War these immediate needs had been largely met - to a significant extent through the organizational vehicle provided by co-operatives. Consequently, some co-operative leaders and activists were suggesting that "social intervention", an integral part of the co-operative raison d'etre, might now be reconsidered. It might no longer be interpreted as an approach adopted as a means to meet the needs of the entire population, but rather to meet those of the under-privileged who exist, and are increasing in number and seriousness of condition, even within the welfare state context. This approach required adjustment from emphasis upon mutual assistance among members - use of the co-operative to meet common interests - to its use as a means for a broader mutuality, within the community, and even within national society. 258/

In other countries where user-owned health and social care co-operatives exist catalytic interventions by co-operative movement leaders have been important (often in collaboration with leaders of trade unions, farmers' organizations and other popular movements). However, this has not been the experience everywhere.

There is evidence that in some countries where the co-operative movement is already well established, existing co-operative organizations find it difficult to tolerate, let alone support, new co-operative enterprises and movements beginning to operate in what they consider to be their own spheres of activity. Exaggerated attention to boundary-drawing seems to inhibit concerted action in new fields of co-operative organization, thereby stifling the expansion of innovative enterprises. Such behaviour appears to be accentuated in those countries in which the co-operative movement is divided

along industrial lines - i.e. into such distinct organized blocks as farmers' co-operatives, consumers' co-operatives, housing co-operatives, etcetera. The consumer co-operative movement in some countries has shown some reservations in respect to the development of provider-owned co-operatives. They have shared these views with the trade union movements, with which they are in some cases closely associated.

In contrast, it would appear that in those countries where the co-operative movement consists of components distinguished from each other on a different basis, for example, having distinct regional, confessional or political origin - there has been a tendency for each to form a multi-branch apex organization which is much more likely to accept, even promote, innovation.259/

However, this has not always been the case. For example, the Mondragón Co-operative Group in Spain, which is both regional and confessional in nature, although establishing a secondary co-operative for social security, including health insurance, for all members, has not promoted a system of associated health co-operatives although it has extended co-operative organization to most other significant areas of the life and work of their members and the communities in which they live.

In Canada the co-operative movement has discussed very widely the possibility of cooperatives taking over from the public sector as part of privatization programmes. However, the larger co-operatives, which have the ability to contribute to such developments, including financial contributions, have not taken any initiatives (although some - such as the farmer-owned co-operatives in Western Canada - had done so prior to introduction of the welfare state. Many aspects required further consideration, and it was the feeling of the Canadian Co-operative Association, in 1994 at least, that progress would be neither easy nor rapid.260/

Moreover, within the co-operative movement of some countries there have been some reservations concerning the acceptability of receiving funding from the public sector - likely to be common if the public sector retains social security functions and co-operatives are one type of provider. In Italy it is considered by some specialists that the fact that the income of social care co-operatives is almost entirely from government sources could constitute a threat to their autonomy.261/

Some apex organizations have attempted to overcome such doubts. For example, with respect to public funding of health co-operatives, the Canadian Co-operative Association has pointed out that where health services are provided largely from taxes, it would be possible for a health cooperative to accept those amounts derived from the taxes of its members and to apply them within its member-controlled service delivery system without prejudice to co-operative principles.262/

(e) Perceptions held by trade unions and other popular movements.

Trade unions have collaborated closely with co-operative movements, particularly in the establishment of co-operative and mutual insurance enterprises, some of which offer health insurance. This has been notable in the case of Israel. Experience here is unique in that a co-operatively organized comprehensive health and social care sector was established in affiliation with the trade union structures which were set up during the early period of Jewish immigration, in the 1920s. With the founding of the State of Israel, and given that almost three quarters of the population were members of the combined trade union/co-operative movement, this co-operative health and social care organization continued as the principal component of societal arrangements for health and social care for the next half century. Because of the trade union partnership the system could be characterized also as an enterprise-based type (a large proportion of these enterprises being in fact

co-operatives enterprises). In this sense the co-operative sector provided the national system of health and social care, combining service delivery with insurance. It was only in 1995 that the entire system, together with other mutual organizations, was nationalized.

(f) Perceptions held by health and social care professionals concerning the appropriateness of co-operative enterprises in the health and social care sector

Possibly because in most of these countries welfare state structures have been superimposed upon the entire health and social care sector, there seems to have been little animosity on the part of doctors directed at co-operative engagement in health and social care. In Spain, and particularly in Catalonia, a most important catalytic function has been performed by health professionals who are also familiar with and have been involved in the co-operative movement. Indeed, in some cases, notably among the group of doctors led by Dr. Jose Espriu, there has been very strong support for an integrated co-operative health sector. 263/

(g) Perceptions held by private for profit-enterprise

In most of these countries individual enterprises were not responsible for providing insurance or services, only for collecting contributions. It is not known if any significant numbers have views on a co-operative engagement in health and social care.

(h) Technical and organizational determinants

User-owned health co-operatives in many of these countries face financial difficulties because some of their members and many "enrolees" pay for services directly or indirectly from public insurance services, now suffering retrenchment. For example, within the Japanese consumers' co-operative movement enterprises face considerable financial problems in view of the fact that income from users (including members) is derived largely from their benefits from the public health and social security system. Thus, the proportion of health co-operatives with deficits had increased in recent years: in the fiscal year 1994 only 14 per cent of health co-operatives had an operational surplus.264/

In Canada one of the principal problems encountered by health co-operatives has been difficulty in reaching agreement with the authorities on the extent to which payments directly to health co-operatives as accredited providers from the public health system were appropriate, and on the procedures whereby such arrangements might be administered. 265/

Health co-operatives have argued that if citizens who are eligible for health services from a public sector system, to which they have paid through taxation, opt to obtain some services from health co-operatives, then an appropriate part of their contributions to the public system should be transferred to these providers. The fact that health co-operatives are not-for-profit community-based institutions constituted a basis for distinguishing their situation from those of private for-profit enterprises. However, health authorities have argued that the basis for the public system is inclusion of all citizens and the avoidance of special arrangements for particular groups.

This appears to be a problem only for user-owned health co-operatives in welfare state environments of the Beveridgean or service delivery based type. It is not a difficulty in Bismarkian or social security based environments.

Social care co-operatives suffer from a number of disadvantages, all of which could be reduced or avoided if they were to combine in secondary and

tertiary organizations. For example, in the United Kingdom they suffer from small size; lack of public visibility, particularly when compared to the much larger private for-profit enterprises which allocate large funds to advertising; lack of familiarity on the part of policy-makers with their characteristics and potential; uncertainties felt by local authorities concerning their accountability for the expenditure of public funds, given their particular organization; higher transaction costs for local authorities in contracting services to them, given their small size and managerial structure.266/

The problem of assuring effective consumer control confronts the larger user-owned health co-operatives. While partnership between all components of the co-operative is essential to success, ultimate control by the customers (user-members) is basic. However, as such co-operatives grow in the size and diversity of their membership and complexity of functions, effective control and even active participation in decision-making processes becomes more difficult. This is a problem which affects all consumer-owned co-operatives, in whatever sector. To these common factors must be added, in the case of user-owned health co-operatives, the fact that a high proportion of users are "enrolees" in employer-organized health plans rather than individual members, and the fact that a considerable proportion of payments for services originate in government programmes, and may not even pass through individual users.

These difficulties are being dealt with by the co-operatives concerned, with some success. In the Group Health Cooperative of Puget Sound, the problem of ensuring continuing ultimate control by members has been constantly addressed by direction and management. The voluntary Board of Trustees has worked closely with management in order to up-date, streamline and strengthen consumer governance. A Task Force on Board Roles and Function reported in 1993 on how trustees could improve ways to govern an organization that had grown much larger and far more complex than what its founders had envisaged almost fifty years previously. Attention was to be given to the development of new models for consumer involvement.267/

The user-owned health co-operatives within the Japanese consumer co-operative movement have given particular attention to the means whereby user-members, whether patients or not, may be able to participate effectively within the policy-making process as well as within the management and operation of their health co-operative and its hospital and clinic facilities. For the last 15 years members and patients have been encouraged to complete questionnaires on the extent of their satisfaction with the services offered by their co-operative. More recently, within most hospital and clinic facilities, the opinions of members and patients have been solicited through suggestion and complaint boxes ("rainbow boxes"). This material is reviewed and appropriate action taken by a "utilization review committee". As of September 1995, such committees had been established in about half of all facilities. They are made up of members of the co-operative who are elected directly by the membership at large. The committees also participate in the process of recruitment of professional staff in order to ensure their suitability for working in the special environment of user-owned health co-operatives.

In addition special attempts are being made to involve members of han-groups in the operation of hospitals and clinics; increasingly han-group meetings are held within hospital wards. Their members meet with professional staff and participate in educational programmes concerning issues both of health and the effective operation of a user-owned health co-operative. Of particular relevance to the further effective participation of members in the management of their health co-operative, as well as in programmes of broad preventive health and the promotion of healthy living, has been the adoption in 1991 of the "Health Co-operative Charter of Patients' Rights".268/

2. The United States

(a) Extent of public sector responsibility and effectiveness

Because of the impact of a highly varied set of developmental factors, and a unique societal organization, the structure of co-operative engagement in the health and social sectors in the United States is distinct among developed market economies: it is partial and diverse, but nevertheless substantial. It can be understood only by tracing its evolution over the last half century.

Prior to the mid-1930s there was almost no public involvement in either insurance provision or service delivery. Health insurance and almost all service delivery was provided by private enterprises and practitioners on a for-profit basis: both were beyond the financial reach of significant sections of the population. Consequently, farmers' organizations, trade unions and some co-operative movements promoted and supported experimentation with user-owned health co-operatives. In some regions, the depressed economic conditions of the 1930s persuaded some private practitioners to associate with user-owned and other community-based health co-operatives, as the only means to secure their livelihood. For the most part, however, providers have been actively opposed to co-operative forms of organization in the sector. Not have they perceived any benefits to themselves likely to arise from their own co-operative organization. In fact legislation has discouraged or precluded many forms of business association between doctors.

During the New Deal period of the later 1930s and early 1940s the public sector began to come into existence. In 1935, Social Security (in respect to retirement income) was introduced, but resources proved insufficient to introduce health insurance as intended. At least in rural areas, there was strong official support for co-operatively organized provision of health services, complemented by directly sponsored semi-public and community-based health services. With war-time prosperity citizens' concerns to make their own provision for health insurance and services abated, and earlier policy emphases became less prominent. Instead of introducing a full national health insurance system, legislation was adopted which permitted and supported an enterprise-based health insurance structure.

In the absence of a comprehensive national health insurance system after the Second World War, predominantly urban user-owned health co-operatives appeared and expanded steadily, particularly in those regions with a strong mutual assistance culture (the North-west and Mid-West from an agricultural co-operative base, but also in major eastern cities from a trade union base). In some cases they built upon earlier trade unions' and farmers' organizations' efforts. During the economic boom of the 1950s collective bargaining between unions and employers brought some success in the promotion of enterprise-based health (insurance) "plans". These began with simple and modest hospital insurance, but expanded to include surgical, comprehensive medical, and then dental, medicine and optical insurance "plans".

While employers were obliged to finance these "plans", it was necessary for specialist health insurance enterprises to be set up to operate them. While some appeared in the private for-profit sector, others, such as the Blue Cross system, were not-for-profit, and to some extent supported by the public sector in that they were tax-free and even received some direct subsidies. User-owned health co-operatives combined health insurance functions - "co-operative health plans" - with service delivery functions, as "health maintenance organizations", and in these societal conditions expanded substantially. Calls for a comprehensive national health insurance system in the 1950s and early 1960s were again unsuccessful, but a partial system was set up, involving Medicaid for the poor and Medicare for the elderly. Associated with these developments was renewed State and Federal support for, and direct engagement in, community-based health service provision, primarily

for poorer sections of society, which included some, but not all, the features characteristic of the co-operative enterprises.

By the end of the 1960s a multiple stake-holder national system existed. The public sector provided substantial health insurance as well as some service delivery for the poor, including the unemployed, and for the elderly (i.e. to persons after normal age of employment). Enterprises, except small and medium sized firms, were obliged to fund health insurance provided by a variety of insurance enterprises. A substantial proportion of service delivery remained the function of private for-profit practitioners and facilities. However, provision by not-for-profit enterprises of both insurance and service delivery was significant, and included a substantial co-operative component. Individual citizens paid for the public sector component through taxes, as well as for part of the enterprise based system (the "complementary" element - in the form of deductibles and co-payments), and in some cases by direct and full payment to practitioners.

While this composite system met most of the needs of the majority of citizens during the remainder of the 1960s and the 1970s, by the mid-1980s it came under pressure, basically because of rapidly rising costs of service delivery. Health insurance premiums rose, and as a result employers were unable to maintain levels of coverage of enterprise health plans. Public sector funds were insufficient to cover increased costs of insurance for the already significant and growing proportion of the population which was poor or elderly. Economic pressures during the 1990s brought the situation to a crisis state, in that an ever higher proportion of employees were forced to change employment, losing in the process rights to favourable health insurance and being forced to accept lesser or no coverage. In the same period the proportion of unemployed increased. Crisis in public budgets forced a reduction in coverage through Medicaid and Medicare.

During 1993 and 1994 unsuccessful attempts were made to bring about comprehensive reforms. Proposals included a number of forms of co-operatively organized health insurance purchasing enterprises as a vehicle for extending coverage to all citizens, and specifically those employed in small enterprises or self-employed. However, support for user-owned health co-operatives was not a significant element of these proposals.

In these circumstances user-owned health co-operatives, which combine a "health maintenance organization" function (thereby reducing costs through emphasis on prevention and operational efficiency) with a comprehensive insurance function, have found themselves in a favourable position, supported by very high levels of consumer satisfaction. Nevertheless, the situation is complex and competition from very large insurance and service delivery for-profit enterprises is very substantial.269/

The situation has been characterised also by a very limited development of the consumer-owned wholesale and retail co-operative movement, and hence the absence of the impact upon nutrition and preventive health commonly associated with such movements in Europe and Japan. Supply and marketing co-operatives are strongly developed in agriculture. Although they have had some involvement in health-related adjustments in production, processing and distribution, in highly competitive conditions, this has not been so substantial as elsewhere.

(b) Governmental perceptions and policy position concerning the appropriateness of a co-operatively organized component of the health and social care sector

New or amended legislation has often been necessary in order that co-operative enterprise in the health and social care sector could begin to

operate. For example, establishment of employer-sponsored health insurance purchasing co-operatives required new legislation at the State level.

Although it is important to bear in mind the distinction between Federal and State levels of Government, it could be said that in general most have been at least neutral, and at best favourable to the co-operative movement, and to engagement by users at the community level, in various types of co-operative enterprise in health and social care. Legislation has been introduced where necessary to allow co-operative enterprise, and judiciaries have been sympathetic to user-owned co-operatives in spite of intense opposition by health professionals. This would appear to reflect broad approval for co-operative organization in agriculture and rural development.

(c) Citizens' perceptions of the appropriateness of co-operative enterprise in the health and social care sector

This has been clearly favourable in the predominantly rural regions where co-operatives, particularly those in agriculture, are well established. It has also been favourable in some of the major urban regions, where thee has been some experience of trade union and worker-owned co-operatives. More generally, and in other regions, however, there has been some caution, possibly arising from misconceptions which have included association of co-operatives with socialist forms of organization.

(d) Perceptions held by co-operative movements and readiness to provide and support co-operative enterprises in the health and social care sector

While the national apex organization, the National Co-operative Business Association, and the Co-operative Bank, as well as the National Rural Electric Co-operative Association, have supported co-operative organization of all types in health and social care, it might be noted that the absence of a major retail co-operative movement has deprived co-operative engagement in health and social care of a usually significant source of support. The very substantial credit union movement, and the major agricultural supply and marketing co-operatives, do not appear to have strongly supported parallel health and social care delivery movements. the strong connection between the credit union movement and co-operative insurance has not resulted in substantial engagement by the latter in health insurance.

(e) Perceptions held by trade unions and other popular movements

Trade unionists and movements have in the past strongly supported user-owned health co-operatives and insurance co-operatives, but in many instances have preferred to set up their own mutuals. Because a decreasing and now small proportion of the work-force is unionized, this source of support is no longer substantial.

(f) Perceptions held by health and social care professionals concerning the appropriateness of co-operative enterprises in the health and social care sectors

Of particular significance for evolution of the entire co-operatively organized component of the health and social care sectors, at least since the Second World War period, has been the strong opposition by private for-profit sector practitioners, expressed through national and regional associations. They have been hostile to user-owned services and insurance and uninterested in their own use of co-operative forms of organization.

In the United States during the 1920s and 1930s the majority of health professionals did not favour the contemporary interest in development of user-owned health co-operatives: in many States medical associations actively opposed their establishment. From 1939 onwards they succeeded in securing

legislation in 26 States that effectively barred consumer-controlled health plans, including those co-operatively organized. The Group Health Co-operative of Puget Sound, Seattle, experienced such strong opposition during the first decade of its operation that it had to take legal action, eventually decided in its favour by the State Supreme Court in 1951.

Health practitioners have formed various types of association in order to strengthen their economic position, but provider-owned co-operatives have been limited to relatively small networks.

In contrast, a certain proportion of doctors have considered the co-operative form of organization to be an appropriate means for their entrepreneurial development. Some have participated in the development of provider-owned health co-operatives. Others have perceived user-owned (or multiple stakeholder-owned or interested parties-owned) health co-operatives to be a satisfactory environment in which to work. In these conditions they are free of administrative and financial concerns, and are able to pursue the interest which many have in primary level family-oriented and community-based medicine.

However, it has been necessary in most user-owned health co-operatives to overcome the concerns of the medical staff that the consumer-controlled directors might intervene in professional matters. In some cases this led to tension, but in general a solution was found in arrangements whereby the medical staff operated autonomously, even quite independently, in respect to their professional work, and would be represented separately on the boards of directors. By these means, at least in the older established user-owned health co-operatives entirely satisfactory relationships have been achieved.

User-owned health co-operatives became one of the most successful of the "health maintenance organizations" which combined insurance with "managed care" (whereby costs were reduced by attention to preventive approaches), largely because they were based upon confidence and commitment organized and empowered by means of the co-operative type of enterprise.

(g) Perceptions held by private for-profit enterprise

Because of the role allocated to private enterprises, that is to employers, within the national health and social care system, the perceptions held by this sector of co-operative engagement in these areas has been significant. For the most part enterprises have acknowledged the advantages offered by user-owned and co-operatively organized health maintenance organizations, notably their ability to prevent ill-health. They have also recognized the benefits of their own recourse to co-operative structures for the purpose of purchasing insurance for their employees.

Alliances developed between private enterprises, in order to manage enterprise-based health insurance systems. "Enrolees" in such insurance plans came to represent significant proportions of the membership of health co-operatives. Co-operative and mutual insurance enterprises, in some cases with strong trade union ties, were providers in certain of these enterprise-based health insurance arrangements. Independent, for-profit, health service facilities set up group purchasing and common service co-operatives, and independent pharmacies set up purchasing and common-service co-operatives.

Most recently, proposals for the comprehensive restructuring of the health and social care sectors have included extension of the present system of enterprise-based health insurance purchasing co-operatives by means of the compulsory membership of all enterprises, including small- and medium-sized enterprises, with some Governmental intervention to spread risks. Although at the Federal level these proposals were not adopted, in many States, experiments are in progress on these lines.

(h) Technical and organizational determinants

On the basis of a review of United States experience it has been concluded that obtaining adequate and affordable financing had been the major problem to be surmounted when attempting to start a health co-operative. This had been particularly the case for user-owned health co-operatives. It had been largely because of the financial difficulties that the development of user-owned and community-based health co-operatives in rural areas of the United States was successful only during periods of substantial governmental support (or where other co-operative organizations provided support, as in the case of the National Rural Electric Co-operative Association).

With deterioration of rural economies and out-migration the population base for such co-operatives has declined to the point where any non-subsidised community-based development would appear very difficult. Thus, in the United States, during the 1930s and 1940s a total of 101 rural health co-operatives had been established of which only 54 remained in operation in 1950 - since then most disappeared. In 1988 there were only 13 healthcare co-operatives, serving about one million members, and mostly in urban areas. Health co-operatives expanded in certain major metropolitan areas, where there were a sufficient population base capable of making the financial commitments (i.e. significant proportions of upper low income and lower middle-income households), combined with a co-operative tradition.270/

3. Japan

(a) Extent of public sector responsibility and effectiveness

In contrast to the course of development of relationships between co-operative and public health sectors in European welfare states, in Japan the service delivery systems of both agricultural and consumer co-operative movements antedated the establishment of a public sector system. Because they were already well-established themselves, and particularly because they were components of strong and broad co-operative movements, neither agricultural nor consumer co-operative health and social care systems were integrated into the public system or displaced by it when this was set up in comprehensive form in the 1960s. They were permitted to continue operation as complementary systems: indeed the agricultural co-operatives' health system assumed formal partnership with the public system in providing services in rural areas, particularly the more remote ones. Hence, with recent retrenchment in the public sector, co-operatives have been well placed to expand and diversify further.

Health insurance was made unnecessary because health services were accessible to all members. More recently, complementary health insurance has been provided by both the consumers' and the agricultural producers' co-operative systems. In this way insurance and service provision elements have been combined within the same organization, controlled by users. Integration has been strengthened by the fact that both consumer and agricultural co-operative movements have become strongly engaged in the production, processing and marketing of healthy foods, in reduction in environmental hazards and in lobbying for a society-wide emphasis upon healthy life-styles.

(b) Governmental perceptions and policy positions concerning the appropriateness of a co-operatively organized component of the health and social care sector

While it appears that no significant support has been provided by Governments to health and social care co-operatives, neither has there been substantial opposition. In 1951, the Welfare Federation of Agricultural Co-

operatives was designated by the central Government as a partner organization, responsible for implementation of public health programmes in rural areas.

(c) Citizens' perceptions of the appropriateness of co-operative enterprise in the health and social care sector

A high proportion of citizens, particularly throughout rural areas, and to a lesser but still significant extent in major urban areas, have been familiar with co-operative forms of enterprise for many decades.

(d) Perceptions held by co-operative movements and readiness to promote and support co-operative enterprises in the health and social care sector

User-owned health co-operatives and co-operative insurance enterprises offering health insurance have developed as integral parts of the broad consumers' and agricultural co-operative movements with the full support of the relevant institutions at local, regional and national levels.

(e) Perceptions held by trade unions and other popular movements

Trade unions have been closely affiliated with the urban consumers' co-operative movement, and farmers' organizations with the agricultural co-operative movement, but because the co-operative organizations have been capable of establishing health and social care co-operatives by means of their own organizational energies, no direct partnership has appeared necessary.

(f) Perceptions held by health and social care professionals concerning the appropriateness of co-operative enterprises in the health and social care sector

Although the consumers' co-operative movement in particular has been strongly critical of the approach of the medical profession to health (being strongly oriented to the ill person and to curative approaches, rather than to the health person and the preventive approach), active opposition by health professionals has not been very strong, possibly because of the integration of health and social care co-operatives within broad co-operative movements.

(g) Perceptions held by private for-profit enterprises

The national health and social care system has not been specifically linked to enterprise responsibilities for work-forces, and so the close operational linkages characteristic of the United States have not appeared in Japan.

(h) Technical and organizational determinants

With retrenchment in the national system of social security, coverage for individuals has been reduced, thereby reducing major sources of income to health co-operatives. In 1995 about 95 per cent of the income of the user-owned health co-operatives associated with the Japanese Consumers' Co-operative Union (which in the previous year had been 22.7 billion yen) was derived from the public health and social insurance system in payment for services provided to citizens who were members. Retrenchment in the national social security system had reduced individual coverage, particularly for elderly persons, who had been proportionally greater users than younger persons. This had caused financial difficulty in many health co-operatives: as a result in 1994 only 14 per cent had a surplus.

The problem of inaccessibility still exists in certain rural regions. The co-operative health services developed in the context of the agricultural co-operative movement have worked to overcome such problems by means of mobile clinics and other outreach services. It had been their ability to reach

inaccessible settlements that led to their status as partner to the public sector services in such regions.

4. Latin American countries

(a) Extent of public sector responsibility and effectiveness

Most of the 10 countries where there is at least some co-operative organization of health and social care are characterised by a predominance of provider-owned health co-operatives. In some cases these are affiliated, through broad co-operative movements and trade unions, with user-owned co-operative insurance enterprises offering health insurance. User-owned health co-operatives are limited: where most developed, in Brazil, they have been promoted by the provider-owned health co-operative movement, which has developed also its own health insurance service.

This situation expresses the fact that public sector engagement in health and social care could be characterized as being of a "limited Bismarkian" type. Social and health insurance provided in the public sector has been extended piecemeal to cover select sections of society - for example, government employees, military, workers in parastatal institutions and some highly unionized private sector enterprises. Direct public provision has been complemented by mutuals organized by professional groups. For the most part these systems have been highly fragmented and ineffective, covering only small proportions of the population. The majority of those not covered could not afford private for-profit insurance or services. There has been little public provision of health services.

At the same time co-operative movements, except for agricultural supply and marketing organizations in some countries, have not been strongly developed. Of particular significance has been the restricted development of any large-scale consumer co-operative movement.271/

During the late 1950s and early 1960s, as part of the implementation of the Alliance for Progress, attempts were made to improve and extend social security systems in order to achieve comprehensive national coverage. Some consideration was given to entry of the public sector into direct provision of health services. At the same time, co-operative development was stimulated, to a significant extent by means of assistance from United States co-operative movements. However, only in a few countries, for example in Costa Rica, were health service delivery systems set up at national level. In a number of countries health professionals identified their organization of provider-owned health co-operatives as an appropriate means to protect and advance their economic status and prospects in new societal conditions. In Brazil in 1967 and Chile in 1968 such movements were organized, while in Colombia during the 1970s a co-operative, which originated as a mutual insurance enterprise set up by health professionals, expanded and diversified to include a provider-owned health service component.

Restructuring of national social security systems included allocation of responsibilities for employee health insurance coverage to enterprises, with individual right of choice among providers of services. Most provider-owned co-operatives took advantage of these opportunities, developing "health plans" to meet enterprise requirements, but with no special emphasis given to development of alliances with other co-operatives. With extension in recent years of national social security programmes to lower-income populations, some provider-owned health co-operatives sought accreditation as providers to those covered by state subsidized schemes of health insurance. In these conditions provider-owned networks at the secondary level have been successful, particularly in Brazil, where the largest such organization in the world is located. Smaller developments, some new, exist in Argentina, Bolivia and Paraguay.

within some countries. In Costa Rica, for example, the prevailing views of many doctors was reported in 1994 to be still not favourable to the experimental establishment - with government support - of a number of provider-owned health co-operatives, even when evaluations showed these to be more effective and popular than analogous public health facilities. It was thought that, until changes in the education and training of health professionals were achieved and brought to bear upon the issue, attitudes might not be altered.274/

(g) Perceptions held by private for-profit enterprises

Because the national social security systems have assigned considerable responsibilities to enterprise-based health insurance, as well as to provider-owned health co-operatives, alliances have developed, and it would appear that at least larger enterprises acknowledge the useful role of such health co-operatives. Recent developments in Brazil suggest that small and medium sized enterprises may be interested in combining to participate in health insurance plans combined with service delivery by user-owned health co-operatives, themselves affiliated with the producer-owned co-operative system.

(h) Technical and organizational determinants

In the lower density and less accessible rural regions of many developing countries the question of accessibility to any type of health service facility is significant, and this has applied to co-operative health services also. Thus in Costa Rica, the successful model of provider-owned health co-operatives in the high density Central Valley region has been thought to require modification if extended to lower population density and less effective transportation.275/

5. Middle-income countries in Asia

(a) Extent of public sector responsibility and effectiveness

Co-operative enterprise in the health and social care sectors in these countries is varied: in India and Sri Lanka user-owned health co-operatives predominant with very minor provider-owned enterprise and no co-operatively organized health insurance. Some of the larger agricultural supply and marketing co-operatives provide significant health and social care services to members. Much more recent, still experimental, and separate user-owned and provider-owned movements have appeared in the Philippines. In Singapore development has been promoted and supported by the national trade union movement, and includes user-owned health co-operatives and pharmacies and substantial co-operatively organized health insurance. In Malaysia a different configuration exists - comprising a provider-owned network, substantial health insurance provision and early phases in the development of a national co-operative health system.

In India during the 1920s and 1930s there was some development of user-owned health co-operatives, particularly in rural areas with some links to various types of community-development co-operative. However, in contrast to contemporary development in Japan it was not associated with any broad co-operative movement. In Sri Lanka the first user-owned health co-operative was set up in 1932.

There was little continuity between these early experiments and the post-Second World War appearance of largely urban, hospital-based user-owned health co-operatives in which doctors played an important catalytic role. Possibly because of the absence of national level sectoral co-operative movements, and because, as in most developing countries, it was generally perceived that health services were a government responsibility, a matter for national development planning and not for citizen participation, their expansion did

not take place. Such factors appear to have constrained the expansion of co-operative enterprise in the health sector, except in Kerala where the State government has supported a partnership between the public sector and health co-operatives. Such a partnership has existed also in Sri Lanka, where there has been also a much stronger association with agricultural, credit union and consumer co-operative movements, themselves close partners of the public sector.

Co-operatively organized health and social care is absent from northern Africa and Islamic countries in Asia, with the notable exception of Malaysia. Co-operative movements are significant in many of these countries, in either the agricultural supply and marketing sector or the consumer sector, with strong partnership with parastatal organizations. Spontaneous and innovative co-operative development is less usual. Although co-operative insurance enterprises operate in Indonesia, Pakistan, Tunisia and Sudan none offer health insurance.

Most of these countries have insurance and service delivery regimes which combine public sector structures with Islamic structures which for the most part are highly effective at the community level. It is possibly because of the existence of the latter that other types of community-based provision, including co-operatively organized services, are absent.

Special conditions exist in some countries, where, at least for citizens, comprehensive welfare state provisions exist, although affected recently by some deterioration in macro-economic conditions. Brunei Darussalam, the Libyan Arab Jamahiriya, Saudi Arabia, Qatar, United Arab Emirates and to a lesser extent Bahrain and Oman are of this type. There is little incentive for citizens to opt for co-operatively organized health and social care in these circumstances.

(b) Governmental perceptions and policy position concerning the appropriateness of a co-operatively organized component of the health and social care sector

Malaysia has been one of the few developing countries where there has been an adjustment of public sector predominance toward co-operative organization in the health sector. It was the initiative of the Government during the 1980s, taken in response to perceptions that public sector predominance was not the most appropriate to changing demographic and economic conditions, that led to formation in 1988 of a secondary level provider-owned health co-operative. Government initiatives also promoted an alliance between these provider-owned health co-operatives, the co-operative insurance enterprise and the mainly agricultural co-operative movement to develop a co-operatively organized health national insurance and delivery system.

In the State of Kerala, India, the partnership between user-owned "hospital" co-operatives and government health authorities has been particularly close. Their establishment has been strongly supported, the State Government contributing 50 per cent of shares. It also nominates the secretaries of the Boards of Directors. In turn the co-operatives provide health services to the work forces of government enterprises. In Sri Lanka user-owned health co-operatives are also supported financially by the Government.

Political backing, not so much in the form of government financing, but in public displays of approval and support, has often been valuable in raising the status of new or experimental health co-operatives. For example, the foundation stone of the Shushrusha Citizens' Co-operative Hospital was laid by the Chief Minister of Maharashtra State, and the Hospital was inaugurated by the Prime Minister of India. One of two local philanthropists who actively promoted the establishment in 1962 of the Gampaha Co-operative Hospital in Sri

Lanka was a Member of Parliament and Minister in the Cabinet of President Jayewardene.

(c) Citizen's perceptions of the appropriateness of co-operative enterprise in the health and social care sector

Individual citizens (and broadly based citizens' movements such as those of women and consumers) have not shown strong interest in the opportunities offered by user-owned health and social care co-operatives. This is to a considerable extent a legacy of the colonial period, and of the developmental approaches of the last several decades, when expansion of public health services was a central component of almost all development plans. Although upper income sections of the population continue to rely upon fee-for-service private professionals and institutions, the poor, and much of the lower middle-income strata, allow their expectations of the public sector to constrain their willingness to take action as a group, through mutual self help and co-operative organization.

In his report to the International Co-operative Health and Social Care Forum held at Manchester, United Kingdom on 18 September 1995, the Dean of the Shushrusha Co-operative hospital in Bombay, India, pointed out that the general public still took for granted the responsibility of State Governments and municipal authorities for health services. This perception has tended to outweigh both the clear unmet need for adequate and affordable health services, and familiarity with the benefits of co-operative forms of organization existing in the same communities but in other sectors.

(d) Perceptions held by co-operative movements and readiness to promote and support co-operative enterprises in the health and social care sector

Of particular importance for the development of health co-operatives has been the actual experience of actual and potential users of membership of co-operative enterprises in other sectors. In Sri Lanka, for example, there was a very widespread savings and credit co-operative movement ("thrift and credit societies), which had begun in 1911, and a consumer co-operative movement begun during the Second World War and extending to almost every community. Consequently, there was a widespread understanding and appreciation of the nature and value of co-operatively organized enterprises. Members of co-operative movements applied their experience to the problem of providing health services. They established health co-operatives in the late 1950s in the North, especially in the Jaffna District, and during the 1960s in the Southern and Western Provinces.

Interventions by co-operative leaders have often been significant, and are likely to occur where the concept of co-operative enterprise is already well established. For example, the President of the Sri Lankan national co-operative organization was in 1992 also a member of the Board of Management of the Gampaha Co-operative Hospital.

Provision of capital from within the co-operative movement has also been significant. For example, the Gampaha Co-operative Hospital in Sri Lanka obtained a loan to purchase land and construct its facilities in 1970 from the Provincial Co-operative Bank, the loan being repaid by 1987. The Shushrusha Hospital Co-operative in Bombay also received a loan from the State Co-operative Bank.

(e) Perceptions held by trade unions and other popular movements

Trade unions in Singapore and the Self-Employed Women's Association (SEWA) in India have found co-operative organization a valuable vehicle for providing health and social care to members. There is every reason to believe that

trade unions and other popular movements can be strong supporters of co-operative enterprise in this sector.

(f) Perceptions held by health and social care professionals concerning the appropriateness of co-operative enterprises in the health and social care sectors

Health professionals, usually doctors, both individually and as a small group, have taken initiatives and devoted considerable personal energy and resources to the foundation and early operation of a significant proportion of user-owned health cooperatives based on hospitals and clinics in the region, such as the Shushrusha Citizens' Co-operative Hospital Ltd., in Bombay, India.

(g) Perceptions held by private for-profit enterprise

In a number of these countries health co-operatives contract with private for-profit enterprises for the provision of occupational health services. There is no reason to believe that most such enterprises would not welcome extension of such arrangements.

(h) Technical and organizational determinants

The weakness of apex and support organizations in the co-operative movements and their possible orientation to primary production and export is a major constraint. While capital appears limited, the improvement of the efficiency of co-operative financial institutions will make possible the concentration of capital internal to the movement and the communities within which it operates.

6. Least developed countries

(a) Extent of public sector responsibility and effectiveness

In most of these countries the public sector, in some cases in partnership with philanthropic or religious organizations, was nominally responsible for health and social care services for all but a small proportion of the population during the colonial period, even if actual service delivery was limited by the scarce resources made available. This situation continued after political independence and was reinforced by national development planning, with its emphasis on the public sector's responsibility. However, for the most part, public service delivery continued to be inadequate. Social security systems provided in the public sector were highly restricted, including usually only government employees, and in some cases more permanent members of the labour forces of larger enterprises. Recently, and particularly as a result of structural adjustment policies, even these limited public sector services have been drastically reduced, in some cases collapsing completely. Private providers cater only for a very small proportion of the population.

Some of these countries experienced significant development of supply and marketing co-operatives in the agricultural sector, but most of these were absorbed into the parastatal sector, constraining what might have been their contribution to genuine co-operatively organized innovation in health and social care. Nevertheless, indigenous pre-co-operative organization is common. This has included in some cases the establishment of co-operative health clinics, particularly by groups of women. A few co-operative organizations have provided limited health services to members, and have supported local and informal experiments in establishment of health co-operatives.

In a few of these countries - Benin, Niger, United Republic of Tanzania, Myanmar and Haiti - very small and localized co-operatively organized experiments have taken place recently, including both user-owned and primary level provider-owned health co-operatives and user-owned co-operative pharmacies. In most cases they have been associated with other co-operatives or with trade unions, and have been partly promoted and supported by partnerships which have included national and international co-operative movements, Governments and inter-governmental organizations. Co-operative insurance enterprises exist in Ghana, Kenya, Nigeria and Uganda, but do not offer health insurance.

(b) Governmental perceptions and policy positions concerning the appropriateness of a co-operatively organized component of the health and social care sector

The perceptions held by the majority of Governments of these countries in respect to co-operative enterprises in general have been affected by the experience of the last half century. All but a few countries experienced colonial administration, characterised during the 1950s and 1960s by forms of development planning which included considerable support for the establishment of co-operatives, particularly in agriculture. With political independence and the adoption of national development planning, enthusiasm for co-operatives continued, but resulted in their progressive transformation into parastatal enterprises which suffered from the inefficiencies of the public sector, both distorted and constrained spontaneous local development and alienated members.

During the last decade, with structural adjustment, there has occurred dismantlement of the parastatal structures, including those incorrectly termed co-operatives. Many opportunities have appeared for genuine co-operative enterprise, but co-operative movements are still too closely associated, in the perception of officials and technical assistance organizations, with unsatisfactory past experience. Consequently, there is often some caution in respect to new areas of co-operative development, although no significant hostility. Both the international co-operative movement and intergovernmental organizations have given much emphasis to dispelling uncertainty and promoting the idea that genuine co-operative enterprises can play a most important role. Governments appear to accept these arguments, as suggested by their willingness to introduce new legislation which acknowledges the special character of co-operatives.

(c) Citizens' perceptions of the appropriateness of co-operative enterprise in the health and social care sector

While citizens in many countries are still cautious of co-operatives, given their negative experience of the parastatal monopolies incorrectly designated "co-operatives", the success of new co-operative enterprises in taking advantage of contemporary opportunities established by privatization may now be overcoming such perceptions.

Of particular significance is the fact that mutual assistance is inherent in many communities in these countries. There are many examples of community initiatives to set up improved health facilities, undertake preventive health programmes, and improve nutrition and sanitation. Some of these have been part of the activities of co-operatives. There would seem to be much scope for using the formal principles of co-operative organization to channel these processes into a more efficient mode.

(d) Perceptions held by co-operative movements and readiness to promote and support co-operative enterprises in the health and social care sector

Until very recently co-operative apex organizations did not appear to give priority consideration to engagement in health and social care, although individual organizations and enterprises frequently included health and social care within the benefits provided to members.

(e) Perceptions held by trade unions and other popular movements

With the exception of trade unions in Senegal, trade unions have not generally supported co-operative involvement in health and social care, and have not opted for co-operative forms of enterprise as a means to provide insurance or services to members.

(f) Perceptions held by health and social care professionals concerning the appropriateness of co-operative enterprises in the health and social care sector

The degree of engagement by co-operatives in health and social care in these countries has been so minor, that it is unlikely that health professionals will have formed any strong perception on their activity, or its relevance to their own concerns.

(g) Perceptions held by private for-profit enterprise

Large-scale private enterprises in these countries often adopted policies of providing health and social benefits to their permanent labour force as a means to build up productivity and loyalty. These took the form of enterprise-based health centres and clinics and day care centres.

(h) Technical and organizational determinants

Although shortage of capital may have been a major deterrent, the experience of savings and credit co-operatives in many of these countries suggests that the cause has not been the absence of capital, but rather that of efficient financial institutions in which individuals can have confidence. Moreover, the organizational structures of health and social care co-operatives are such that they can effectively utilise a large volunteer labour force, available within many local communities where contribution to communal projects is inherent. Capital requirements for many of the broad preventive programmes of such co-operatives are not large. The weakness of national apex organizations and co-operative support institutions is a major constraint.

7. Transitional economies

(a) Extent of public sector responsibility and effectiveness

A largely enterprise-based system of social security, health insurance and health services was established in almost all these countries during the period of socialist central planning. Those enterprises defined as "co-operatives" (in fact state and parastatal "collectives" and not genuine member-controlled enterprises) operated health and social care services by means of specialized departments or units termed in most countries "medical co-operatives". During the recent process of societal restructuring many of these structures disappeared with their parent enterprises or organizations. However, in some cases, particularly among the consumer co-operative organizations which have undergone an only partially completed transition to a genuine co-operative status, the "medical co-operative" has remained in operation (as in Belorus, Moldova, the Russian Federation).

In these circumstances provider-owned health co-operatives existed only in Poland, where they were first set up in 1945 and continuing upto the transition period. Here and elsewhere during the early period of transition

entrepreneurial experiments in the health as in other sectors were legal only in the form of "co-operatives", and for this reason there was a significant, but largely temporary, growth in the number of health co-operatives owned by doctors and dentists. More recently, with legalisation of the full range of private enterprises, entrepreneurs have found other legal forms more appropriate than that of the co-operative. They continue in small numbers in Poland. That recently appearing in Mongolia may be of the early type, one of entrepreneurial convenience, or a genuine private sector co-operative experiment.

It should be recalled that a substantial user-owned health co-operative system developed in the then Yugoslavia during the 1920s and 1930s, and that it constituted a model for a smaller system in Poland during the same period.

(b) Governmental perceptions and policy positions concerning the appropriateness of a co-operatively organized component of the health and social care sector

Since the process of transition began most Governments have passed from a position of strong antipathy to any form of co-operative enterprise - perceived to be a residual of parastatal structures no longer supported - to one of cautious neutrality as the difficulties of privatization became more apparent, and as the international co-operative movement succeeded in explaining the potential of the genuine, democratically owned and controlled co-operative enterprises which already had a significant status in advanced market economies.

(c) Citizens' perceptions of the appropriateness of co-operative enterprise in the health and social care sector

Until the very recent period of transition, it is probable that most citizens considered health and social care matters to be the responsibility of the state and the party. Most forms of spontaneous mutual aid were considered to be inappropriate in the context of the predominance of arrangements made within the context of the larger collectivity.

(d) Perceptions held by co-operative movements and readiness to promote and support co-operative enterprises in the health and social care sector

Until the recent period of transition, the co-operative movement was very largely integrated within the parastatal sector, and was unlikely to have formed an independent opinion concerning co-operative engagement in health and social care. During the recent period, the sectoral and national organizations set up by genuine co-operative enterprises have been concerned most probably with the very difficult problems faced by the movement in the context of rapid privatization. There is little evidence that the potential for engagement by co-operatives in health and social care was identified.

(e) Perceptions held by trade unions and other popular movements

Trade unions, farmers' organizations and other forms of popular movement are still in the process of effective organization in many of these countries. Consequently, the situation is likely to be more one of identifying the mutual benefits of partnership with co-operative enterprise in health and social care, than of their taking the initiative, as has been the case in many developed market economies. It could be argued that co-operatives could provide the organizational means whereby such movements may be able to satisfy member needs, thereby strengthening their own positions.

(f) Perceptions held by health and social care professionals concerning the appropriateness of co-operative enterprises in the health and social care sector

The position of health and social care professionals is not fully known: some took advantage of early periods of privatization to set up provider-owned "co-operatives", but these were actually private for-profit enterprises termed co-operatives because legislation recognized no other form of non-public organization.

(g) Perceptions held by private for-profit enterprise

In the previous structure of social security and service delivery the system was in fact largely enterprise-based. With privatization many of these social functions were terminated.

(h) Technical and organizational determinants

Development of health and social care co-operatives, and particularly the former, face very serious problems of obtaining capital, and securing competent management. Their relationship to newly established national social security and health systems will need to be worked out in an environment where there has been no experience of co-operative forms of organization in this sector. However, the task is not impossible, as the recent successful promotion and development of credit unions in these countries has shown. Very considerable support from the international co-operative movement will be required.

VIII. BENEFITS TO USERS, PROVIDERS, AND SOCIETY OF ENGAGEMENT BY THE CO-OPERATIVE MOVEMENT IN THE HEALTH AND SOCIAL CARE SECTOR

In previous chapters it has been shown that both the societal conditions relevant to engagement by the co-operative movement to health and social care, and the particular forms which that engagement has taken, differ to such an extent that they are best examined separately in respect to a number of distinct groups of national societies. It was felt also that consideration in this Chapter of the benefits and costs to principal stakeholders of different types of co-operative enterprise active in the health and social care sectors cannot be generalized for all societies, but might best be presented for the same major groups of national societies as distinguished previously.

A. Developed market economies

Previously, among the groups of country distinguished as having some similarity in respect to societal conditions relevant to co-operative engagement in health and social care, as well as some similarity in co-operative movement response, the European Welfare States, Canada and Israel, the United States and Japan have been considered separately. However, in considering the benefits (and costs ?) to users, providers and society as a whole of co-operative engagement in health and social care the similarities between these three groups (particularly those in respect to broad socio-demographic trends which establish principal parameters for the sector) appear to be so great that their separate examination would result in unnecessary repetition. For this reason they are combined, and mention made of any significant differences only where appropriate.

The most significant difference, of course, is that of the different configurations of types of co-operative enterprise engaged. In the European Welfare States there are no user-owned health co-operatives, only a few provider-owned health co-operatives, some health insurance provided by co-operative insurance enterprises and some primary-level co-operative pharmacies. In Japan, in contrast, there is a far greater development of user-owned health co-operatives, and some provision of health insurance, both as integral parts of broader agricultural and consumer co-operative movements, but no provider-owned health co-operatives. The pattern is similar in Canada. In the United States a very mixed configuration exists, with predominance of user-owned health co-operatives of the joint "health maintenance organization" and insurance plan type, some additional health insurance provision by co-operative insurers, limited provider-owned health co-operatives but significant development of co-operative forms of support enterprises and secondary level co-operative networks of independent pharmacies.

Consequently, discussion of the benefits of user-owned health co-operatives refers to the situation in the United States and to a lesser extent in Canada, and to the rather different organizational situation in Japan. Discussion of the benefits of provider-owned health co-operatives refers to a rather limited situation (except for Spain where the configuration of co-operative engagement in health and social care is close to that in some Latin American countries).

1. Benefits derived by users

(a) From user-owned health co-operatives

The benefits which a citizen gains from membership of a user-owned health co-operative are derived from the fact that an enterprise of this type is organized on the basis of general co-operative values and principles which have been applied successfully to a very wide range of human endeavour. The single most significant of these principles is ownership and control by members. Because the consumers of the services provided by the health co-operative are its members and thereby its owners, they are able to direct both the overall policy and the operational practices of their enterprise. Consequently, a professional and organizational structure can be established which is highly appropriate to their needs. Moreover, it is not necessary for the users to wait for the usually long process of revision of public policy, then the delays prior to implementation of new or adjusted services, before these become available. Rather structures and programmes can be constantly adjusted and improved in order to continue to meet members' needs in ever changing societal conditions.

It is because of this organizational capability of allowing consumers to take into their own hands the organization of their own health care and that of their families and communities (which brings with it a strong incentive to maintain their own health, and prevent illness) that the co-operative model of a health sector enterprise appears to be more appropriate in many societal conditions than those enterprises which are solely controlled by, and are solely responsive to, the interests of either health care providers or general investors.

This does not, of course, imply that other models may not be more appropriate in certain societal circumstances: given the variety of such circumstances it would be unreasonable to claim that any one model was alone capable of meeting all types of consumer needs. Nevertheless, because the co-operative health enterprise model is capable of very great operational flexibility, while retaining basic principles which remain relevant to a very wide range of societal conditions, it may well be considered an organizational model of universal application.

There appear to be only a few comprehensive evaluations of the costs and benefits of user-owned health co-operatives, whether from the points of view of owner-consumers, of associated providers, other stakeholders, or of society in general. The analysis set out in this section has been drawn in part from a study of the effectiveness of co-operative and other consumer sponsored health care delivery in Canada prepared in June 1990, which summarizes American and Canadian experience as presented in a number of studies from the 1970s and 1980s, and from a study undertaken for the Ministry of Health and Social Services of Quebec, prepared in 1988.276/ Additional material was derived from the 1992 Annual Report of the Group Health Cooperative of Puget Sound: "Control costs - and prove you've done it; improve quality - and measure it; provide access - for all", prepared by Don Glickstein; material prepared by the Medical Co-op Committee of the Japanese Consumers' Co-operative Union and distributed at the International Health-Medical Co-op Forum in 1992 and the International Co-operative Health and Social Care forum in 1995; as well as other information dispersed widely in the sources referred to in the Notes and listed in the Bibliography. It should be emphasized that neither the United Nations nor ICA have commissioned any comprehensive and independent evaluation of health and social care co-operatives.

Some of these studies are concerned with all types of community-based and consumer-oriented organizational models of enterprise in the health sector (e.g. community health centres, not-for-profit health maintenance organizations) rather than with co-operatives alone: hence it has been difficult to isolate those results which relate to health co-operatives alone.

Nevertheless, the available material is sufficient to identify a number of what appear to be the principal advantages. On balance, it constitutes an impressive corpus of evidence suggesting that user-owned health co-operatives, particularly when they are integrated in a single broad strategy together with provider-owned health co-operatives and supported by the contributions of most other elements of the co-operatively organized economy, have a very significant potential for contributing to the resolution of health problems which still exist in many countries.

However, it appears necessary to combine this favourable view with an acknowledgement that (a) there are likely to be circumstances where health co-operatives are not the most appropriate form of organization; (b) in most societies the best overall solution is likely to be a combination of public, co-operative and non-co-operative private sector institutions working in close collaboration within a jointly agreed strategic approach to health.

(i) Access to health services at a cost to the individual which is both affordable and clearly value-for-money and which is lower than in non-cooperatively organized health service systems providing the same type of services

Users, who are members, owners and controllers of their health co-operative, are able to make their own decisions concerning the balance between what they consider an acceptable quality of benefit and its costs. They expect to receive value for money, and accordingly require that the services for which they pay must be provided in a cost-efficient manner. Consequently, in seeking costs that are affordable, they do not seek the lowest cost *per se*, but rather a cost which they can accept as reasonable in respect to the benefits received in exchange

This is the case whether member-users are meeting costs by drawing on their own financial resources including insurance, or benefiting from public insurance and assistance programmes. Aware that they are at least partly responsible as taxpayers and citizens for the costs of health insurance to the public budget, they are in a position to contribute directly to ensuring the effective use of public resources.

Costs are kept to the lowest level commensurate with agreed enterprise goals and levels of benefit to members (as well as "enrolees" in associated health insurance "plans" and other customers) because individual members determine the positions adopted by the voluntary and elected Board of Directors (sometimes termed trustees), who in turn direct the professional management. Consequently, managers are cost conscious.

In successful user-owned health co-operatives the cost to the customer is acceptable and affordable to members: acceptable because of their participation in the management process and their consequent understanding of the factors which determine cost; affordable because they will not agree to management policies which result in costs which are beyond their capacity to pay. Where there is a risk that this might occur, they are in a position to decide on alternative procedures and benefits, or simply to do without - a solution which is acceptable if decided by the persons deprived of the benefit themselves.

Acceptable levels of cost can be achieved not by allowing a reduction in agreed quality, but rather by an appropriate strategic approach and effective internal structures and procedures. Both are possible not solely on the basis of consumer control but also on the basis of consumer confidence in both management and professional employees. In addition to the advantages to the user of reasonable cost or affordability, the pre-payment characteristic is

also helpful in that it facilitates their own financial management: for the contractual period health costs are known in advance and can be budgeted.

a. Evidence of lower costs

The review of the literature on Canadian and United States experience during the 1980s found that co-operative forms of consumer-sponsored community health centres in Canada appeared to be in general more cost-effective than fee-for-service practices: no evidence was found that they were less cost-effective. Their overall care cost per patient was lower than a comparable group of patients of fee-for-service practitioners. Thus a 1983 comparison of the costs of 15,000 users of the two largest community clinics in Saskatchewan with those of 15,000 users of private practices in the same localities concluded that costs in the former were 17 per cent lower than in the latter. Out-patient services and such support services as x-ray, laboratory, and physiotherapy were provided at lower cost than by hospitals which were not community-based or consumer-sponsored. Co-operative and other consumer-controlled hospitals offered rational emergency services of at least the same standard as other facilities.

Indeed, the review pointed out that the studies reviewed may have underestimated the cost-effectiveness of co-operative facilities for these served poor or otherwise disadvantaged sections of society which had higher than average incidence of disease and disability, and therefore a greater need for health care. This probably would have imposed costs higher than those for organizations where users were from more advantaged sections of society.

These findings have been supported by American studies. In 1993 the United States Congressional Budget Office noted that "fully integrated health maintenance organizations (HMOs) with their own delivery systems" (i.e.staff model HMOs where user/patients, health professionals/providers and managers are integrated formally in a mutually dependant structure within a single organization) were the forms of managed care for which demonstrated cost savings were the greatest. The Office estimated that these HMOs reduced personal health expenditures by 15 per cent from their levels under traditional health insurance with typical coinsurance. Co-operatively organised HMOs were more cost-effective than the average.277/

Mutual organizations have been shown to bring about a similar restraint in the market. In France, for example, Mutual Aid Societies forming the "Mutualité Française", as non-profit organizations, are able to keep charges close to that accepted by the National Social Security System. They operate health and social care services whose higher quality services and lower costs are intended to put pressure on the health care market. Where facilities operated by the mutual societies occupy a certain market share within an area they are able in fact to influence all prices. In the Department of Tarn, for example, where Mutual Aid Societies operate half of the dental clinics, fees in the private sector are much lower than in adjacent departments where there is less mutualist presence. 278/

b. Principal means of cost control

i. Integration of insurance with service delivery functions

This is possibly the most significant of those characteristics of a user-controlled health co-operative which are conducive to an affordable cost. In a user-owned health co-operative the health insurance function is integrated with its health care function. User members and non-member customers or "enrolees" in a "health plan" (a health insurance policy and associated arrangements for providing services) make agreed pre-payments to the co-operative. Having done so, any costs arising from their ill-health must be

borne by the co-operative, however high they may be (and whether directly or through reinsurance). Such costs cannot be transferred to any other institution. Whichever department or programme of the co-operative generates the cost, the enterprise as a whole must absorb it. If this happens, there is a lesser surplus for investment in the improvement of future services. There is also a higher pre-payment charge to members for subsequent periods of insurance which makes membership less attractive, constraining size and hence opportunity to benefit from economies of scale. Less satisfactory and more costly future services are both disadvantageous to members, who accordingly seek to avoid them.

Because charges are spread equitably over the membership, and are not varied according to risk (whether directly on medical grounds, or indirectly on grounds of gender, age, occupation or other socio-economic characteristics) every member of the health co-operative has an interest in ensuring that the increased costs which will arise from the ill-health of any member are eliminated. Consequently, those members at lower risk have an interest in bringing about a reduction in the higher risks faced by less advantaged members. This is a strong motivation toward both effective operation of the co-operative and a strongly preventive emphasis.

Costs could be reduced if the co-operative were to refuse to admit as members those individuals at high-risk - notably those from less advantaged sections of the community in which it operates. This option is rarely followed, however, partly because it contradicts co-operative principles of open membership and concern for the community, partly because it is not compatible with the long-term interests of members. If the health status of some in their community is low, this constitutes a threat to the health of all. It is less costly to resolve such a situation by inclusion of those at risk as members, and then extension to them of the co-operative's preventive health programmes, than to exclude them from membership and thereafter to have to deal with repeated high cost protection, cure and rehabilitation of a limited number members exposed to "higher risk community environment".

However, while all members, and hence both management and professional staff, have an interest in cost reduction wherever possible and feasible, none has an interest in inappropriate cost reduction. Those "managed healthcare" organizations which fully integrate healthcare delivery and healthcare financing and which are "staff and group models" - that is have their own professional staff, and base their activities upon group pre-payment - have an incentive to avoid unnecessary procedures. However, they must take care not to save on needed care, because if members do not receive high-quality treatment they sooner or later become even more sick and the health co-operative remains obliged to pay for their ultimately more expensive care. Short-term savings are likely to cause long-term additional expenditures if prevention or early intervention is not effective.

While various organizational modalities for staff model managed health care institutions are possible, only the user-owned co-operative model ensures affective consumer control of management and thereby actual delivery and enjoyment of these potential benefits. In contrast, private for-profit health insurance is obliged, in order to achieve profit objectives, to link the nature of care to profits. There are no incentives to control costs. Consequently, some "managed care" organizations are in fact "managed cost" organizations, relying solely for this purpose on pricing and utilization controls which constrain the quality of care and service: they ignore quality, focusing only on cutting costs.

It must be noted, however, that even if they are reasonable and affordable, costs are nonetheless not minimal, given that members expect a reasonable amount of care, and given that prevention and early intervention is essential, that certain curative services cannot be avoided and that

rehabilitative measures must be effective. This is why user-owned health co-operatives have usually appeared, or at least succeeded, within a middle- and lower middle-income context, rather than in the lowest income communities, except where supported by other co-operatives or trade unions, or where members are eligible for public sector insurance and other assistance, paid to the co-operatives.

Low-income households are more likely to be able to afford the costs of membership in a user-owned health co-operative than to afford obtaining the same level of health care from private for-profit enterprises. Nevertheless, a still high proportion may not be able to afford even the lower costs of services from a health co-operative. Where public health insurance, oriented to low-income households, is available their difficulty is resolved.

In a number of countries user-owned cooperatives provide reduced or free cost services to low income households. This is done partly out of solidarity but partly out of self-interest, given that achievement and maintenance of comprehensive community health is essential to success in prevention and hence to the viability of the co-operative. However, the proportion of low-income members that can be accepted, or the extent of free service provision to non-member low-income households, both have limits established by the resources available to the co-operative.

<u>ii</u>. <u>Significantly lower hospital utilization rates than in non-co-operatively organized facilities and systems</u>

The most significant and incontrovertible finding of the numerous American and Canadian empirical studies which were examined in the 1990 Canadian study was that lower hospital utilization was one of the principal reasons for the superior cost-effectiveness of consumer-controlled and community-based health organizations, including user-owned health co-operatives. Of particular relevance for overall health costs, given the significance of a growing elderly population, was the finding that the size of the reduction in hospitalization costs was greatest for persons in the older age groups.

The cause of the lower levels of hospital utilization had been identified by a 1973 study in Saskatchewan, Canada, which had concluded that the entire nature of physician practice in the co-operative clinics was relevant. Such factors as general practitioner versus specialist, place of graduation, or age of physician were shown not to be significant explanations of the differences. The modalities of payment to health professionals used by health co-operatives, such as salary paid to staff professionals, and capitation or fixed budget payments to consultant physicians, were associated with rates of hospital utilization from 10 to 40 per cent below those for the patients of fee-for-service doctors. Numerous studies had shown that the capitation or salaried staff methods generated incentives for a more efficient use of resources. Conversely, the fee-for-service method led to over-servicing of patients: unnecessary visits and hospital admissions, more intensive servicing, excess referrals, etcetera. Doctors responsible for patients in the health co-operatives had no personal stake in hospitalization. A 1987 report on experience in Ontario, Canada, had noted that the reasons for lower hospital utilization, and therefore costs, included "ambulatory investigations, early discharge options, day care surgery and other health and social programmes". Studies in Ottawa had shown that earlier recognition and treatment of disease and the integration of health and social services to permit continuity of care, were also among the factors most often cited as being responsible for the lower hospital utilization rate.

Studies of the experience of health maintenance organizations in the United States (not limited to those co-operatively organized) in the 1980s showed even greater reductions in proportions of hospital admissions and duration of

stay, and a consequent substantial reduction in hospitalization costs compared to fee-for-service modalities. This resulted in part from the vertically integrated nature of services, and the associated availability of a range of alternative interventions within the same organization.

It was acknowledged in both Canadian and United States studies that reductions in hospital costs might make necessary an increase in costs at the clinic and doctor's practice levels. However, these were likely to be smaller than the savings on hospitalization, achieving thereby an overall reduction in cost.

iii. More cost-effective use of human resources, particularly of health professionals

American and Canadian studies showed that emphasis on multi disciplinary teams ensured that co-operatively organized and other community-based and consumer sponsored and controlled health organizations were better and more cost-effective users of health care professionals than non-cooperatively organized organizations. It permitted far greater, though still appropriate, use of health professionals other than doctors, including nurses, nurse-practitioners, mid-wives, physiotherapists, occupational therapists and nutritionists. Such health professionals, assisted by appropriately trained para-professionals, had been found to be as capable as doctors of undertaking much preventive and promotional health work as well as some curative and rehabilitative work. More effective prevention of ill-health, a cost savings in itself, could be achieved by means of such entirely functional substitution of lower cost for higher cost labour. Moreover, studies in Canada suggested that doctors in these organizations dealt with larger numbers of patients, increasing their loads, but not to inappropriate levels. This in itself contributed to lower costs per patient.

This characteristic makes consumer-controlled and community-based health service entrepreneurs, notably those co-operatively organized, particularly suitable in those circumstances where doctors are scarce, whether because an insufficient number are trained or because financial resources are insufficient to employ them. In these circumstances, it is often possible to employ less expensively trained para professional staff at lower salary levels.

The doctors employed in these organizations were found to have been much more positive about working in multi-disciplinary teams which included professionals with complementary training and experience than those engaged in private for-profit enterprises, where there was opposition to the use of other health professionals and para-professionals. This suggests either some predisposition among those doctors seeking employment in this type of organization, or a process of learning whereby doctors, once employed there, come to appreciate the advantages of such organizations.

The emphasis upon inclusive community-wide membership and broad preventive health and social care outreach is reflected in the nature of the staff employed. Everyone in the community must be given access to the benefits of the co-operative's activities though membership or enrolment in an associated health plan. This arises from the application of a basic principle of co-operation, as well as self-interest - the health of individual members cannot be isolated from the health of the communities and society in which they reside and work. However, the resultant user demand is likely to be highly diverse, reflecting the different components within the communities from which members are drawn and in which the health co-operative operates. Consequently, services offered must be equally diverse and flexible: and to ensure that this is done, and done at a high level of quality, the human resources available to the co-operative must also be diverse, widely experienced and flexible.

In the "integrated-care model" of health maintenance organization, including those which are co-operatives, choice of what care is provided, by whom and where, is dictated by what is most appropriate for the user (customer, patient) and not for the provider or anyone else in the community. Thus effective care might be provided best by a nurse, a family doctor or a consulting specialist. It might be provided best at home, in the community or in a clinic or hospital. Such an approach requires great flexibility in management and administration, and the availability of a wide variety of efficient staff, facilities, equipment and programmes. The availability of such a diverse staff within a single organization is in itself an opportunity for provision of more efficient and ultimately less expensive services. Moreover, integrated management approaches imply that individual staff or departments are able to work together without worrying if others might benefit at their expense, or adopt an opposed approach: this in itself leads to greater efficiency in use of human resources.

Moreover, because the diverse programme and staff components must be integrated and coordinated, their design and management requires an effective partnership between professional providers, administrators and consumers acting as policy-makers. This may cause additional costs in administration, as it may require, for example, maintenance of more complex data systems. However, it also provides savings in terms of optimal use of human resources, which are likely to be in the medium- and longer-term far greater.

Of particular importance to the effective use of the human resources constituted by health professionals in user-owned health co-operatives is the resolution of the potential conflict between users and providers, doctors and patients. It is made effective because of their unique system of democratic control and responsible management. It is only in an environment of full mutual confidence between user-owners and professional providers that decisions can be reached on the optimal balance between the appropriateness of services and their costs. User-owners are not in a position to understand a high proportion of the requirements of medical science, nor of many administrative and financial considerations: consequently they must have confidence in both the health professionals as well as the managers and administrators whom they employ. Possibly more than in any other type of enterprise in the health sector, this mutual confidence has been most easily and satisfactorily established within a user-owned health co-operative.

Consumer-controlled health co-operatives which employ professional staff (i.e. staff model enterprises) have come to realise that it is necessary to reach a mutual understanding with the health professionals, who, within broad policy guidelines, must be given autonomy. Conversely, professional staff have shown a propensity to support the goals of user-owned health co-operative, and are also willing to accommodate, provided they feel professionally comfortable.

Success has been achieved by experimentation, often made necessary by initial conflict, in the development of formal and informal mechanisms and procedures which encourage and facilitate continuing dialogue between representatives of user-owners, health professionals and managers. The Group Health Co-operative of Puget Sound has engaged in almost fifty years of successful experimentation in the development of confidence between professional staff, user representatives and management. In the health co-operatives within the Japanese consumers' co-operative movement the programmes of member education provided by professional staff to members have become a means for broader interaction and collaboration between staff and users. Within this collaboration process, staff have learned from members and gained better understanding of their situation, needs and capacity for autonomous action.

Within small communities tension between producers and consumers is likely to be small, because - even with specialization - most producers, and their dependents, are simultaneously consumers of goods and services produced by others, and most consumers, and their dependents, are simultaneously producers of goods and services consumed by others (and additional mutual dependencies exist). However, in larger communities and in society as a whole the mutual dependencies can become obscured. Consequently, individuals may believe that they are not mutually dependent, or at least not in the short-term, so that there may be little interest in inter-generational consequences, or of the relevance to their own health of the condition of other sections of society.

In contrast to such a general tendency, members of co-operative enterprises, whether producers and consumers, are likely to acknowledge and accept the reality of mutual dependency: because of (a) their acceptance of common values and principles and their experience of the practical value of solidarity and mutual self-help; (b) practical experience of vertical extension of activities from sides which may appear to have opposed interests, until they meet in mutually beneficial and efficient operations; (c) greater concern for externalities at community and societal level, and to inter-generational dimensions; (d) recognition of common contextual factors, and awareness of the nature of the operation of broad societal systems; (e) greater experience in identifying costs and benefits as these vary over short, medium and long periods; and (f) perception of their co-operatives as parts of social movements, established in co-operation with management and with doctors and other professionals working in health institutions, and having a single and common purpose.

iv. Lower drug costs per patient than under other delivery models

Provision of fewer, more appropriate and less costly prescriptions, especially for the elderly, has substantial relevance to contemporary concern over health sector costs and proposals for their reduction. A 1983 study in Saskatchewan showed that doctors in community clinics prescribed fewer prescriptions for elderly patients, and that those which were prescribed entailed less expensive drugs, than fee-for-service doctors. The Group Health Cooperative of Puget Sound has actively sought to reduce the costs of medicines. It participated in joint purchasing agreements wherever appropriate. If suppliers resisted offering volume discounts, the Cooperative sought alternatives from other manufacturers. Where suppliers had made unjustifiable price increases, the Cooperative ceased doing business with them. Every effort was made to ensure that drugs were used in an optimal way, and to use equivalent but less expensive drugs wherever possible. The Co-operative participated in joint purchasing agreements.

v. Adoption by management of cost-effective internal procedures and continuous innovation

As is the case for all co-operatives operating in conditions of open competition, their survival implies efficiency and ability to meet a need. Hence, the fact that even user-owned health co-operatives have survived, and in some cases expanded in highly competitive conditions such as those existing in the United States, suggests that they can be at least as efficient as other types of enterprise active in the health sector. Moreover, a wide range of independent researchers have examined their programmes and have concluded that they are in general at least as effective as similar but non-co-operative enterprises, and are in important respects more effective.

Managers of user-owned health co-operatives must be transparent and accountable to representatives of user-owners, who are strongly motivated to keep costs as low as possible in relation to agreed schedules of services. Because they are responsible to the owners of the enterprise, who are its members and users of its services, managers recognize that they must not only

control costs, but prove they have done so. This requires that all activities and their impact must be measured effectively.

A Canadian review of experience during the 1980s pointed out that most consumer-controlled and community-based health organizations employed professional administrators with a training in business or health administration, whereas this was uncommon in private free-for-service organizations. In consumer-controlled health organizations, because of the pre-paid sources of income and salaried staff, it was possible to develop better cost and expenditure control, more predictable budgets and hence more effective programme planning. For this reason, management information systems were relatively easier to establish and operate, allowing for more efficient financial management.

Costs are kept down by means of "utilization management" - for example ensuring that patients receive the care they need, but not redundant, unneeded care: this is particularly the case in respect to hospitalization rates. Control of costs requires appropriate management of the services provided - "managed-care" - requires that services respond to real need, and avoid the costs originating in low priority activities, including those with limited multiplier impact on the total health status of members.

Emphasis is given to limiting overhead costs. For example, the Group Health Cooperative of Puget Sound in the United States, during the two years 1991-1992, increased administrative staff positions by 1.3 per cent, but positions in patient care by 7.3 per cent. In 1993 91.4 per cent of the budget was allocated to patient care, one of the highest of any comparable organization. Major attention has been given to greater efficiency in staffing patterns. For example, in 1993 in the hospitals of the Group Health Cooperative of Puget Sound "patient care technicians" took over routine duties from registered nurses.

Payments for services from external suppliers have been cut by establishing the Cooperative's own central facility for the supply of goods and equipment, expected to bring about annual savings of one million dollars. Together with renegotiation of contracts with suppliers in order to obtain more favourable terms (made possible perhaps because of the continued growth in the size of the Cooperative and the value of its bulk purchase) this made possible a reduction of 6 per cent in outside purchases from 1991 to 1992.

(ii) Better (and more appropriate) quality of care

Reviews of experience in Canada and the United States have shown no evidence that community and consumer-sponsored health institutions, including health co-operatives, compromised on the quality of care provided. Indeed, many studies had shown that they provided higher quality care than other health service delivery organizations, particularly in respect to promotional and preventive measures, such as the provision of comprehensive examinations, well-baby care and perinatal care, childhood immunization and cancer screening.

The Canadian review also pointed out that the criticism directed by pay-for-service practitioners against co-operative and other consumer-controlled health organizations, namely that their policies of reducing costs resulted in underservicing of patients, could not be justified by any available evidence. Indeed, several United States studies had rejected this hypothesis. In a system in which patients had free choice and easy mobility, where codes of patient's rights were well developed, and in which doctors typically obeyed their own code of ethics, underservicing was unlikely. Moreover, it was much easier for patients to recognize underservicing and respond to it, than for them to recognize that they were being given more services than might be necessary.

A comprehensive review of health maintenance organizations, including those which were co-operatives, published in June 1993 in the business magazine, Fortune, stated that clinical studies carried out by universities, hospitals and other research centres throughout the United States had compared diagnoses, treatment, results and mortality rates for patients treated by such organizations with those for patients treated elsewhere. Results showed that the care received by the former was at least as good as that received by the latter. 279/ A study undertaken by the National Cancer Institute and published in March 1991 showed that members of HMOs were significantly more likely to have received screening tests for cancer within the previous three-year period than persons whose medical care was provided by fee-for-service private doctors. In 1987 the Rand Corporation's federally sponsored, multi-year "Health Insurance Experiment" concluded that "Our results are consistent with a hypothesis of no differences in health status measures between the two systems (HMO and fee-for-service). We conclude that the cost savings achieved by this HMO through lower hospitalization rates were not reflected in lower levels of health status." 280/

Of all types of fully integrated health maintenance organizations, those organized as a genuine user-owned co-operative have the greatest inherent potential for managed care in which the combination of reasonable cost and acceptable quality is the best achievable, because of the synergic relationships between users, managers and professional health providers.

While emphasis is given to controlling costs, equal attention is given to improving quality. There is no question of achieving cost reductions by compromising on quality: this is so because users desire high quality care and are prepared to pay for it, provided that they can be sure that provision is cost-efficient. Presented with reasonable costs, based upon efficiency and selection of appropriate services, they are able to judge for themselves the relative value they attach to available options.

Services are of high quality also because they are appropriate and relevant to the consumer, which is, in turn, the result of the consumer having been a full participant in their design, implementation, monitoring and review. Services are flexible: consumers are able to choose programmes that respond best to their individual needs.

Adoption of an emphasis upon prevention requires that relevant staff be trained to deal most effectively with individuals in the community, and have the appropriate equipment. As an extension of the basic principle of co-operation which emphasises the fact that every co-operative has an interest in the well-being of the community in which it operates (an expression of the fact that its members are drawn from that community, which includes not only themselves but their families, neighbours, colleagues and others), user-owned health co-operatives display social (or community, societal) responsibility in their actions. It is for this reason that they seek partnerships with all stakeholders in health and social services operating in the same region.

Emphasis upon efficient management, expressed in the continual adoption of innovations, including "total quality management", and structuring to encourage greater individual decision-making authority and accountability is based upon the principle of listening to the users and then energetically trying to find the best way to meet their needs.

(iii) Greater patient satisfaction and significantly increased consumer choice in respect to decisions about health services

Most health co-operatives report widespread user-member and other customer satisfaction, extending to preference over other available providers, public and private. They appear to enjoy considerable respect and support in the communities in which they operate. Users of co-operative and other

consumer-controlled health services were in general satisfied, with the sole exception of concern that they were likely not to see the same doctor at consecutive visits.

A review of Canadian and American experience during the 1980s concluded that there was very little empirical data on the extent of patient participation in the design of the care they received. However, there was some evidence that doctors employed in co-operative and other consumer-controlled health organizations were more receptive to patient involvement than those engaged in fee-for-service modalities of health provision. It was presumed that the basic principles and philosophy of such organizations, their emphasis on patient education, service to marginalized and other disadvantaged groups, belief in holistic health care and decentralization of medicine, all involved acceptance of patient involvement. Certainly this was much more likely than would be the case in fee-for-service care, in which any such involvement was known to be minimal. The user-owned health co-operatives within the Japanese Consumers' Co-operative Union have given increasing attention to ensuring effective user participation.

(iv) Emphasis upon a broad preventive approach to health, including adoption of a "healthy life-style" and capability to mobilize the human resources latent in most communities

User-members are aware, often as a result of information provided by their co-operative, that the risk of ill-health can be significantly reduced by means of a broad preventive strategy designed to achieve and maintain a state of individual "healthy-living" or a "healthy life-style". However, in order to achieve this goal, both health co-operative members and other users, as well as the community at large, need information, guidance and programme support. This is particularly the case in contemporary societal conditions. Consequently, the health co-operative must include within its activities broad health education and prevention programmes. A circular process is established: once they have become better aware of the benefits of health life-style, user-members increasingly expect their co-operative to help them understand the factors involved and to undertake appropriate measures. Consequently, as owners, they direct it to expand its programmes in this area: but to help reduce their costs user-members are willing to assume considerable responsibility for making their own contributions to achievement of their health objectives. By doing so, they bring an additional resource to the mutual enterprise. This is a resource not available to non-cooperative health enterprises, whether public or private and is not available in those communities where health services are provided only by public or private for-profit enterprises.

User-owned health co-operatives are better able than any other type of enterprise in the health sector of promoting and facilitating the rapid diffusion of knowledge and experience to such a degree that the entire population is able to function as health para-professionals. In this sense users and health professionals enter into a new form of synergy.

Health promotion, the reduction of risk and the prevention of illness are goals that certainly require that the health co-operative expend resources, but savings in expenditure on curative and rehabilitative services exceed these costs. At least this is the case over the medium- and certainly over the long-term. This implies that, in order to gain long-term benefits, members must remain committed to their health co-operative for a significant period of time, and must have the confidence that benefits will be ultimately forthcoming. This in turn increases their interest in securing the long-term efficiency of the enterprise.

Because member-owners understand the processes involved, control the relevant policies and can themselves decide to make commitments which will

bring future rewards, a user-owned co-operative enterprise is better able to provide long-term benefits than an enterprise which must satisfy goals, such a profit maximization, immediately. At any one point of time, it must give attention to both curative as well as broad preventive programmes: certainly an emphasis on the latter does not imply neglect of the former. Nevertheless, over time, the success of preventive programmes (if broadly applied) is likely to progressively reduce the need for curative services, although not, of course, to replace them completely. In the same way, expansion of community self-help and para-professional services, designed for rehabilitation and maintenance of health status for elderly persons and persons with disabilities, implies an overall reduction of the total cost of maintaining satisfactory levels of health among the membership of the co-operative.

Public sector health services require emphasis upon visible curative and rehabilitative successes, which implies that the allocation of resources to this goal must be emphasized and hence a reduction in the longer-term more cost- efficient preventive interventions. Consequently, resources for prevention provided by the public budget are inadequate (because it is less easy to argue for their effectiveness and to identify specific results). Even where they are provided, citizens have reduced confidence in their relevance and efficiency because the numerous intervening factors are beyond their control (non-transparent political and administrative processes and management, and less managerial and technical accountability and efficiency). In contrast, health co-operative accountability and transparency is within their control, and they are able to decide themselves upon the appropriate balance between long-term preventive strategies and short-term interventions (both recognized as being necessary).

The Medical Co-op Committee of the Japanese Consumers' Co-operative Union emphasises that the user-owned health co-operatives within its system are organizations "composed mainly of healthy people", and "established by inhabitants to solve problems concerning their health and daily life." Emphasis is given to the responsibility of the individual to "reform themselves". Such an emphasis is considered to be of particular importance given the demographic and social changes which have brought about a significant decline in mutual support systems based on family and community, which previously had been capable of providing for a substantial proportion of health and social care needs. Of particular relevance had been the multi-generational structure of families and their consequent capacity for caring for both children and the elderly.

Such support systems would have constituted a sound basis for the building up of an effective preventive and health promotional programme based upon collaboration between user-members and health professionals. However, with the increasing break-up of the family and community, growth of individualism and increasing physical isolation of individuals, it had been considered that such social institutions could no longer function as the base for such collaboration. Consequently, new forms of local mutual assistance had to be established: of which one of the most appropriate was felt to be the "*han*-group", a neighborhood group for mutual aid and joint activity. Moreover, in the new demographic and social situation the continuing central function of women was recognized as being of enhanced value.

Many of the individual branches of the user-owned health co-operatives have specialized departments which organize training courses for leaders and particularly active members of local "*han*-groups" (almost all of whom are women): these are termed "health colleges". The graduates return to their communities where they constitute a "health committee" which undertakes promotional and preventive health measures among members at the neighbourhood level. The intensive courses in the "health colleges" are complemented by broad user education programmes, including member education by correspondence.

Canadian and United States studies undertaken during the 1980s showed that co-operative and other consumer-controlled and community-based health services had a clear and distinct lead over fee-for-service delivery modalities in respect to provision of prevention and health promotion services. These included prenatal services; occupational health programmes; stress management; screening for breast and cervical cancer; attention to local sources of environmental pollution and health risk; and distribution of literature on preventive health and "healthy living". Doctors working in fee-for-service conditions, whether as solo practitioners, in group practice, or as employees of for-profit health institutions, had agreed that their fee schedules did not encourage their provision of preventive services.

For example, the bylaws of the Group Health Cooperative of Puget Sound commit the Cooperative to promoting the health of the community. This not only reflects the Cooperative's collective values, but its members' self-interest: if the health of the community is poor and citizens are unable to afford health care, including preventive care, then the cost of the resultant impact upon the community is high and must be met by all. To meet this obligation the Co-operative established an autonomous institution - the Group Health Foundation - through which substantial financial and other resources are channelled each year to community clinics, research in the public interest and innovative community health care programmes for poor and other high-risk people. During 1993, and through this Foundation, the Cooperative has supported child immunization throughout the State of Washington, as well as other efforts to decrease infant morality. It sponsored public events in support of persons with AIDS and health care programmes for homeless families. It financed a gun buy-back programme in Seattle as a means to begin addressing the problem of violence in the community - which it perceives to be without doubt a public health issue.

In Canada there has been in recent years an increasing interest by middle and upper income sections of the population in health co-operatives, which are perceived to be more active promoters of a healthy life-style than other types of health service organization. Moreover, persons in these sections of society wish to become more involved in the planning and operation of the health services available to them.281/

(b) From provider-owned health co-operatives

In many cases health professionals who have set up their own health co-operatives have been imbued with concern for the community. Thus, the Malaysian provider-owned secondary co-operative network stated in 1990 that: "In setting up a doctors' organization ... the choice was either to form a company or a cooperative. It was decided to run a doctors' organization as a cooperative, which stresses service to the Community and not only profit." (underlining in original).282/

One advantage of standardization of services, sharing of common services and bulk-purchase savings characteristic of provider-owned health co-operatives would be the increased capacity to prepare information material for users in such areas as preventive health.

(c) From co-operative insurance enterprise

Because it is a co-operative, this type of insurance enterprise usually has a wider perspective than that common in many enterprises in the sector. Policy-holders who are members and owners, whether directly as individuals or indirectly as members of the co-operatives which own these enterprises, entrust their co-operative with the responsibility to look after their interests in a comprehensive sense, and specifically to prevent losses

wherever possible to limit the effect of loss when it occurs, and to rehabilitate injured policy-holders.

To prevent losses efficiently, it is necessary that the co-operative insurance enterprise engage in research directly, or to promote it in various ways appropriate to the circumstances of the society in which it operates, including by means of collaboration with other stake-holders. An example of this type of research activity is provided by the experience of the co-operative Folksam Group in Sweden, which serves both the co-operative and trade union movements. Since the mid-1960s Folksam has made an internationally recognized contribution to automobile safety for the benefit of all automobile users and insurers. Traffic safety research and research on personal accidents and design of cars, has resulted in publication of regular reports on the interior safety level of cars. Other kinds of research has been undertaken in collaboration with universities and other interested parties: promotion of orthopaedic developments; investigations into the ambulance system in order to enhance the training and education of personnel, and improve facilities and equipment in ambulances; research on patients with neck and shoulder pains, both work-related and as a result of road accidents; asthma and allergy problems; heart attacks and vascular disorders; and experimentation with models of rehabilitation to be offered as services to members of trade unions insured by Folksam.

These activities are initiated and administered by Folksam's Scientific Council. This type of research has often resulted in practical measures being undertaken to promote health and prevent accidents and losses. In collaboration with other social economy organisations, Folksam has established Folksam's Social Council to promote information on loss prevention, health, etc. Projects have included problems of the homeless; alcohol and drug abuse; situation of persons with disabilities; immigrants in the welfare state; the situation of children and young people; problems of working life; early retirement; equality and men's and women's roles; consequences of changes in the welfare state; pollution and environmental conservation; cancer; good working conditions; injuries in sports activities and their prevention; mental health; suicide; the use of seat belts; and many others.

Books and other publications prepared by Folksam offer policy-holders and others a wide variety of information concerning health and rehabilitation matters, social welfare policy, economic and legal matters, school issues, traffic safety, etc. 283/

In recent years, Folksam's Social Council has promoted research, information diffusion, public debate, and policy development in respect to criminality, vandalism, the situation of children in large cities, suicide, women's health, violence against women, marriage and equality in the work-place. The results of its research and policy-oriented analyses have been used in the development of innovative business practices and insurance products which have made pioneering contributions to social protection and well-being in Sweden. 284/

Co-operative insurance enterprises have been pioneers in "ethical business practice", whereby they have adapted ethical and holistic approaches to their business activities. They have been able to combine caring for their members and the wider community, with commercial viability, even success (in fact that success. Indeed, it has been found that commercial success has been an expression of public recognition of, and support for, their ethical policies.

For example, in Sweden, the co-operative insurance enterprise, the Folksam Group, since its establishment in 1900, has based its business goals and practices on an understanding of the close links between insurance risks and losses and their consequences on the one hand, and on the other hand the socio-economic conditions in which its members live and work.

Co-operative insurers are pro-active in fully researching not only trends, but in seeking realistically an understanding of the underlying societal structures and processes. They recognize an obligation to their members (and the communities in which members live and work), and constantly seek better means of protection against loss, appropriate to their members' needs in new societal conditions. In doing so they benefit from considerable member feed-back and participation. Thereby, they are able to identify new conditions and develop realistic solutions.

Moreover, insurance products and services are not developed in order to satisfy profit-making goals, but in order to best satisfy member needs. In the face of societal changes which involve in most countries an increase in the risks faced by significant proportions of the population, combined with reduction in public sector coverage, the responsibility of insurance enterprises for providing appropriate and sufficient coverage becomes all the greater. While those insurers whose business goals are to maximize profits are obliged to take short-term advantage of such new situations, and may not even attach a high priority to changing them, given their profitability, co-operative insurers have no such pressures, and can seek solutions which will best protect members and their dependants. They also seek to constrain or reverse societal changes having negative impact. Thus, they have a strong economic and ethical interest in counteracting tendencies which lead to addiction, violence, criminality and increased loss.

Thus changes in societal conditions make necessary new types of broad collective insurance: but also make them possible in circumstances where the public sector either no longer attempts to keep up with such developments or progressively limits its area of responsibility. The considerable customer satisfaction which results is translated into high levels of business success and ability to compete in a highly competitive market, and hence capacity for continuing to exist and serve members.

Co-operative insurance enterprises are able to contribute to better protection against loss for the significant proportions of the population who are members, direct or indirect. This is the case particularly in those countries where co-operative insurance enterprises have significant shares of the market. Moreover, having a certain weight in the market, they are able to act to ensure acceptable market conditions, preventing exploitation and excessive profit-taking in the non-co-operative and non-mutual components of the private sector.

(d) From social care co-operatives

In a discussion of the expansion of "social co-operatives" in Italy, an explanation of this development was "the endeavour of groups of self-organized citizens to create new forms of social intervention which respond more closely to the effective needs of local communities and, above all, of disadvantaged people". Other explanations of the numerous new initiatives were a desire, on the part of potential users and wider communities, to activate preventive and promotional services, to meet real needs, to adopt forms of democratic management instead of hierarchical organizations with a bureaucratic mentality.

With increased awareness of the statist model, social cooperatives began to attract close attention as a viable formula with which to bring about and manage the "depublicization of social services", by means of models that catered for "intermediate social formations" (movements). It had been seen increasingly to constitute a formula able to guarantee social protection for all citizens and "thus able to create that welfare community that is today the only apparently viable alternative to indiscriminate privatization and residual social policies." Social co-operatives were in fact enterprises managed in a democratic and transparent manner, with a high degree of

responsibility for the rights and well-being of beneficiaries. Indeed in Italy the legislation adopted in 1991 in respect to "social cooperatives" stated that their purpose was "to pursue the general interest of the community in the human enhancement and social integration of citizens". 285/ In Sweden, despite the amount of work involved, parents who have been members of a child care co-operative for a while seldom resign if their children subsequently have an opportunity to attend a municipal day-care centre.286/

(e) From other types of co-operative enterprise contributing to health and social well-being

Prior to the establishment of the Welfare State in a number of developed market economies, a very considerable proportion of the health and social care needs of significant sections of society were met through their membership of consumer-owned retail co-operatives. This was the case, for example, in the United Kingdom, where in the early 1920s a total of 42 per cent of households were members of such co-operatives, which supplied them with half of their food requirements, as well as with a wide range of health, disability, household and other types of insurance, pension, recreation and sports, sanitoria, and other services.287/

2. Benefits derived by providers from health co-operatives

(a) From user-owned health co-operatives

That the co-operative form of organization of health services is acceptable, even preferred by at least some health professionals, is shown by the fact that so many have been involved in the setting up of and early development user-owned health cooperatives. This has been the case in India, Panama, Sri Lanka and Sweden, as well as in pre-Second World War Yugoslavia. In Canada, for example, although many health professionals have reservations about cooperatively organized health facilities and services, some have been prepared to work in the community/cooperative environment.

One advantage of employment as staff within user-owned health co-operatives has been that doctors were freed from the financial imperative which would otherwise persuade them to perform medical procedures for financial rather than patient benefit - the incentive to undertake unnecessary procedures. This gave freedom of conscience. At the same time their freedom to control their professional activities was not compromised, because user-owned health co-operatives have learned to avoid direct intervention in the medical aspects of the operation of their enterprise - this they leave to the health professionals themselves. They have developed various organizational structures and managerial procedures to ensure that there is close collaboration between the co-operative management and the medical staff, under the overall control of boards of directors on which medical staff sit, and thereby, eventually, the member-owners, users or actual and prospective patients.

A further advantage has been release from the very onerous administrative and financial requirements of private practice, these functions being taken over by the control management of their co-operative.

Employment opportunities offered by user-owned health co-operatives for professional and para-professional personnel can become significant generally when economic conditions are unfavourable, as during the 1930s depression in the United States. They can be significant also in certain regions where health co-operatives command a significant share of employment opportunities - the case in certain parts of the United States. For those professionals who are interested in community-based, user participative and broadly preventive approaches user-owned health co-operatives offer opportunities which may not

exist in either public or private for-profit sectors, and which may be difficult to organize as private practitioners.

(b) From provider-owned health co-operatives

In the United States and in some of the European Welfare States (Germany, Portugal, United Kingdom) only a few provider-owned health co-operatives are present. They operate at the primary level. In Canada and Japan there are none. The health professionals who have established them do so primarily to take advantage of economies of scale in respect to operations, common services, group purchasing, and thereby to improved professional conditions and economic benefits and security in much the same way as in the developing market economies (notably Brazil and Malaysia) which will be discussed below. The only country within this group which has a significant provider-owned component (and no user-owned enterprises) is Spain. Here there is an additional strong feeling for the provision of appropriate and affordable health services which pre-dated the establishment of welfare state structures.

Employment opportunities - or perhaps more precisely - assurance of an acceptable income in favourable working conditions - are made available in provider-owned health co-operatives, particularly where these are part of larger secondary networks and national tertiary systems.

Particularly in the United States independent facilities providing health services (hospitals, clinics), including both those that are themselves co-operatives and others, have found it advantageous in economic terms, but also in terms of professional conditions, to combine as group purchasing, common service and marketing co-operatives. Their combined weight has been significant in enhancing their ability to lobby for broad improvement in their own condition, but also that of the entire health and social care sector, thereby benefiting professionals working in the member facilities. Co-operatives of this type established by facilities in rural areas have been particularly successful in improving conditions sufficiently to attract professionals.

Independent pharmacies have combined in similar co-operative networks for the same economic reasons - that is benefits from their resultant ability to secure economies of scale.

(c) From insurance co-operatives

By means of collaboration with co-operative insurance enterprises providers of health services often gain access to a substantially increased clientele, comprising members, employees and their dependents of co-operative enterprises, trade unions and mutual association which are owners of the insurance enterprise.

(d) From social care co-operatives

In Italy, it has been argued that "social co-operatives", including health co-operatives which are in effect primary provider-owned health co-operatives as defined in the typology presented in chapter I, are preferable to other organizational forms benefitting from the privatization of public services. This is so because they combine entrepreneurial energy and participative innovation - which allows for a viable response to the need to create structures which are stable and well-organized but also flexible and efficient, and which are responsive to the need for new forms of social intervention. Their democratic and administratively transparent and responsible forms of direction and management are important in that they encourage persons and institutions willing to commit themselves totally to the support of disadvantaged members of the community, either as paid professional staff or consultants, or volunteers or providers of funds. Such persons are

likely to be convinced by the ability of "social co-operatives" to meet the real needs of the local communities in which they operate.

For these reasons, "social co-operatives" are perceived to be preferable both to public agencies characterised by hierarchical structures and bureaucratic mentalities and, therefore, less able to respond adequately to the specific circumstances of disadvantaged persons in local communities, and for-profit enterprises which are beneficiaries of the process of "indiscriminate privatization", and which are unlikely to be directed or administered in a democratic and transparent manner.

In most cases the professionals who are members, and who are likely to have been the founders of these co-operatives, given their recent origin, explicitly identified them as an organizational means for their enhanced professional development, in an environment not as bureacratized as the public sector, from which most transferred, and not subject to purely profit considerations as in the non-co-operatively organized private sector. This was certainly the situation reported in Italy, Sweden and the United Kingdom.

In those countries where there is substantial development of provider-owned social care co-operatives, as in Italy and Sweden, those professionals who have established such enterprises have stated that these are the organizational form most likely to generate entrepreneurial management of social services in a democratic and transparent manner. They are stable and well-organized structures, but ones which are also flexible and efficient, well suited to those (professionals) who wish to commit themselves totally to persons with disabilities.

Experience in Sweden has shown that providers have enjoyed a high degree of work satisfaction, good opportunities to influence the goals and practices of their co-operative, and much room for professional and personal development. Of particular interest has been the fact that provider-owned co-operatives had been established predominantly by fairly average middle-class persons, often former employees of public sector institutions. Their adoption of co-operative forms of organization was not an expression of ideological conviction, but a pragmatic decision based upon evaluation of the possibilities offered by co-operative forms of enterprise, supported subsequently by their generally satisfactory experience of working within a co-operative structure. Common motives for starting worker co-operatives include increased control over one's work, the possibility of providing better quality services, the freedom to choose workmates and the ability to reduce of eliminate administrative structures that hinder flexible, efficient work. They seem to be fulfilling the objectives they were formed to.accomplish. Since these co-operatives are still very young there is little research evaluating their performance, but a subjective impression is that they are greatly appreciated and directly supported by their clients/ customers (for example, in negotiations with the local authorities).288/

Moreover, and of major significance, the enhanced quality of working-life for professional and para-professional staff had in no way been achieved at the expense of users. On the contrary, high levels of user satisfaction had been measured. For example, the fact that there was a strong demand for places in provider-owned day-care co-operatives, even in areas where there was a clear over-supply of day-care places, was a significant indication of the quality of services offered by the co-operative option.

Indeed, there was good grounds for arguing that the provider-owned co-operative form of organization in this sector was better suited than other organizational forms to the creation of optimal solutions to the issue of balancing staff and users' well-being. It was better able to realize the potential of the professional work-force, including an ability to adjust and experiment in order to meet the specific needs of users. 289/

(e) From other types of co-operative enterprise contributing to health and social well-being

Particularly in the United States independent facilities providing health services (hospitals, clinics), including both those that are themselves co-operatives and others, have found it advantageous in economic terms, but also in terms of professional conditions, to combine as group purchasing common service and marketing co-operatives. Their combined weight has been significant in enhancing their ability to lobby for broad improvement in their own condition, but also that of the entire health and social care sector, thereby benefiting professionals working in the member facilities. Co-operatives of this types established by facilities in rural areas have been particularly successful in improving conditions sufficiently to attract professionals.290/

3. Benefits to society as a whole from the engagement of co-operative enterprise in the health and social care sector

There can be no doubt that there remains a widespread need for community-oriented preventive health services complemented by social care services. These must be backed by curative and rehabilitative services which are affordable and appropriate - that is, which are closely responsive to local conditions, and in the design and operation of which there is full participation by citizens. This exists in developed countries where public systems are not effective and where private for-profit services still stress curative and non-participatory approaches and are in any case too expensive for use by the low-income sections of the population. Indeed in some developed countries substantial minorities of the population are still without adequate health care.

In considering the relevance to society of user-owned health co-operatives it might be useful to take account of each of the organizational means whereby an individual can achieve and maintain health. The following appear to be among the principal such means:

1. oneself (by adopting a healthy life style, including taking actively preventive measures);

2. the immediate family/household/wider individual support system (support for healthy living and preventive actions as well as help in curative interventions and rehabilitative care);

3. the wider local community (including indigenous institutions);

4. institutions directly owned and controlled by the individual (co-operatives);

5. institutions which citizens own in a legal sense, but which de facto they do not control: that is public sector institutions;

6. not-for-profit institutions (charitable organizations with no private for-profit sector sources of funding);

7. "not-for-profit" institutions (foundations and similar associations with significant funding by private sector for-profit sources);

8. for-profit health sector enterprises (from individual physician-owned practice, through group practice to commercial stockholder-owned enterprises), of which some are organized through employment (for-profit enterprise's own health service or employee subsidy for use in obtaining services elsewhere).

If one considers in particular those sources available to the poor, then although sources 1,2 and 3 are available to them, and capable of satisfying a considerable proportion of needs, they are insufficient in themselves. In any case, they are no longer able to operate effectively in the conditions of radical social change which characterize almost all countries, including break-down in immediate family and community support systems.

If one considers source 8, many individuals, and not only of the poor because of inability to pay but middle income persons are excluded because they are not engaged in the formal sector. Hence only sources 4, 5, 6 and 7 are available. In many of the countries where there are large numbers of poor persons, source 5 is limited because public resources are highly constrained. Source 6 and 7, exist, but are variable in their presence, and not within the control of the poor, and hence not necessarily appropriate to their real needs, as identified by themselves. In source 4 only - services from health co-operatives (and in fact only from user-owned health co-operatives) are the poor able to exercise influence over types of service, and hence to select those appropriate to their condition.

Research undertaken by co-operative insurance enterprises as an expression of their responsibilities to policy-holders to explore all means to reduce risk and prevent injury (see section E above), is frequently of benefit not only to the co-operative membership and wider movement, but also to the whole of society. This is made possible in part by the co-operative acting as a model of "best practice" which others in the insurance sector emulate, or are obliged by public regulatory bodies to adjust to. In part it is possible as a result of the widespread diffusion of information through the media channels of the co-operative insurance enterprise itself, or through those of the wider co-operative movement, which are in many countries, very extensive.

Thus not only are health co-operatives one of the means available to fill the gap between a constrained public sector and a for-profit sector not necessarily appropriate to needs, but they are the only means whereby individual citizens are able to participate, to contribute and to achieve the environmental conditions which are essential complements to successful professional intervention in current circumstances.

WHO and UNICEF guidelines suggest that community participation in planning, design and operation is an essential prerequisite for the achievement and maintenance of viable and self-sustaining primary health services. Both user-owned and provider-owned health co-operatives stress a combination of high quality but "appropriate" curative treatment with a broad preventive approach to health care, involving in particular individual, family and community efforts to establish healthy life-styles and a health-supportive environment. While programmes and facilities can be provided by various types of non-profit community institutions, it can be argued that only a co-operative form of organization ensures that level of commitment by the community which is required to make such institutions work effectively.

The particular contributions of health and social care co-operatives may be summarized as follows:

(a) by mobilizing user energy in, for example, participation in preventive and social care outreach, and to some degree also by mobilizing provider energy in more stimulating professional environments, more societal resources are made available to the overall task of improving health and social welfare than would otherwise be the case. This includes enhanced interest by citizens in health and social care issues, policies in respect to which otherwise they might consider they have no opportunity to influence.

(b) by establishing an efficient alternative to the private for-profit health and social care sector, pressure is brought to bear on that sector to

increase its efficiency, provide appropriate services to the public, and use public funding in a more responsible manner (this is a specific aspect of the general capability of consumer-owned co-operative movements to overcome monopolies);

(c) by existing as an efficient and appropriate alternative to public programmes, opportunities are made available for the meeting by Governments of their responsibility to provide health and social care at less cost to public budgets than provision through public agencies, particularly as co-operative partners are less expensive, and allow for more efficient financial management of public budgets, than private for-profit enterprises.

In Japan the user-owned health co-operative system developed within the framework of the Japanese Consumers' Co-operative Union (JCCU), led by the Medical Co-operative Committee of this Union, in co-operation with health professionals and experts, has formed a social movement with the objective of achieving improved individual health and a health sector more appropriate to contemporary and expected societal conditions, particularly those characteristic of a predominantly urban and ageing population.

However, some care needs to be taken by the co-operative movement that government enthusiasm for the "co-operative" option within privatization does not result in either imposition of an excessive and inappropriate responsibility, possibly accompanied by loss of autonomy, or of the strengthening of public perceptions of co-operatives as either parastatal organizations or as "collectives" which are not appropriate to pluralistic democracies based on free-market economies.

Members of user-owned health co-operatives (and usually also other residents of the communities in which they operate) benefit from the flexibility and capacity to adjust to changing societal conditions characteristic of this type of health provider. These qualities are expressions of the close involvement of citizens in their management: changing needs which are felt by members can be transformed into changed business goals and practices because members of the community have effective access to decision-making within the health co-operative. Conversely, the emphasis of such health co-operatives upon educating members and stimulating community awareness of health-related processes in society results in members of such co-operatives being much more aware of the significance of such trends and of the need to take preventive action or adjustments. In such circumstances, the qualities intrinsic to user-owned health co-operatives (provided that they are functionally effective) become highly relevant to societal efforts to improve health and reduce the economic burden of health care systems.

These relationships and their expression do not exist to the same extent where public health systems or private for-profit systems operate (and are predominant). In the case of public health systems, although notionally "owned" by citizens and taxpayers, channels of communication are poorly developed: usually in fact there are no direct means whereby users can express their views and indicate their needs to policy makers in the health sector. It is possible to bring about changes in health policy only through the electoral process, and as part of a much broader and more complex set of issues. Even where policy changes have been made, effective adjustment within the bureaucracy may be delayed, while there is often an in-built resistance to change, and often a failure to perceive the public as the ultimate "owners" of the system. Moreover, little emphasis having been given to education of the public in health matters, citizens are much less able to identify relevant developments in their environments.

In the case of for-profit health systems, policy goals are less related to public service than to profit maximization. This logically restricts emphasis

upon prevention and health-living. Attempts to educate the public are often targeted at high-risk groups or those already ill, as these are the only ones likely to come into contact with the service providers.

Engagement by the co-operative movement in the health and social care sectors has particular significance for women. The emphasis on healthy life-styles and on energetic preventive measures includes elements which are most valuable to women's own health, and also to women's responsibilities for the health of young children. The outreach programmes undertaken by most health and social care co-operatives designed to support persons with disabilities and infirm elderly persons relieves the pressures upon women, who are usually the unpaid and unacknowledged care providers. While they continue to provide the greater proportion of care, they are able to do so in improved conditions and with better recognition, in some cases already as members of their own provider-owned co-operatives.

The emphasis given by consumer-owned retail co-operatives, and increasingly by agricultural production, processing and marketing co-operatives, on improved nutrition is clearly of particular relevance to women, who retain the largest responsibility for final processing and distribution of food.

The emphasis given by housing co-operatives to the particular needs of women, and for women's own housing co-operatives is significant. Co-operative insurance enterprises have begun to adjust their products to meet the particular needs and circumstances of women members.

In some countries the health co-operative movement - particularly where developed from the consumer-owned retail co-operative movement - is in fact largely a women's movement. This is the case with the health co-operatives within the Japanese Consumers' Co-operative Union (JCCU), whose members are predominantly women, and whose prevention and community outreach programmes are organized very largely through the neighbourhood "han-group" system all but a few members of which are women.

(a) <u>Extension of concern for prevention and cost-control to those broader societal processes which cause high levels of ill-health and consequent high ccsts of health care</u>

User-members of health co-operatives who seek to identify the immediate causes of increased risk to their health and the factors which hinder their adoption of a healthy life-style, are obliged to extend their concerns from themselves and their immediate household and family members to the communities in which they live and work, and beyond these to the condition of wider society. This is so because many of the relevant factors arise from processes derived from the underlying structures and behaviour of national and ultimately, global society. Concern for health in the community, long-term prevention and avoidance of risk, requires extension of concerns to the causes of ill-health, which lie far beyond the purely medical area and include social, economic and ultimately political factors of broad societal significance. They include, for example, violence in households, families and neighbourhoods; stress leading to suicide; consumption of narcotic drugs, tobacco and alcohol; risk of accident in traffic, the home or the workplace; malnutrition resulting from poverty, which in turn may be caused by unemployment or employment in exploitive conditions. Ultimately all arise from the nature of economic structures and processes.

A logical extension is to argue for a much broader strategy of reduction of risk, prevention of ill-health, and support for healthy-living. However, this may be contrary to some other interests in society, including those of some components of the health sector itself. Because of its experience of bringing together providers and users, the health co-operative movement is in

a good position to help resolve such broader societal issues of conflict of interest.

Given that user-owned health co-operatives must operate within a mixed health sector, certain of their costs arise from unavoidable inputs from the private for-profit or public sectors. Consequently, their members must be interested in cost-effectiveness throughout the sector: all are asked to share responsibility for cost and quality of health care. The overall impact is to bring about greater responsibility throughout the sector.

For example, the Group Health Cooperative of Puget Sound has worked since its establishment in 1946 for reforms in public policy that would make health care affordable and accessible to all: these attempts often met with resistance, and during the late 1940s and early 1950s it was even subjected to considerable opposition by supporters of traditional providers of health care. More recently, the Cooperative had actively sponsored the work of the Washington State Health Care Commission and its president-emeritus had served on a prestigious national group ("Jackson Hole East") engaged in the development of healthcare reform innovations. The Cooperative had developed its own reform proposal - "Fair Care" - which contained the principles of managed competition. This proposal sought to improve quality and control costs by requiring managed-care organizations to compete using uniform benefits packages. It also sought to improve access by creating large, publicly sponsored buying groups.

The Japanese consumer-owned health co-operative movement has been involved very energetically in promoting public discussion of broad issues of health policy and the need to take into consideration broad societal structures and processes. The movement perceives its role as one of seeking to extend a base in preventive health through the promotion of healthy living and the expansion of social services to development of the function of health co-operatives as an organizational focus of daily life within neighbourhoods and communities, characterised by increased co-operation and solidarity among all members, and particularly between generations.

(b) Better integration of health and non-health services, and greater accessibility of services to disadvantaged sections of the population

Canadian studies have revealed that, because they were obliged to respond to demands arising within the communities from which their members were drawn, co-operative and other consumer-controlled and community based health services had been particularly innovative in providing a wide range of services not available - at least in an affordable form - from other types of health institution. Examples included minor surgery; chiropody programmes; occupational health; geriatric day hospital programmes; and dental services.

Co-operative and other consumer-controlled and community-based health services were engaged with a wide range of non-medical services. Their emphasis on health promotion and the prevention of ill-health involved the extension of programmes to counselling, monitoring and identification of risk. Follow-up and rehabilitation resulted in the extension of their activities into social medicine and social services. Both required interaction with families, neighbours, colleagues and others in the communities in which individuals lived and worked. They were required to employ a wide range of professionals and paraprofessionals devoted to social medicine and social service provision. Consequently, there was much less of a distinction between health and social service provision within their programmes than was the case in either public or private for-profit health care sectors.

Indeed, user-owned health co-operatives constituted natural mechanisms for facilitating the integration of health and social services within the communities where they operated. This had arisen largely by means of the

response of the organizations to community needs as expressed through community participation in their direction and management. The integration of health and social services - and even their further extension to housing, education, legal protection, and social security matters - reflected their orientation toward a more holistic approach to health than that limited to a medical model. There was a strong tendency toward social service strategies in which medical interventions, although significant, were only one among several emphases.

This focus was an expression of the concern of such organizations with those sections of the community - primarily those marginalized or otherwise disadvantaged - who needed an integrated constellation of services not readily available from other health care delivery modalities. They provided numerous programmes targeted on particularly disadvantaged sections of local communities: such as visiting nurse and self-help programmes for the elderly; birth control programmes for adolescents; counselling for victims of family violence and sexual assault; preventive and educational programmes for drug and alcohol problems; counselling and social work services for persons with disabilities; and programmes designed specifically for low-income women, indigenous populations, immigrants and rural populations. They had shown a particularly impressive record in respect to provision of services for rural populations, the elderly and women.

Community demand, channelled through community control, stimulated a high degree of innovativeness in respect to extending primary health and social services to sections of the community not well served by other delivery modalities; and the integration of health, social and other community services.

Indeed, such organizations were already putting into practice what Governments had come to acknowledge increasingly, that the determinants of health included much more than the provision of medical services. They believed that an array of social, educational, economic, housing, nutrition, counselling, preventive and health promotional programmes were needed, and health co-operatives had frequently introduced and developed them to a greater degree than other institutions in health and social care.

In Sweden the development of child-care co-operatives has had a favourable impact not only in meeting a specific need, but in acting as a model for more general community-based action. Throughout the late 1980s and early 1990s, it had been an important Swedish political goal to meet the childcare needs of every family seeking provision for children of more than one year of age. By 1995 only 50% of municipalities had achieved this goal, despite passage of a law that obliged them to provide this service to any family in which both parents were working or studying. The increased number of co-operatives in the childcare sector had made an important contribution towards fulfilling this objective. Since the parent-co-operatives cost the municipalities less than their own institutions, they gave better value for money. The unpaid work invested by parents (such as locating and repairing the nursery premises, recruiting staff, and performing administrative tasks) meant that thousands of parents could return to work (and paying taxes) when they and their employers wanted, instead of waiting for a nursery place somewhere else. For the family it was satisfying to know that their child was spending the day in a safe and stimulating environment over which they had some control.

Several co-operatives had been established in rural areas, thus enabling young people to remain in their villages rather than having to move to a large city to gain access to childcare. Especially in Jamtland, in northern Sweden, there were many "village co-operatives", which originally started as daycare centres. Having succeeded in this capacity, the inhabitants had gained the self-confidence to develop the whole village by identifying income-generating activities such as handicrafts.291/

(c) Substantially increased public (community) involvement in the setting of priorities, operational policies, programme planning and administration in the health and social care sectors and resultant enhanced awareness of strategic issues

Partly because of the complexity of the issues, the intensive professional training required, the lack of transparency associated with public sector engagement, health and social care are areas in which many citizens feel themselves to be not competent enough to participate in policy making or in management of programmes and facilities. Health co-operatives have provided opportunities for diffusion of knowledge and meaningful participation by laymen.

(i) The contribution of user-owned health co-operatives

A review of Canadian and United States experience in the 1980s noted that most consumer-sponsored and community-based health institutions were managed by an incorporated non-profit community board directly accountable to the public. This form of involvement was considered more likely to result in services that responded to the real needs of the community as defined by its own members, than was the case for any other type of health care providing organization. The expansion of democratic health governance and acceptance of patient rights was possible within such organizational forms to an extent greater than within others.

The consumer-owned health co-operative movement in Japan considers that the impact of health co-operatives in society has been greater than that achieved in respect to member's health status alone. The Medical Co-op Committee of the Japanese Consumers' Co-operative Union leads the entire health co-operative movement in its involvement in the national debate concerning policies on health, social security and social welfare. One focus has been to ensure that the needs of citizens can be met through the health co-operative movement; a second focus has been to bring about a change in the public policies, which have during the last two decades emphasized retrenchment in the public health and social security system. The movement has been active in attempting to alter the quality of the health sector as a whole. The movement considers that it has a significant mission within national society.

Although still including only a small proportion of citizens, members of user-owned co-operatives, particularly in Canada and the United States and especially in Japan, where they form a coherent movement at the national level, have played a significant role in influencing national health policies. In Japan they had a major impact upon health and social security provision for elderly persons, and upon the development of the concept of "patient rights", having adopted a "Charter of Patient Rights".

Currently, retrenchment in the public health sector forms part of a broader governmental policy which emphasizes individual and community responsibility for social security and health, transfer of health care to for-profit enterprises, and dismantling of social security and its transformation into a new form of community mutual aid. In these circumstances the movement considers the complementary expansion of user-owned health co-operatives as an important means to protect and serve the health status of the population. At the same time it perceives that it is necessary to lobby for improvement in the public social security system and national health service. Simultaneously it considers its role to be one of promoting a broad preventive approach to health by emphasizing healthy living and by suggesting ways by which ordinary citizens might be able to deal with all the stressful elements of everyday life, as well as improvement in all aspects of the societal and natural environment.

It considers that the expansion of the co-operative organization of health care is a necessary complement to the decline in the ability of families and communities to provide such care, a consequence of the processes of nucleariz-ation of families and individualization of everyday life. This had involved a considerable loss of indigenous knowledge and experience in maintaining healthy living conditions and in dealing with ill-health. The ability of women to carry out their former role as principal care-provider and promoter of healthy living within the family had come under severe strain. A central objective of health co-operatives, to be achieved largely through the activities of "han-groups", is to promote communities devoted to a healthy life-style.

Numerous of the innovations introduced by health co-operatives within their own facilities and programmes are considered by the movement to be relevant to the entire health sector. In particular, the nature and quality of relationships between patients and professional staff is considered to be in need of urgent revision throughout the health sector along the lines already put into effect within health co-operatives. The health co-operative movement also perceives its objectives as extending to community solidarity and the protection of family and community life and culture at risk of severe erosion in modern societal conditions: this is considered not only a necessary aim in itself, but as an important means of preventive health, given the significance of viable families and communities for individual health. The approach adopted by the movement is considered to be particularly appropriate to the situation of a rapidly ageing society, where geriatric diseases can be substantially reduced in individual incidence and societal impact by an emphasis upon healthy living throughout the life cycle.

(ii) The contribution of provider-owned health co-operatives

In Spain the CES Clinicas co-operative in Madrid plays an active role in the consumer arbitration council set up by local authorities in the metropolitan region, seeking to protect consumer rights in the area of its competence.292/

(iii) The contribution of co-operative insurance enterprises

This type of co-operative enterprises understand that levels of risk and loss are an expression largely of basic societal conditions, and hence can be brought within acceptable bounds only by addressing underlying societal structures and processes rather than their symptoms. This insight if made public, contributes to better understanding by citizens of the bases for changes in their condition and prospects, including their security and their need for protection against risk, particularly in highly volatile conditions. For example, the co-operative insurer in Sweden, the Folksam Group, established in 1971 a "Social Council" which has been able to make pioneering contributions to health and medical care, road safety and social policy.293/

(d) Suitability as partners in comprehensive mixed public and private sector health strategies

Co-operative and other consumer-controlled and community-based health organizations are appropriate partners in any such multiple actor strategy. Their integration of preventive and health promotion elements corresponded with the emphases agreed upon internationally, and which constituted major components of the health strategies of most Governments. As practitioners of decentralized and community-responsive health, they are particularly well suited to implement these now central components of public health strategies. At the local level already, almost every community-based health organization was engaged in community networking and participated in many organizations concerned with the harmonizing delivery of health or social services.

They offered better cost and expenditure control, and hence helped in the overall development of predictable budgets and programme planning. Because their health professionals were paid on capitation or salary basis they did not take part in frequent disputes concerning doctor's pay. Costs of professional services could be budgeted in a more predictable way. This in itself was a means whereby overall costs could be kept down.

From the point of view of governmental agencies responsible for overall planning of health and social security budgeting, the process of auditing, monitoring, and reporting within, for example, a comprehensive health sector involving public, co-operative and non-co-operatively organized private sector, was enhanced by the inclusion of a co-operative component.

Costs are kept down also because management and health professionals make every effort to establish a partnership with users (who are either actual or potential patients) whereby users themselves make every effort to avoid health costs to their co-operative (and thereby, ultimately, to themselves) by maintaining a healthy life style: the co-operative helps them achieve this by providing appropriate information, guidance and other programme support.

In this sense the user-owned health co-operative is a microcosm of wider society: users are ultimately required to pay for the benefits they receive. However, unlike broader society, and national systems of social security and health care, where procedures are anonymous, and far removed from immediate user control and where any responsibility for consumer behaviour is so widely diffused as to become meaningless, the activities of the health co-operative are transparent and the impact of irresponsible behaviour clearly visible.

Thus, at least partial substitution of an amorphous public health service with more user-responsive, accountable and transparent user-owned health co-operatives, would appear to be a valuable step toward any equitable but effective societal system of health and social services.

(e) Greater participation in broad community, sub-regional and regional planning

A review of Canadian experience during the 1980s showed that co-operative, as well as other forms of consumer-controlled and community-based health institutions, had shown keen interest and involvement in broad community and regional planning. This was a logical extension of their involvement in planning the health and social service sectors and their concerns for, and interventions in, the societal environment made necessary by their preventive approach.

4. A note on costs to society

In the available literature, most of which originates with health and social care co-operatives themselves, or with other co-operative institutions, no significant disadvantages are identified, at least for the co-operative movement and its members.

In all cases of allocation of resources, it must be borne in mind that the same resources could be allocated to alternative institutions or programmes: therefore their application within the co-operative movement implies that they are not available to other potential providers. This could imply a reduction in the aggregate benefit to society in general. Whether this is the case or not must await comprehensive investigation of the relative benefits and costs of co-operative, non-co-operative private, and public systems. This is not known to have been undertaken by independent researchers in any of the countries in which health and social care co-operatives are well established.

However, it might be pointed out that some considerable part of the resources applied within the co-operative health and social care sector have been mobilized from members' own resources and would not be available for any other type of provider if these same individuals were not organized in co-operative enterprises and thereby empowered to undertake, to a substantial degree by means of organized self-help, improvement in their own health and well-being.

Moreover, the information that is available suggests that co-operative health and social sector institutions are more efficient and more appropriate than other types of institution in the communities in which they operate. They utilise resources more effectively. Furthermore, large sections of the co-operative movement are able, because of their special characteristics, to contribute to a healthier society.

Consequently, it can be presumed that, at least from the point of view of users, and also of a certain section of the health and social care profession, there are significant advantages and only minor disadvantages, if any, in co-operative engagement in this sector. The balance, therefore, may be considered to be largely positive.

B. Latin American countries

The configuration of co-operative engagement in the health and social care sectors in these countries is distinctive: an emphasis on secondary level provider-owned health co-operatives and a significant presence of co-operative insurance enterprises offering health products, all within a health and social sector characterised by a "Bismarkian" approach (i.e. provision of social security, but free choice of non-public providers). As in the European countries with a similar approach, there has been a strong growth of mutual organizations acting as providers of health insurance. There has been only a very limited development of user-owned health co-operatives, and no co-operative pharmacies.

1. Benefits derived by users

(a) From user-owned health co-operatives

Only a few of this type of co-operative exist - in Bolivia, Panama, and in Brazil, where expansion is likely to be the greatest, as part of the comprehensive Unimed system. In Brazil they are intended to meet the needs of societal strata at lower levels of income than those households, mostly within the labour force of large enterprises and institutions, served through health plans by the provider-owned co-operatives of the Unimed system. Persons ineligible for the private health plans offered through employment will be major beneficiaries. As the efficiency of this group of user-owned co-operatives will benefit from their integral membership of the Unimed system, it seems probable that they will be able to provide efficient services to this group of users. It is anticipated that a significant proportion of persons formerly served by philanthropic and religious institutions will find these user-owned co-operatives more satisfactory means to satisfy the needs, as in recent years these institutions have been overwhelmed by their tasks of providing for the poor.

(b) From provider-owned health co-operatives

A national network of provider-owned health co-operatives is likely to be able to provide to the same clientele a higher quality and more affordable services than would the separate practices of members. Because it is likely to grow in effectiveness and in soundness of financial base, such a network is likely to be able to extend services to lower income sections of the

population, in part by providing curative and rehabilitative services formerly too expensive, in part by supporting preventive services.

Provider-owned health co-operatives appeared and expanded in Brazil, Chile and Colombia precisely to occupy the gap between an inadequate public sector and a new and aggressive for-profit private sector. Their users - for the most part employees in larger enterprises and public and semi-public institutions, as well as members themselves, particularly in Colombia - were able to obtain higher quality and more accessible service than had been available to them from public sector facilities, while at the same time avoiding the high costs of the private for-profit sector.

In Costa Rica users of the recently established provider-owned community health co-operatives have responded well to the organizational and programme innovations introduced by these enterprises after the transfer to them of certain of the public sector responsibilities. Users have particularly appreciated their emphasis upon broad community participation in their direction, and prefer this type of co-operative to either public or private for-profit facilities.

(c) From co-operative insurance enterprises

In Colombia the co-operative insurance enterprise offers affordable and appropriate health insurance to members of many of the co-operative organizations active in the country. The fact that it includes among its clientele the members of trade unions and other components of the social economy enable it to take advantage of economies of scale, thereby keeping costs to each user within acceptable limits.

(d) From social care co-operatives

Only one example of a user-owned social care co-operative operating in a Latin American country is included in the study (although it can be presumed that many others exist): that established by young persons with disabilities in El Salvador. It not only provides employment and sources of income, but services, including transportation, none of which would be otherwise available to them.

(e) From other types of co-operative enterprise contributing to health and social well-being

Co-operative pharmacies are not known to exist in Latin America. The large-scale consumer-owned wholesale and retail co-operatives common in Europe have not developed to the same extent, and hence have been less able to have an impact upon improving nutrition and diffusing information promoting "healthy living". The co-operative agricultural sector, although significant in some countries, is more fragmented than in Europe, is primarily concerned with export commodities and hence less able to influence production of safe foodstuffs for internal markets.

2. Benefits derived by providers

(a) From user-owned health co-operatives

The provider-owned Unimed system in Brazil has adopted a strategy of promoting an associated network of user-owned health co-operatives whose members are largely persons unlikely to have been included within the enterprise-based group health insurance plans which have hitherto provided most of its clientele. This can be seen both as a means to extend Unimed market share, and as an opportunity for the practice of the community-based and family-oriented medicine which members consider a professional challenge. Given the serious deterioration in the capability of the philanthropic and

religious health service delivery institutions operating at the community level, this is a very large area for future expansion and diversification, and one relatively free from the aggressive competition from "commercial" health enterprises which is more characteristic of the middle-income spectrum of the market.

(b) From provider-owned health co-operatives

The largest existing system of provider-owned health co-operatives, Unimed do Brasil, was set up by doctors concerned both to maintain their professional integrity and their financial security, in the face of aggressive competition from commercial health enterprises owned and managed by non-professionals which expanded rapidly during the mid-1960s in response to a new national social security environment. Members of the health co-operatives considered the new commercial sector to be not capable of pursuing a family- and community-oriented approach, or of taking the long-term interests of patients into account.

Expansion of the basic secondary networks of health co-operatives, involving the setting up of specialized institutions such as credit unions for the benefit of members, individually, and as enterprise managers, as well as the construction of clinics and hospitals, has been a response partly to market opportunities, but partly also to opposition by other elements of the medical profession and purely for-profit commercial facilities.

With the successful development of specialized services within the Unimed system, capable of providing professional and entrepreneurial training, business advice, and most importantly, capital, individual health professionals have been able to benefit very significantly from membership in the system. Favourable tax status granted to co-operative enterprises has also been a significant benefit.

In the three Latin American countries where provider-owned health co-operatives have been most successful - Brazil, Chile and Colombia - they have been able to benefit also from being accredited as providers by newly established and comprehensive national systems of social security. This has brought a large clientele formerly unable to afford adequate health services.

The provider-owned health co-operative system in Colombia, COOMEVA, is in fact one element of a multi-functional user-owned co-operative, supplying a wide range of insurance and other services to the professional and technical workers and their dependants who constitute the membership.

(c) From co-operative insurance enterprises

Provider-owned health co-operatives (at the secondary level) and a co-operative insurance enterprise offering health insurance coincide within a single country only in Colombia. Here, at the initiative of the latter, a strategic alliance has been developed between the two, which should be of considerable benefit to members of the provider-owned co-operative, who will be assured of the large clientele in the co-operative movement, in trade unions, and in other components of the social economy, who have group health insurance policies with the insurer.

(d) From social care co-operatives

No examples of provider-owned social care co-operatives in Latin America have been included in the study.

(e) From other types of co-operative enterprise contributing to health and social well-being

There are no known cases of what have been defined as health and social care support co-operatives in any of the Latin American countries, except in the case of Brazil. However, here the Unimed system has developed its own very comprehensive system, which has very clear and readily acknowledged benefits to the providers of services who are member-owners of the basic Unimed system of health co-operatives. To the extent that systems modelled on that of Unimed are set up in other Latin American countries, it can be expected that providers will benefit in a similar way.

3. Benefits derived by society as a whole from engagement by co-operative enterprise in the health and social care sectors

Provider-owned health co-operatives, particularly in Brazil, where one third of all doctors are members, but also in Chile and Colombia have a quantitative significance which gives them some weight in national policy development. It has allowed them to some extent to counter the influence of the large-scale corporative element, growing in importance in most Latin American countries, and thereby constraining to some extent predominance of profits as the only criteria within the health sector. To some extent the co-operative insurance enterprises have had a similar influence in their sector, some introducing innovative approaches to health insurance. These influences have been beneficial to society as a whole.

Provider-owned health co-operatives have been active, particularly in Brazil, in promoting the re-invigoration of community-based health services by means of new partnerships with philanthropic and religious institutions. These are established by the local level co-operatives, which, through their membership in the nation-wide Unimed system, are able to call upon very substantial resources certainly not available by any other means to local health delivery systems. These alliances are to be strengthened by the development of affiliated user-owned health co-operatives. These developments appear to hold considerable promise for low-income sections of the population who, even though they are now covered by the comprehensive national health system, have no access to efficient services in their own communities.

In the area of social care, the potential for influencing national policies which co-operative enterprises possess is illustrated by the user-owned co-operative set up by young persons with disabilities in El Salvador (ACOGIPRI). In addition to its employment, income generation and service functions, it has included among its objectives since its inception the adoption of more favourable public perceptions of disability. It has contributed energetically to development of national policies supportive of the disabled. This has been achieved by wide distribution of a newsletter and active lobbying as one of the leading elements in the national movement of persons with disabilities.

Evaluations of the producer-owned co-operative COOPESAIN in San Juan de Tibas, Costa Rica, undertaken by the Escuela de Psicologia in the Facultad de Ciencias Sociales of the Universidad de Costa Rica in 1991 and by the Universidad Latina de Costa Rica in 1992, showed that the services it provided were of higher quality and were more appropriate to the needs of the community in which it operated than similar facilities in the public sector. The co-operative has been able to provide easier access to better care, as judged by clinic clients, and has done so at a cost that is lower to government than the amounts that have been spent under the preexisting arrangements. The bureaucratization that, in the public sector, can result in delays of up to 1 year for procurement or repair of equipment has been eliminated, and a commitment to a community participation and organized programming permits greater responsiveness to community needs.

In the year 1990/91, 88% of all visits up to the clinic were of a general medical nature, with the balance involving specialty care. Of all cases

presented to the clinic, 97.3% were resolved there; 2.7% were referred to more specialized settings. Of all paediatric cases, 90% were attended to in-house. This performance reduces the impact of inappropriate usage on area hospitals. The clinic's emergency service handled an average of 35 patients daily, further alleviating the burden on hospitals in its referral network.

Almost all clinic service is provided on an appointment basis. For those clients presenting without an appointment, the average waiting time is one-half hour. The duration of pharmacy visits is extended by a patient educational component. Physicians see, on average, four patients per hour. Ambulatory surgery affords the advantages of reduced waiting time for the patient and better doctor-patient relationships insofar as the patient is attended by familiar persons.

Data collected in two opinion surveys indicate client satisfaction with the clinic at Tibas. Among 346 patrons, nearly all (96.5%) rate the treatment received as "good" (26.3%) or "very good" (70.2%). Among the advantages of clinic use these clients cited "good care" (59.9%), closeness to home (31.3%), and rapid access (no delay) (26.88%). In another survey of users of specific clinic services, all but 3.7% of the responses rated the care as "good," "very good," or "excellent."

A cost analysis comparing the clinic at Tibas with four others that are operated by the government but are otherwise equivalent indicates that the public-private partnership offers some advantage. The average cost per consultation at the cooperative clinic in its first 5 months of operation was 44.54% lower, and from July through October 1991, this cost advantage increased. The average cost of a consultation at the cooperative clinic for the 5 month period was 1086 Colones (US $11.25) while that at the four comparison clinics was 1565 Colones (US $16.20).

The newest experiment in health service delivery retains those elements of the existing public system for health care that are desirable while introducing innovations aimed at increasing client and provider satisfaction and organizational efficiency. The stated goals of the co-operative are as follows:

- To apply and fortify the strategy of primary health care, featuring a focus on the family and with emphases on health promotion and disease prevention;
- To provide ambulatory health care that is easily accessible, of high quality, and integrated with primary health care;
- To involve the community in responsibility for its own health;
- To eliminate bureaucratic constraints;
- To improve the utilization of human, material and financial resources;
- To promote excellence by means of more selective hiring and better in-service teaching programs;
- To encourage employee motivation and identification with the work of the clinic.

It is the intent of the cooperative to provide for community oversight of its function. Toward this end, community participation is being cultivated and affiliation with 36 existing community organizations is under way.

Ambulatory care otherwise provided by the Social Security Bureau and certain of those services typically associated with the Ministry of Health are provided by clinic personnel. The latter services, falling under the rubric of primary care, include prenatal care, vaccination, visits to families in their homes on a regular basis as well as when a specific need arises, visits to schools, and community health education. The Ministry of Health retains the responsibility for comprehensive health planning, program evaluation, epidemiological investigation, environmental sanitation, and enforcement of health regulations.

While the experiment in Tibas may resemble the closed panel health maintenance organization familiar to North Americans, it differs in at least two important ways. Contractually bound to serve a defined population, the clinic may not alter its subscriber mix in the interest of ensuring solvency. The incentive to operate efficiently and to promote community health is, therefore, more powerful. Also, the co-operative is not responsible for hospital care. Free of this obligation and its financing, the clinic is able to give priority to the provision of ambulatory and community care.

A 1990 study compared the newly established co-operative models in Costa Rica, constituted by provider-owned enterprises working in close partnership with the public sector, with the "traditional" model, constituted by clinics owned by the Costa Rican social security system (CCSS) or by the Ministry of Public Health. The following were identified as the principal characteristics of the former and the latter (in parenthesis): emphasis - biosocial and preventive (biomedical, curative and pharmacologia); focus of attention: family, community and environment - continuous attention (individual - discontinuous attention); provider - multidisciplinary team (doctor); facilities: network of public and private services, with participation of enterprises and beneficiaries (clinics and hospitals under the control of officials); financing - tripartite, obligatory and solidaritist, managed by the State together with other resources and with local management (no additional resources and centralized management); degree of centralization - low (high); level of participation - high (weak); planning approach - based on priorities and needs (based on demand).294/

C. Other developing countries

Although a distinction was made in previous chapters between middle-income and least developed countries in Afria, Asia and Latin America, it is likely that retention of the distinction in this chapter would lead to repetition. It can be understood that the comments made in this section are equally applicable to all countries, unless otherwise noted. The countries include those in Asia except Japan and the transitional economies, those in Africa, and those in the Caribbean, which differ significantly from the other countries in Latin America, examined above.

Co-operative enterprises are directly engaged in the health and social care sectors in India, Sri Lanka and the Philippines, and South Africa, where user-owned health co-operatives are predominant, although with a few provider-owned co-operatives in India and the Philippines; and in Malaysia and Singapore, where health insurance offered by co-operative insurance enterprises is significant, in Malaysia in association with provider-owned co-operatives, in Singapore in association with health co-operatives established under the auspices of trade unions. In a small number of the least developed countries very recent experiments in co-operative organization of health and social care exist, without significant impact as yet on either providers or users.

1. Benefits derived by users

(a) From user-owned health co-operatives

Given the inadequacy of the public sector, the availability of affordable, appropriate and reliable services from their own health co-operative is of obvious benefit to members: indeed, in most cases these co-operatives were set up by individuals (and, in Sri Lanka, by the co-operative movement itself), expressly in order to complement the public services, given that private for-profit services could not be afforded.

Not only members but persons residing in the communities in which these co-operatives operate benefit from the contributions made by these enterprises to broad prevention and health education. The poorest members of these communities benefit directly from the outreach programmes delivered free of charge by user-owned health co-operatives - including eye and skin disease prevention, early diagnosis and treatment, and free immunization campaigns.

The inclusion of indigenous health knowledge and practice - a characteristic of the user-owned health co-operatives in the State of Kerala in India, is likely also to assure the inclusion of a higher proportion of persons unlikely to be reached effectively by other types of provider.

(b) From provider-owned health co-operatives

Persons of low income are the principal beneficiaries from the services offered by the provider-owned health co-operatives in Mindanao, Philippines. Extremely poor women are the beneficiaries of the work of the community health workers (also women) who have formed a co-operative within the health system promoted and supported by the Self Employed Women's Association in India. In neither case would they have been able to obtain adequate health care from the public sector.

It is not known to what extent users of the provider-owned co-operative in Malaysia are from the poorest income sections of the communities in which they operate. As a result of the alliance between these co-operatives, the co-operative insurance enterprise, and other co-operative organizations, acting on behalf of their own members, a considerable number of the latter are assured higher quality and standardized services throughout the country. These would not have been available from the public sector, given the fact that it was undergoing retrenchment.

(c) From co-operative insurance enterprises

It may be presumed that policy-holders of the co-operative insurers in Singapore (where NTUC INCOME occupies almost 20 per cent of the national market in health insurance) benefit from the emphasis upon high quality at affordable cost which characterises this enterprise. In Malaysia the alliance between the Malaysian Co-operative Insurance Society Ltd. and much of the co-operative movement makes available to its members, particularly in rural areas, coverage not otherwise available to them.

(d) From social care co-operatives

That there are very considerable benefits for members of this type of co-operative is evidenced by the experience of the admittedly small number in this group of countries for which information is available (it is most probable that there are numerous other such co-operatives operating in these countries). For example, the demand for the daycare centres established by co-operatives in the Philippines has been so great that they were opened soon after their inception to all parents in the communities in which they operate.

(e) From other types of co-operative enterprise contributing to health and social well-being

It is known that not only members and their dependants, but all in the communities in which they operate, benefit from the health services set up by a number of the larger co-operative enterprises and movements existing in this group of countries: the principal example being those established and supported by the sugar producing and processing co-operatives in the State of Maharashtra, India. There are numerous smaller co-operatives of all types, and in all of the countries in this group, which include health facilities and, if not professional and paraprofessional staff, then at least partially trained members of the community, within the set of benefits which their members have decided should constitute the purpose of the co-operative.

Unlike the situation in many European countries there are no large consumer-owned wholesale and retail co-operative systems in most of these countries. The exception is Singapore, where consumer-members of the system of co-operative supermarkets certainly benefit from an emphasis upon consumer education and supply of nutritionally appropriate foods, as well as from the chain of co-operative pharmacies set up on their premises.

2. Benefits derived by providers

(a) From user-owned health co-operatives

In India and Sri Lanka health professionals have been initiators and strong supporters of the user-owned health co-operatives, which, as vehicles for their practice of a community-oriented approach which emphasizes prevention, they find to be more appropriate than either public or private for-profit practice.

(b) From provider-owned health co-operatives

The recently established provider-owned health co-operatives in Mindanao, Philippines offer opportunities for those health professionals who seek to contribute their knowledge to communities quite inadequately served by the public sector, and out-of-reach of private for-profit services. Their motivation is the same as that in other countries, where the vehicle of a user-owned health co-operative has been preferred - or has been the only opportunity available in local circumstances.

Members of the small provider-owned co-operative formed by the community health workers employed by the Community Health Committee of the Self Employed Women's Association (SEWA) in India have found that they benefit through exchange of experience, mutual training and mutual support and collaboration in everyday operation of the community health centres for which they are responsible.

The Malaysian provider-owned health co-operative, KDM, has stated that:

"KDM was formed ... to meet the need to protect the professional and economic interests of doctors, especially in the private sector, to meet the challenges of privatization of aspects of the Government's medical services ... . Experiences in many developed countries have shown that an aggressive private sector running health care services with profit motive and concerned with cost-control may encroach on doctors' professional freedom. The commercialization of health care has also threatened the traditional doctor-patient and doctor-doctor relationships. Doctors have responded by forming their own doctors' organization such as the independent practice associations (IPA) in USA which either collaborate with the private sector or manage their own health care systems, with the belief that doctors are better able to balance the conflicting needs of patient care and cost control." (underlining in original) 295/.

Specifically, professional interests would be looked after by the opportunity afforded by co-operative membership to upgrade the quality of health care, including provision of continuing care and more effective specialist and hospital referrals. A national network would be better able to provide continuing care to mobile patients. Provider co-operatives make possible an extended version of group practices, expanding the advantages thereof: for example, access to shared equipment and support services which could not be afforded individually; rationalization of client work loads and time schedules, thereby allowing more free time and greater ability to pursue professional studies; and opportunities for consultation with colleagues, and for offering from the same facility a broad range of specialization.

In certain circumstances membership of provider-owned health co-operatives assures greater financial security for some health professionals than is available through any other form of enterprise in the health sector. Where government funded programmes exist, such as Medicaid and Medicare, direct payments to private for-profit facilities, group practices and even solo practitioners are not only possible but guaranteed. Consequently, there is little advantage to providers in membership in provider-owned co-operatives. However, with the reduction of public programmes, an increasing proportion of the population is forced to cease being consumers of health services except in emergencies - when public and charitable facilities might still be available to them. Hence, any means to enable this segment of the population to remain active users of health services is beneficial to providers. Their establishment of a health co-operative permits them to offer services at a low enough cost to attract customers otherwise unlikely to seek their professional services. This is an argument for a comprehensive co-operative system including both providers and users, and for provider engagement as staff or consultants even in user-owned health co-operatives.

A certain proportion of health professionals have concluded that provider-owned health co-operatives are a compromise that should satisfy both those who favoured the private control of medicine, and those who sought communitarian solutions to the deficiencies in medical care. By strengthening the private sector, it was felt that co-operative forms of its organization could preclude the expansion of the public sector (this was a major concern during the 1930s in the United States - in contemporary conditions of public sector retrenchment it is perhaps much less relevant). Doctors could benefit because, within their own provider-owned co-operatives they could continue to retain physician control of medicine, believed, whether correctly or not, to be impossible in government controlled health schemes.

It was also felt that co-operative organization could counter the rise of commercial medicine in the form of for-profit enterprises which were much larger than group practices. The analogy was the impact of supermarkets and chain-stores on corner family retail outlets - they would put not only solo practitioners but group practices out of business.

All of these advantages could be greatly enhanced by the horizontal and vertical extension of such co-operatives to form secondary and tertiary networks with subsidiary specialist enterprises. This would be facilitated by the combination of capital which co-operative organizations make possible.

KDM, in literature distributed to potential members, has stated that the primary objective of the enterprise was to improve economic status through enhanced possibilities for income generation. By establishing a co-operative network, operating costs could be reduced through standardization of clinic procedures, which in turn would allow for bulk purchase of drugs and equipment, use of shared facilities and services and other cost-sharing activities and facilities. Concentration of individual capital, and enhancement of credit-worthiness, would make available financing needed to upgrade the quality of facilities and services, as well as provide a sounder

basis for the entrepreneurial and personal finances of members. By means of peer review it would be possible to monitor costs.

As a national-wide entity, it would be possible to negotiate more effectively for the use of under-utilized government facilities. More effective linkage with hospitals would facilitate more meaningful collaboration with insurance providers. The Co-operative would be able also to negotiate more effectively for corporate enterprise clients. Provision of health care to members of other co-operatives (which totalled over three million), by giving them discounts in accordance with cooperative principles of mutual cooperation among cooperative societies, would bring in more clients. As the only nation-wide network of private clinics providing quality care in both urban and rural areas and linked with selected private hospitals, the co-operative would be in a strong position to be accredited for reimbursement of patient-care costs when the national health insurance scheme was set up, an event expected in a few years time.

(c) From co-operative insurance enterprises

Their alliance with the Malaysian Co-operative Insurance Society Ltd. within what is probably the only co-operatively organized national health services to be in the process of establishment, assures providers in Malaysia a large and assured clientele - the members of the co-operative organizations for whom health insurance is provided by the co-operative insurer. They benefit in the same way as health providers in those countries with a public or mixed public/mutual system of health insurance, with freedom of choice of provider. This possibility was in fact one of the reasons explicitly identified by the initiators of the provider-owned co-operative network, and used by them as an argument used to persuade individual health professionals to join the co-operative.

(d) From social care co-operatives

There is no information on the perceptions which the professionals who have set up co-operatives of this type have of the benefits they obtain. It is most probable that they are the same as those documented elsewhere.

(e) From other types of co-operative enterprise contributing to health and social well-being

While no information is available, it is probable in the circumstances existing in many of this group of countries (and particularly those resulting from retrenchment in the public sectors) that professionals and paraprofessionals value the employment opportunities made available in the facilities provided by agricultural and financial co-operatives to their members and the communities in which they operate. Providers have not set up their own support co-operatives, as they have in Brazil.

3. Benefits derived by society as a whole from engagement by co-operative enterprise in the health and social care sectors

The quantitative significance of co-operative engagement in health and social care is significant in Singapore, moderate in Malaysia and Sri Lanka, and still rather limited in India (except Kerala) and the Philippines. In the least developed countries, it is still extremely small. In the first three countries interaction with Governments has been substantial - in Malaysia involving direct Governmental intervention in favour of a comprehensive co-operative national health system. Through the influences inherent in such partnerships it may be assumed that the community-based, highly participative and broad preventive approaches characteristic of co-operative engagement in the health and social care sectors have achieved greater recognition by

policy-makers, wider emphasis within national strategy formulation, and larger acknowledgement by citizens.

In a number of countries it has become clear that health co-operatives have played an important role to play in the public debate concerning adjustments in social security and health. It has been precisely in such a discussion of the relative merits of a comprehensive public system and a private system that the co-operative movement has been able to intervene from an intermediate position of community-owned not-for-profit health insurance and health care providers.

In India, for example, the Dean of the Shushrusha co-operative hospital at Bombay, in a report to the International Co-operative Health and Social Care Forum held at Manchester, United Kingdom, on 18 September 1995, noted that health co-operatives in that country were the only organizations which could play a role as both opinion maker and catalyst in respect to the formulation and implementation of public policy concerning health care, currently the subject of intense public debate.

D. Transitional economies

In the countries with transitional economies the former parastatal collectives, some of them termed "co-operatives", but not characterised by the co-operative values and principles recognized by the international co-operative movement, formed one of the components of the enterprise-based health and social care insurance and service delivery system. In some cases, elements of that system, not yet fully "privatized" or "co-operativized" maintain some of the health and social care services derived from that earlier period. Although termed "medical co-operatives" they are in fact the specialized departments of enterprises which are co-operatives or partial co-operatives as defined in the new societal circumstances.

In a few countries another type of "co-operative" specific to these countries has been the provider-owned health co-operative which has been the legal form chosen by members as a temporary expedient given that full private enterprises were not yet legalized. Most such co-operatives were converted into group practices and private for-profit health enterprises once this became legal at a later phase in economic restructuring.

Thus, genuine co-operative engagement in the health and social care sectors is extremely limited in most of these countries: a few genuine provider-owned health co-operatives (in Mongolia and Poland); recently established co-operative pharmacies in the Czech Republic; and a few social care co-operatives, some provider-owned, others of mixed membership, notably those involving persons with disabilities in Poland and Romania. As far as is known there are no user-owned health co-operatives, and no insurance co-operatives offering health insurance.

This situation is hardly surprising given that the entire health and social care sector is undergoing radical restructuring, and given that the co-operative movements in most of these countries are still at a very early stage of recovery from their long periods of co-option as parastatal collectives. It is, therefore, not useful to discuss the benefits of co-operative engagement in health and social care to users, producers or society as a whole on the basis of current dimensions.

There appears to exist a very large potential for expansion of co-operative movements, for their engagement in health and social care, and for the appearance of all the forms of co-operative organization in these sectors known elsewhere. The current situation is very similar to that existing in

some Latin American countries until recently: a public sector which does not meet the needs of the majority, a private for-profit sector which is aggressively commercial but serving only the privileged, and a large proportion of the population without real health and social care insurance or access to services.

Individual professionals and facilities find themselves in entirely new economic circumstances, faced not only with radical internal restructuring of their business practices, but with developing relationships with entirely new networks of suppliers of goods and services. At the same time they are faced with a actual or potential customers who find themselves in entirely new conditions in respect to choice of insurance and services.

In such circumstances there is obvious scope for both user- and provider-owned co-operatives, insurance co-operatives, and many forms of support co-operative.

Unlike conditions in Latin America, co-operatives in the health and social sector have to overcome widespread distrust and even opposition on the part of the general public and policy-makers. The term "co-operative" has negative connotations, not only arising from its application in the period of socialist central-planning, but, and possibly to a greater extent, from its use by entrepreneurs during the early years of transition.

IX. COMPONENTS OF A STRATEGY FOR A COMPREHENSIVE ENGAGEMENT BY THE CO-OPERATIVE MOVEMENT IN HEALTH AND SOCIAL CARE

A. Desirability of guidelines for use in formulating strategies at national levels

The following suggestions are extremely tentative. It must be emphasized that neither the United Nations nor the International Co-operative Alliance considers them to constitute formal proposals which should be adopted by the co-operative movement. Certainly they are not to be taken as an ICA policy statement. Rather, they are a set of suggestions made by the United Nations after analysis of the evolution of health and social care co-operatives, and of the concerns expressed by the broader international co-operative movement in respect to the impact of co-operative enterprise upon health and well-being. The United Nations has drawn also from its experience of approaches made to similar problems of organization in different social sectors, and on the policy debate prior to and during the World Summit for Social Development and the Fourth World Conference for Women, and during preparations for the United Nations Conference on Human Settlements (Habitat II).

In setting out proposals for further development of a strategy for more comprehensive engagement by the co-operative movement in the health and social care sectors the intention is to provide an input to discussions by the co-operative movement itself. It is fully anticipated that in each country the movement is likely to consider the proposals to be only generally relevant to their circumstances, and only suggestive of the contents of a strategy appropriate to the circumstances in which they operate. Each will respond as it feels appropriate, and will undertake a quite distinctive approach. The proposals are set out in the hope that other stakeholders, including Governments and intergovernmental organizations, will find them a useful indication of the steps which all might take in order to achieve desirable forms of partnership between themselves and the co-operative movement.

The United Nations is fully aware that further development of the health and social care co-operatives sector, and further engagement by other parts of the co-operative movement in health and social care, must be entirely autonomous and voluntary processes decided upon by the individual co-operatives themselves. Developments must be based upon the business goals of the relevant co-operative enterprises, and such enterprises alone must decide the course of international collaboration, as they are themselves responsible for financing the various procedures and institutions engaged in coordination and technical assistance.

Nevertheless, it is important to bear in mind the principle of co-operation among co-operatives, which expresses the fact that co-operatives serve their members and strengthen the co-operative movement most effectively by working together through local, national, regional and international structures. Analysis of the development of health and social care co-operatives, and of the broader engagement of the co-operative movement in health and social care matters, has shown conclusively the benefits of such "co-operation among co-operatives". It has also shown the value of collaboration by co-operatives with other stakeholders, including, for example, trade unions, women's organizations, consumers' organizations and, given the continuing and basic responsibilities of Government for health and social care, with local, regional and national authorities (see Annex IV).

The suggestions made here are based on the proposition that the potential impact of the co-operative movement on health and social well-being is very great, but is as yet far from having been realized. It appears that the unfavourable factors within most of the societies where health and social care co-operatives already operate have often been stronger than positive factors: this has undoubtedly constrained expansion. Elsewhere unfavourable factors may have prevented even the appearance of such co-operatives. However, an additional reason for the slow realization of the potential appears to have been the fact that there has been no coordinated and comprehensive response by the co-operative movement itself to this situation, little intervention to support health co-operatives, and few actions designed to establish an enabling environment.

The suggestions made here are based upon the conviction that greater engagement by many components of the co-operative movement will serve to enhance the image of co-operatives among members of the public, and among opinion leaders in other interested stakeholders, notably among Governments and intergovernmental organizations. The need for improved health and social care is acknowledged throughout the world: for a significant proportion of humanity this is a matter of vital importance - for the remainder, it is certainly a matter of considerable priority. At present there is large-scale dissatisfaction with the ways in which health and social care are provided - hence the opportunity for alternative forms to enter or expand their contribution has never been greater. Co-operative enterprises of all types have shown conclusively that they are able to make such a contribution to the full satisfaction of their members, but also to that of the communities in which they operate. Hence, it would seem highly beneficial to the co-operative movement, and to society as a whole, that they seize this opportunity.

B. Approaches to strategy preparation at national level

Co-operative business enterprises active in many economic sectors are clearly capable of adjusting their goals and practices in order to combine with their primary purposes certain actions to bring about an enhanced impact upon the health and social well-being of the communities in which they operate. Possibly to an important extent their individual actions could be made more effective if harmonized, if common approaches could be identified, and if the numerous opportunities for collaboration and mutual support could be seized.

Moreover, by using the potential of numerous other sections of the co-operative movement for supporting and collaborating with health and social care co-operatives themselves, the chances of the establishment and successful expansion of these specialist enterprises would be very much greater than if they are left to develop in isolation from the larger co-operative movement. Given that the numerous opportunities for such collaboration are separate, even if related, it might be that a comprehensive and systematic approach to identifying and strengthening them is more likely to achieve better results than leaving health co-operatives to develop in isolation.

For these reasons it would appear useful that **a comprehensive and integrated national strategy for the enhancement of the capability of the co-operative movement to contribute to improved health and social well-being** be formulated and put into operation. Such a strategy would be relevant not only in those relatively few countries in which health and social care co-operatives are now active, even significant, but in all others where there is a significant co-operative movement but as yet no co-operatives of these types. This is so firstly because of the capacity of co-operatives not directly engaged in the health and social care sectors themselves to contribute to improved conditions, and secondly because, by promoting greater

awareness and activity in this respect, a more favourable environment is established in which health and social care co-operatives themselves are likely to be able to appear and develop successfully.

Given that harmonization of activities and promotion of operational collaboration between many different segments of a national co-operative movement are called for, it would appear that the function of bringing together interested parts of the movement for the task of formulating such a strategy, and then for promoting and supporting its implementation, might fall most appropriately on the **national co-operative apex organization**. The task might be achieved by means of a **working group**, or similar body, organized under the aegis of the national organization, with the participation of representatives of all concerned elements of the movement. Proposals made by the group could be considered firstly by the appropriate bodies of each of the relevant sections of the co-operative movement, and then by the representative body of the entire national movement.

To help in this task, it might be useful for **external advisers** to participate, drawn from the relevant components of the co-operative movements in those countries where health and social care co-operatives are well developed, as well as from those co-operatives themselves. **Guidelines and background information** might be prepared under the auspices of ICA, and specifically of its specialized body on health and social care co-operatives, when this becomes operational. The task of developing guidelines might be supported by a **network** made up of the more experienced of existing health and social care co-operatives and the national co-operative movements in the relevant countries. Participants should not be limited to health and social care co-operatives themselves, because the objective is to establish that broad strategy which will provide an enabling environment for health and social care co-operatives. Consequently, relevant components of national and sectoral co-operative movements should participate also. The **Regional Offices of ICA**, possibly in collaboration with regional offices of WHO and UNICEF, might also engage in the development of the guidelines supporting this national procedure. This would be useful particularly if the health and social care co-operative movement itself develops initially along regional rather than global lines.

If there is no single apex organization serving the entire national co-operative movement, as is the case in a few countries, and no health or social care co-operatives are yet in existence, then a working group with representatives from appropriate components of the movement could still be set up, hosted by one of the sectoral apex organizations, preferably that most closely engaged in activities having a significant impact upon health and social well-being (for example, the consumer co-operative movement).

The emphases within any such movement-wide strategy for bringing about a more effective impact upon health and social well-being are likely to vary between countries: general guidelines could only assist in the early phases of formulation at the national level. However, certain basic approaches might be formulated given the widespread incidence of certain conditions, including both those favourable and those unfavourable. For example, it might be worth taking into account the fact that it has been the persistence and strength of negative factors that has prevented development in what appeared otherwise to be promising circumstances. Efforts might be concentrated, therefore, on reducing the strength of these negative factors - thereby giving greater scope for spontaneous initiatives. Indeed, this might be the most appropriate approach, as it could be achieved by means of concerted efforts at national and even international levels without endangering the autonomy of local initiatives. Such efforts could be complemented by attempts to enhance the positive factors, strengthening those likely to have the most immediate impact upon the situation and requiring a relatively limited expenditure of

resources. Exploration of possible operational alliances between existing co-operatives might be an effective approach.

Given the limited specialist resources, and the small number both of health and social care co-operatives and of countries in which these types of co-operative are well established, it would seem appropriate to begin in those countries where the environment appears most promising, ensure that a strategy is successfully formulated and put into operation there, and then gradually extend the process to other countries as these become interested in the success achieved in the "innovation core". This would certainly not constitute an imposed global strategy, only a state of readiness to provide support as and when it is requested. It would be most important to rely as much as possible on local initiatives, promoted by the diffusion of information on existing "best practices" and followed by meaningful support through the co-operative movement's own developmental institutions.

During the preliminary phases of the formulation of strategies a number of complementary activities could be undertaken:

- diffuse as widely as possible among citizens, co-operators, trade unionists, and members of consumers', women's, older persons' and other organizations an awareness that co-operative forms of enterprise in health and social care insurance and service delivery are possible, have been effective in a number of countries and over significant periods of time, and may be worth considering as one among a number of alternatives to contemporary arrangements, if these are felt to be unsatisfactory.

- establish a situation monitoring facility whose function would be to identify areas in which the potential for health and social care co-operative development appears high, and then, within those areas, to bring to bear a programme for the diffusion of awareness more focused and energetic than that applied generally. This programme should include means to identify very specific cases of interest among potential organizers, and to respond quickly by making contacts and providing initial planning guidance and support.

- engage in dialogue with existing health and social care co-operatives in order to identify areas in which external support could be helpful, and in order to promote internal adjustments leading to improved efficiency as well as more effective partnerships with other such co-operatives - i.e. by establishing secondary and tertiary organizations if none so far exist.

- engage in dialogue with existing co-operative enterprises and organizations which might constitute bases for direct co-operative engagement in health and social care. Many types of co-operative, but notably agricultural and fisheries supply, common services and marketing co-operatives, as well as utilities, housing and community development, retail, savings and credit, banking and insurance co-operatives, could be persuaded to take an interest in sponsoring and supporting health and social care co-operatives and various forms of support co-operatives for the use of their own members. It has been seen that some co-operative organizations of these types have been highly successful in setting up health and social care programmes for members, employees and dependants, as well as in supporting autonomous co-operatives in some form of affiliation with them.

- engage in dialogue with potential partners and stakeholders in health and social care sectors, introducing the concept of co-operative forms of organizations as means of providing members with viable and efficient services: included might be local governments, trade unions, private employers, women's movements and others.

C. Elements of a national strategy

The following points may be perceived as political elements of a national strategy which are probably relevant to and applicable in most national conditions, albeit after adjustment. They should be taken as a checklist for use in the development of national strategies. Some points will appear in specific circumstances to be less relevant than others, less worthy of immediate and priority consideration. Section G-5 below will examine the principal differences in strategic approach likely to be most appropriate in each of the groups of country identified throughout this review.

1. Strengthening of the co-operative health and social care sector

Within a national co-operative strategy for health and social well-being, clearly a principal element must be that component made up of the health and social care co-operative sector itself. It may be recalled that this includes all types of health and social co-operatives themselves, as well as co-operative pharmacies, many types of health sector support co-operatives, the health and social security programmes of co-operative insurance enterprises, and the health and social benefits provided by all co-operative enterprises to members, employees and their dependents.

(a) Establishing a national apex organization

(i) Functions

The principal functions of such an organization might include the following:

(a) **formulation of a national strategy for the health and social care co-operative sector itself** within the context of the comprehensive and integrated national co-operative strategy for health and social well-being discussed above.

(b) **representation** of this sector **within** the apex organizations and bodies of **the national co-operative movement**. An initial task might be to convince all sections of the movement that the sector is an entirely legitimate and distinct component of the co-operative movement, consisting of co-operative enterprises established by their members as a means whereby they may achieve their goals, just as co-operatives are established and operated in any other economic sector or area of social activity. The idea should be promoted that health and social care co-operatives are not engaged in a social activity marginal to the central goals of the co-operative movement but rather in an activity which is an expression of one of those central goals, namely attainment of a better society for all.

(c) **representation and liaison with other parts of the co-operative movement** in order to establish effective collaboration and to realize all elements of the potential for mutual support within an overall strategy of enhanced co-operative movement impact upon health and social well-being.

(d) **establishment of a health and social care co-operative development programme** in order to monitor favourable or unfavourable conditions and recommend appropriate intervention; to identify and bring together in an effective network all health and social care co-operatives in the country; to identify potential interest in establishing such co-operatives as well as spontaneous attempts to do so, and then (and only then) to provide all necessary support, if requested; to develop guidelines for their development; to establish links with co-operative development institutions in other sectors in order to learn from general experience of co-operative development; to develop links with health and social care co-operatives in other countries;

and to develop appropriate links with sources of technical assistance within the international co-operative movement.

(e) **establishment of an information and research facility** in support of health and social care co-operative development which would establish a data base, develop an information network available to all such co-operatives, establish links with other relevant institutions, prepare information materials for promotional purposes as well as operational guidelines.

(f) **establishment of a training facility** specifically for the health and social care co-operative sector, responsible for developing the human resources required for the special forms of management and accounting appropriate to these co-operatives, and also for liaison with institutions training health professionals in order to ensure that specific preparation for professional activity in the special environment of health and social care co-operatives is made available to medical students.

(g) **promotion of self-confidence and solidarity among health and social care co-operatives** as a distinctive component of the national and international co-operative movement.

(h) **representation and liaison with other stakeholders in the health and social well-being sector**: including associations of health and social care professionals and para-professionals and of facilities, such as hospital associations; associations of business enterprises; employers' organizations, farmers' organizations, trade unions; consumers' organizations; women's organizations; organizations representative of disadvantaged sections of society; governmental agencies; legislative committees and bodies; national offices or programmes operated by international bilateral or multilateral agencies; national associations for UNICEF, UNESCO and the UN.

(i) **representation in regional and global organizations of health and social care co-operatives and other forms of liaison with them.**

(ii) Organizational sequence in its establishment

During early phases in the establishment of institutions appropriate for establishing a distinct national health and social care co-operative sector, the functions identified above might have to be undertaken by appropriate existing co-operative institutions.

One approach might be for the relevant national level co-operative institutions to take on these functions temporarily. For example, the initial representation and promotion activities, and the first steps in formulating a strategy for the health and social care sector, might be undertaken by the same working group established within the national apex organization for the purpose of preparing a comprehensive and integrated national strategy for the enhancement of the capability of the co-operative movement. During at least the earliest period of the establishment of an apex organization for the co-operative health and social care co-operative sector, it would appear necessary for the national apex organization of the co-operative movement as a whole to act as its operational host. There should be no confusion, however, between the distinct functions of the national apex organization in respect to the comprehensive strategy and that of the co-operative health and social care sector's own apex organization, even during the temporary phases when operationally they work very closely together.

Developmental activities in health and social care could be included within the programmes of the existing co-operative development institution. Similarly, special training programmes could be included in the activities of existing co-operative training institutions.

A second approach might be to distribute the functions among existing health sector enterprises or groups: i.e. where there is already a national-level body for at least one type of health co-operative (for example, a joint committee of the two health co-operative movements in Japan), or where a single health co-operative or group already has substantial organizational resources (for example, the Group Health Co-operative of Puget Sound, or Unimed do Brasil).

It is important to bear in mind that health and social care co-operatives can only be formed by groups of individuals acting at the local level. Members of the initiating group must perceive in each other trusted partners with a sufficient overlap of interests to make worth while the often very unusual experiment in the organization of resources constituted by a co-operative enterprise in these sectors. The various factors favourable to successful initiation of the process, and successful development through a number of early phases, have been examined in Chapter VI. It must be emphasized that only when a number of distinct, even if related, favourable factors and conditions converge at the same place and time, are health and social care co-operatives established.

Normally national-level co-operative apex organizations have been formed only after a critical mass of its potential member co-operatives have been established and have gained some substantial operational experience. While not impossible, establishment of an apex organization for the health and social care sector prior to appearance of a sufficient number of primary level co-operatives would be unusual. Moreover, its founders would require very considerable sensitivity and openness.296/

Certainly it may be asked, if stakeholders in these sectors have not themselves decided to experiment by forming co-operatives, is it likely that intervention by an external institution will achieve significant results? The history of the initial processes of establishment and early development of the health and social care co-operatives surveyed in Chapters II and III in fact suggests that in many cases a catalytic impact was made by external institutions or persons. This was done in circumstances where local conditions were highly favourable - but where it was not at all certain that purely local or internal processes would have reached the same outcome - that is to experiment with a co-operatively organized form of enterprise in order to meet the needs they identified.

Thus, it might well be the case that, in the absence of a desirable convergence of favourable processes and conditions in at least certain regions, and of an associated high level of propensity to accept a co-operative model, establishment of a national apex organization would most likely not achieve significant results. On the other hand, if circumstances at the local level are favourable and the potential substantial, but not yet realized by internal processes alone, then the existence of a national apex organization might be sufficient to promote and encourage local action, and at the same time constitute an organizational base for bringing about "a level playing field", by means of lobbying for the removal of discriminatory laws and regulations.

More evidently, where a significant, but still not major, health and social care co-operative movement already exists, then a national apex organization can be valuable not only as a promotional and catalytic institution, but as a means for the achievement of greater solidarity, and for the support of operational developments, both vertical and horizontal.

A further function for a national apex organization might be that of lobbyist within the existing co-operative movement. As had been pointed out in Chapter IV, it is not the case that the established components of the movement include those in the health and social care sector. Where resources

are scarce they may wish to see national-level apex organizations devote most attention to serving their own needs, rather than use them in new ventures.

The question remains of whether or not an apex organization can be useful even where there is little or no development of health or social care co-operatives. It might be the case that the scope for an independent specialist organization would be limited. However, it might still be argued that, in those national circumstances where there is a large unmet need and a high potential for co-operative solutions, but where this potential has not yet been identified - or at least realized - a promotional and catalytic entity might still play an important role. This might be the case even if it were only a small component of a national apex organization with broader responsibilities.

(b) <u>Undertaking a system-wide programme of operational support for initial development of the co-operative health and social care sector</u>

It may be expected that the specialist institutions within the co-operative health and social care sector itself will take some time to become operational. However, there is a clear need to provide urgent operational support to existing individual health and social care co-operatives in order to enhance their efficiency, and in particular to promote collaboration between themselves at secondary and tertiary levels.

Consequently, the national apex organization might formulate an urgent programme whereby all relevant institutions, particularly those concerned with co-operative research and development and information and training, undertake special supportive activities, the objectives of which would be to:

(a) strengthen the efficiency of existing health and social care co-operatives by improving management, accounting and the effectiveness of member participation; and

(b) assist existing health and social care co-operatives to establish secondary and tertiary organizations.

In any case the existing general institutions for research and development and for training and information management should begin immediately to include within their programmes a special component supportive of co-operatives in the health and social care sector.

(c) <u>Promoting an enabling legal and administrative environment</u>

In a number of countries there still exist laws and administrative practices which impose constraints upon the free establishment of co-operatives in the health and social care sector, upon their vertical and horizontal development and their formation of secondary and tertiary organizations, and upon the provision to them of capital by other co-operatives, notably financial co-operatives. Constraints continue to exist also in the form of the practices of associations of health professionals: these have the effect of limiting the ability of doctors, nurses, social workers and other professionals interested in co-operative forms of organization in the health and social care sector to participate, either as staff or as members.

Given this situation, it would be important for the national co-operative apex organization to lobby with legislatures and administering governmental agencies for the removal of these constraints. The goal would be to establish an enabling and supportive environment within which the co-operative movement as a whole, and specifically the co-operative health and social care sector, might realize its full potential for contributing to the health and well-being of society. Where appropriate, legal measures could be taken as

test cases by the co-operative movement in order to remove discriminatory practices.

(d) Promoting research

Most of the proposals for strengthening the co-operative health and social care sector, and for strengthening collaboration between health and social care co-operatives on the one hand, and on the other hand those co-operatives whose activities also have an impact upon health and social well-being, require considerable further research, analysis, development of guidelines, undertaking of experimental projects and evaluation of progress. They require an active research and development capability within these sectors at both national and international levels.

Rigorous evaluation of the capabilities and achievements of health co-operatives, followed by policy-oriented analysis and presentation of findings, is essential if arguments are to be prepared which will be sufficiently strong to persuade other stakeholders (including other components of the co-operative movement in some cases), but particularly governments (as primary controllers of policy environments, administrative practice and legislative development) of the value of co-operative forms of organization.

While some of the larger health co-operatives, both user- and provider-owned, and many of the co-operative insurance enterprises, undertake research designed to reduce risk and prevent ill-health which extends to examination of both specific and broad issues within the societal environment, there is clearly scope for both an expansion of such activities by those co-operative enterprises with appropriate resources. Possibly of even greater urgency is to promote and support collaboration between the various relevant components of the co-operative movement: between, for example, health and social care co-operatives and co-operative insurance enterprises, and between both of these and the larger retail co-operatives in such areas as promotion of improved nutrition and household safety.

There would appear to be considerable scope also for collaboration between those components of the co-operative movement directly concerned with health and social care, and the remainder of the movement, specifically co-operative media, in order to diffuse widely information and guidance, particularly on "healthy living" and broad preventive measures which individuals and communities are able to undertake using their own resources.

2. Strengthening collaboration between co-operatives delivering health and social care services and other co-operatives whose activities have an impact upon health and social well-being

(a) Strengthening the sensitivity of co-operatives in all sectors to their impact upon health and social well-being, and to opportunities for collaborating with health and social care co-operatives

Increased awareness of the nature of the impact of their activities upon the health and well-being of their own members and employees, their dependants, the communities in which they operate, and wider national society could be achieved by means of the establishment of a promotional unit within each of the national apex organizations representing each sector of co-operative activity.

The effectiveness of such individual units could be enhanced by the formation of a network between them, the operation of which might be undertaken eventually by the specialist information institution within the national apex organization of the health and social care co-operative sector.

(b) Establishing joint programmes between co-operatives delivering health and social care services, co-operative pharmacies, sector support co-operatives, co-operative insurance enterprises and all co-operatives providing health insurance benefits to members and employees and their dependents

There is clearly a substantial benefit in the collaboration between these groups within the co-operative movement. Health and social care co-operatives benefit from an assured membership, enrolment or other clientele. This supports their financial viability. In most cases they provide services not only to their own members, but to institutional members, usually enterprises or institutions providing health and social security insurance to their work-force or own members. Because they are member-controlled, or, in the case of provider-owned health and social care co-operatives, have effective means for user participation in policy formulation, they are able to offer programmes responsive to the specific needs of any section of the population. Consequently, their effectiveness can be enhanced if co-operative enterprises designate them, rather than non-co-operative enterprises, as providers of services to their members, employees and dependents.

From the point of view of the co-operative enterprises which offer health and social insurance and privileged access to health and social care services to their own members and employees and their dependents, the value of such benefits can be enhanced in respect to both affordability and relevance to broad healthy living, if provided by health and social care co-operatives. Contracts between the two types are likely to be mutually beneficial.

Co-operative insurance enterprises also benefit from an expansion in the number of their members - that is policy holders. They are experienced in offering innovative insurance products and services, appropriate, for example, to women, and to the particular needs of the self-employed - as members of co-operatives are considered in legislation and administrative practice in many countries. Compared to non-co-operatively organized insurers, they can offer affordable products and services more appropriate to the situation of most members (and employees) of co-operatives. Clearly, co-operative enterprises would benefit if they designated such enterprises as the insurers in the health and social security plans provided to their members.

Such collaboration between types of co-operative directly involved in the health and social care sector might be initiated by means of a working group comprising representatives of each, perhaps hosted by the national apex co-operative organization, or by one of the groups themselves. Eventually, a more permanent institutional arrangement for collaboration between these key elements of a comprehensive co-operative strategy for health and social well-being would appear necessary. It could be based within the co-operative health and social care apex organization or within the general national apex organization, depending upon the particular circumstances of the co-operative movement.

At the same time, action could be taken by each of these types of co-operative independently in order to enhance the benefit of collaboration. All co-operative enterprises should provide their members and employees, where they have inadequate health insurance or access to health services, with appropriate benefits. Wherever practical these could take the form of policies issued by co-operative insurance enterprises in which health and/or social care co-operatives are designated as the provider. Such co-operative enterprises (at primary, secondary and tertiary levels) could become institutional members of health and social care co-operatives. In this capacity, they could contribute capital to their capital.

Co-operative insurance enterprises could reciprocate by developing health and social insurance products specifically designed for the use of co-

operative members at health and social care co-operatives. They could further support and promote the emphasis provided by health co-operatives for broad preventive and participatory programmes.

(c) <u>Strengthening collaboration in support of improved occupational health programmes within co-operative enterprises</u>

One function of fully developed co-operative health institutions would be to promote, support and harmonize the occupational health programmes of all co-operative enterprises. Because they are owned by worker-members, or because their employees are drawn from the same communities as user-members, and are often family members and neighbours, members of co-operatives usually place high priority on occupational health among their business goals and practices. The assistance provided by public agencies in many circumstances is limited, and even in the best circumstances may not aspire to the particularly high standards expected in co-operative enterprises. For this reason, it would appear appropriate for national co-operative movements to have their own specialized institution for occupational health. This could be associated organizationally with the co-operative health and social care sector's apex organization.

(d) <u>Strengthening collaboration between co-operatives delivering health and social care services and housing, community development, sanitation and utilities co-operatives</u>

Co-operative enterprises providing health and social care to members, such as housing and community development co-operatives, have goals which are closely related to those of health and social care co-operatives. Collaboration is likely to be most useful at the local level, where its purpose would be to ensure the most effective harmonization of activities. However, exchanges at the regional and national levels might be valuable in establishing guidelines for such local collaboration.

(e) <u>Strengthening collaboration between all co-operatives directly engaged in health and social care and those engaged in production, processing and distribution of nutritionally appropriate and safe foods</u>

Given the emphasis of health co-operatives upon healthy living and broad preventive approaches, and the very large capability of co-operatives engaged in food production, processing and distribution, it would appear highly valuable if some permanent liaison procedures were established and maintained.

(f) <u>Strengthening collaborative programmes designed to achieve a healthy environment</u>

An important element of preventive health and healthy living is a supportive built environment; the availability of acceptable housing, infrastructure and utilities; and attention to environmental hazards. Co-operative enterprises in the different sectors which are engaged in these matters do not always collaborate sufficiently. Consequently, in addition to operational partnerships at the community and sub-regional levels, it appears that it would be useful at national level to establish arrangements whereby the respective tertiary organizations exchange views, formulate common policy guidelines and harmonize their activities in support of their members on these matters. Health and social care co-operatives should be included in these exchanges, which might be undertaken most effectively under the auspices of the institution responsible for the comprehensive co-operative health and social care strategy in each country.

(g) <u>Strengthening collaboration between co-operatives directly engaged in health and social care and financial co-operatives</u>

One significant means for resolving the financial difficulties faced by many health and social care co-operatives would be to establish partnerships with financial co-operatives. Savings and credit co-operatives ("credit unions") are capable of mobilizing capital even from the poorest communities. This reflects the fact that members have confidence in their own institution as a secure and affordable means to deposit savings, manage their finances and obtain credit. As improvement in health and social well-being of members and their dependents is usually one of the principal goals in these as in other co-operatives, there would be little opposition on the part of members to the use of the funds to make loans to the health and social care co-operatives which would then provide them with improved services.

The capacity of savings and credit co-operatives, even in poor communities, need not be exceeded because loans to health and particularly to most social care co-operatives need be small during the early phases of their development. Co-operative banks would be able to make the larger loans needed at later phases of such co-operative development.

While necessary arrangements can usually be made effectively at the local level between interested co-operative enterprises as required, it would appear useful for collaboration at the tertiary level to take place in order to develop policy guidelines concerning financial co-operative's support to co-operatives in the health and social care sector. Until the co-operative health and social care sector developed its own tertiary organization, it might be possible for the general national apex organization to undertake this function.

Policy guidelines might be worked out also in respect to dealing with financial assistance from external co-operative movements, as well as from sources outside the co-operative movement, including from Governments. It would appear most appropriate that these be channelled through national financial co-operatives as a means to supplement their own financing programmes.

3. Strengthening the internal efficiency of the co-operative health and social care sector

(a) Increasing efficiency in user-owned health co-operatives

Analysis of the present situation suggests that the most successful of user-owned health co-operatives are those which quickly reach the developmental phase of owning their own facility and employing their own health professional staff. Users, acting through their elected and voluntary directors, quickly establish a mutually acceptable working relationship with professional employees which affords the latter full professional autonomy while acknowledging the primacy of user-interests.

Development of user-owned health co-operatives has been characterised by a substantial extension both vertically - to the integration with basic operations of a wide range of specialized services owned by the co-operative - and horizontally, including development of a cluster of core hospital and specialized health facilities, outreach clinics and programmes, and alliances with institutions not themselves co-operatively organized but with whom mutually beneficial operational collaboration has proven useful.

While not ignoring the achievements of many other user-owned health co-operatives, the model afforded by the Group Health Cooperative of Puget Sound is certainly one worth emulating. The model it constituted must be acknowledged in all discussions of possible strategies, and taken into consideration in their planning. It must be borne in mind that this health co-operative has developed over a period of almost five decades: certainly its achievements cannot be replicated elsewhere in a short period of time. On the

other hand the experience it has accumulated through trial and error can be drawn upon by more recently established health co-operatives.

User-owned health co-operatives have developed where particularly favourable circumstances have existed. Once they have achieved a certain developmental phase they appear able to survive even in a hostile environment, because they have proven to a sufficiently large number of customers that they are capable professionally and managerially of meeting their need for affordable but high quality services. However, it would seem that to achieve a sufficiently large clientele, that is a critical mass of users, such co-operatives must have achieved their own critical mass in respect to equipment and staff, so as to provide a sufficiently wide range of services of acceptable quality. One characteristic of a successful model appears to be extension of clientele beyond members to a category of user "enrolees" in group plans associated with other enterprises, both public and private. This alone has allowed achievement of the necessary critical mass of users.

To reach that phase existing user-owned health co-operatives - at least as exemplified by those in the United States - have required specially favourable circumstances, of which the most significant has been the energy and commitment of participating members acting within a community which is familiar with the co-operative approach to the organization of mutual self-help, and which understands what must be done to ensure success (including making commitments, persevering in their support, and delaying some degree of satisfaction in early phases of their co-operative development in order that its later rapid achievement of the necessary critical mass can be accomplished).

In promoting further development of user-owned health co-operatives, it must be borne in mind that such favourable circumstances by no means exist in all communities where health and social conditions and the capabilities of other providers suggest that the potential for co-operatively organized health and social services is very large. Moreover, even where user-owned health co-operatives of sufficient critical mass have become well established, as in the United States, there still exist smaller co-operatives which are less strong, while others have failed.

The question is whether or not it can be expected that other communities will be capable of spontaneously adopting the user-owned health co-operative model in their own societal circumstances. It would appear that a certain degree of external promotional and early support activity will be necessary in many cases. In this regard it might be borne in mind that the currently successful co-operatives, such as the Group Health Co-operative of Puget Sound, although themselves established, largely by a determined and accomplished group of persons within the community, also responded to stimuli received from external initiators. They seized upon the concept and themselves innovated by trial and error the means of making it operationally successful.

Thus, there appears to be no theoretical or empirical reason why external stimulus and promotion might not be attempted. It might not be possible nor even appropriate to attempt this universally, given limited resources, but it should be tried where the potential appears to be high. If this is the case, the task of identifying such communities is important. If this is done, efforts may be concentrated upon supporting further development in the most promising circumstances, hoping that diffusion of this successful organizational innovation will proceed by reputation to communities characterised by lesser capacity for self-mobilization.

Moreover, the question arises of the nature of the external support which could be provided. As is the case with all types of co-operative, a balance must be found between respect for independent action and continuing autonomy

and the value of external support. Wherever possible, support should be provided as a form of solidarity within the co-operative movement, preferably by a specialist health co-operative development institution.

In countries where user-owned health co-operatives are still relatively small and isolated, it would appear that an important element of any strategy would be that which is normal for any type of co-operative system development - namely combination of small enterprises within a secondary co-operative organization, thereby achieving strength in numbers. For operational reasons this would appear to be possible only where the primary co-operatives are located in sufficient proximity to each other. A complementary approach would be to support the vertical and horizontal integration and expansion of existing user-owned health co-operatives.

These approaches can be combined by supporting the development of a type of secondary co-operative not consisting of equally small primary members, but based upon a core primary member which is already a large and viable enterprise in countries where relatively large, vertically integrated and horizontally extended "staff model" and user-owned health co-operatives already exist. This approach might utilize the normal tendency of such co-operatives to expand horizontally - setting up clinics (some of which are subsequently up-graded) in localities not accessible to the original central facilities, and establishing various form of operational collaboration and alliance with other health organizations, both co-operative and non-co-operative. It could be envisaged that, where such a "core" co-operative was in danger of becoming so large that user-participation in its direction and management might become ineffective, then autonomous primary co-operatives might be established, collaborating operationally with its "parent". Even where the larger prospective "core" co-operative and separate smaller co-operatives existed in the same sub-region, there would still be utility in their forming a secondary support co-operative.

In contrast, the experience of the Group Health Co-operative of Puget Sound appears to have been that an effective vertical functional extension - involving for example, undertaking own common management as well as certain specialist professional services - was best achieved within the co-operative, rather than by means of alliances with separate support co-operatives. This may have been the result of the fact that there were no similar primary health co-operatives in the sub-region during the early phases of development, while in later phases the Co-operative became so large that there was no scope for new primary user-owned co-operatives to enter the regional market. This might not be the case in other sub-regions, and is certainly not the case in many regions where it appears that health co-operatives might be an appropriate organizational model for improved service to users.

(b) <u>Increasing efficiency in provider-owned health co-operatives</u>

Where this type of health co-operative is well developed (as in Brazil), the experience has been one of relatively rapid expansion among providers of the concept of a primary level co-operative, followed soon afterwards by their combination in sub-regional and then regional secondary level and almost simultaneously in national tertiary level co-operatives. It appears to be inherent in the nature of a co-operative formed by providers that their interests can be met best by rapid development of operational networks.

Given the entrepreneurial focus of provider-owned co-operatives there has been also an inherent interest, once networks have been established, in the setting up of specialist enterprises fully owned and integrated within a tertiary system: enterprises capable of delivering both professional support and common managerial services (this has been most extensively developed by Unimed in Brazil, but appears to be a tendency elsewhere).

As an alternative to fully-owned subsidiaries for secondary and tertiary level networks, it is possible to promote the development of their collaboration with independent co-operatives, including labour-contracting co-operatives, and those providing specialised and general goods and services for the health (and to a lesser extent) social care sectors. These could collaborate with individual primary provider-owned health co-operatives or with secondary or tertiary networks. They could substitute for only part of the set of fully owned subsidiaries, or they could provide all required inputs.

While provider-owned health co-operatives have found it easy to expand horizontally by establishing networks, as well as to expand vertically thereafter by backward linkages, they have not significantly developed the considerable potential for forward linkages, that is for integration of their users, clients or customers. While there has been substantial development of contractual structures with individual users and group-users (primarily through enterprise-related group health insurance plans), there has been only limited interest in either promoting the autonomous organization by users of their own health co-operatives (even if at the early developmental phase), or of integrating the user component as member partners within the co-operative, making it a "mixed" user/provider-owned enterprise. Such a development has appeared in Brasil, with the "usimed" system of co-operatives promoted by Unimed, and has been discussed in Malaysia.

(c) Bringing about greater collaboration between user-owned and provider-owned health co-operatives

Previous chapters have shown that in those countries where health co-operatives operate it is usually the case that only one type is present, but rarely a variety of types. Moreover, although under discussion in a few countries, there is not as yet an organization at national level which includes the full range of health co-operatives, and certainly not one which operates as a coordinated system.

This is a special variant of the basic issue of collaboration within the co-operative movement between user-owned and provider- or producer-owned enterprises. consumers and producers have different, even conflictual, interests, at least, in the short-term, but it can be argued that they can be mutually supportive in the longer-term.

The following options appear to be feasible in appropriate circumstances:

(i) user-owned health co-operatives continue their vertical development, including operation of fully-owned facilities and employment of their own professional staff in all medical and paramedical as well as specialized managerial and operational positions (in a sense this preempts formation by health professionals of a provider-owned health co-operative). This would appear to be a development appropriate where a sufficient proportion of health professionals perceive that they can best satisfy their own interests by working as employees of such a co-operative: which depends largely on the ability of the user-owned co-operative to develop mutually beneficial collaboration with its professional employees.

(ii) where health professionals prefer to work independently (i.e. not in user-owned health sector enterprises) they may wish nevertheless to collaborate within provider-owned health co-operatives, which may operate within the same sub-region as user-owned health co-operatives. Collaboration in this case may take the form of operational arrangements with user-co-operatives (varying according to the degree of the vertical development of each). From the point of view of provider-owned co-operatives these are likely to be not significantly different from collaboration agreements with

non-co-operative enterprises in the health sector. However, some "solidarity" factor might be present, particularly where the co-operative movement as a whole is well developed within the communities and sub-region affected.

(iii) collaboration may arise where a provider-owned co-operative promotes the formation of user-owned co-operatives within the communities in which it operates and among individuals, households or enterprise work-forces which already constitute its customers/users "enrolees" (as in the case of Unimed/usimed in Brazil).

(iv) again where user-owned and provider-owned health co-operatives operate within the same sub-region, a further option for collaboration is joint membership in a secondary co-operative providing common services or acting as a purchasing co-operative. This secondary level enterprise could function exclusively for the benefit of primary co-operatives of both user-owned and provider-owned types, or it could include also as members non-co-operatively organized enterprises also.

(d) Bringing about greater collaboration between health and social care activities

There already exists a marked tendency for health co-operatives, particularly those which are user-owned, to extend and diversify their functions from purely health to social care, social welfare and social service functions. This tendency is natural, particularly when taking into consideration the marked emphasis in both user-owned and provider-owned co-operatives upon prevention, broad health promotion, as well as family and community care and rehabilitation, where technically appropriate. This involves a continuum of functions from curative interventions though "social medicine" to concern with the overall condition and societal environment, particularly of those at risk and subject to the particular processes and conditions which cause ill-health.

At the same time, autonomous co-operative enterprises exist entirely within the social service sector: these include both user-owned and provider-owned enterprises. To a greater extent than among health co-operatives, various forms of mixed-ownership are common, including also persons acting on behalf of those who are beneficiaries, and if not disadvantaged, normal user-owners. Members include natural persons (parents, guardians) as well as institutional persons (whether private charitable or service organizations of public authorities).

4. Strengthening partnerships with other stakeholders in the health and social care sector

Although efforts to bring about a system-wide approach to health and social care within the co-operative movement are likely to mobilize significant resources, it will always be necessary for co-operatives to work in this area with other stakeholders. These include health and social care professionals; employer's organizations; farmers' organizations; self-employed persons organizations; trade unions; women's organizations and organizations of young persons and of the elderly; government agencies at local, regional and national levels; and the national representative offices of relevant international organizations. Responsibility for developing such partnerships lies with both the tertiary institution established by health and social care co-operatives, and the body within the general national co-operative apex organization responsible for the comprehensive co-operative strategy for health and social care.

Considerable priority should be attached to this activity, as it can serve to reduce the very considerable opposition to co-operative organization within the health sector which is still common among health professionals, as well as to secure the collaboration of many sections of society which might find health co-operatives to be an appropriate means to resolve their particular problems. This is suggested, for example, by the interest shown by self-employed women's trade unions in both health and co-operative organization, and in the interest of older persons, confronted by health-related problems, in co-operative solutions. Regular liaison with the organizations representing these sections of the community would be important.

In developed countries affected by adjustment in welfare state structures and programmes, the question of stronger links between health co-operatives and co-operative insurance and trade unions requires consideration.

Particularly in conditions of greatly increased competition from private for-profit enterprises, there is a need for co-operative insurers to strengthen their base by developing further their often special relationships with trade unions and other broad people's associations, each of which is likely to share their concerns to counteract increased segregation of population groups in respect to levels of risk.297/

(a) With trade unions

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Collaboration with trade unions is already substantial in some countries and could be strengthened further. The experience of the Self Employed Women's Association (SEWA) in India is a model which appears to have very considerable potential. Through its Awareness Community Health Programme it has shown how a very significant section of the population without adequate health care - in this case the very poor women who are self-employed in a wide variety of production and service provision occupations - have been able through their own efforts (organized by means of a trade union and co-operative forms of enterprise) to obtain affordable and relevant health services. Moreover, the fact that it is women who are engaged in this experiment, and that women are acknowledged to be the key actors in any process of improving health and social well-being among these populations, is of major significance.

It should be noted that SEWA has proceeded cautiously and by means of the gradual mobilization of the energies of women hitherto lacking any form of empowerment in extremely hostile conditions. Hitherto, health service intervention has been confined to broad preventive and limited first curative interventions provided by its own health team, internes and community health paraprofessionals trained by SEWA itself. Further curative intervention is provided in facilities and by personnel not employed by SEWA: largely those provided by the public health services.

The next step might be for SEWA to upgrade its community health centres to fully equipped clinics, then to establish its own hospital facilities, and thereafter continue a process of vertical and horizontal expansion. The services provided by SEWA's single urban pharmacy could be expanded. To increase user commitment, the system could be converted into a secondary organization combining a number of user-owned health co-operatives which could be organized in full collaboration with the trade union but as an autonomous entity. The existing community health paraprofessional workers' co-operative might be developed further as an autonomous provider-owned co-operative, or re-absorbed into the larger user-owned health co-operative system. As part of these developments SEWA could extend fully the health and social security insurance scheme already partly introduced. Opportunities for collaboration

with the health services provided by other co-operative organizations and with other trade unions and other women's organizations could be taken up.

Because the capital requirements of such a comprehensive system are likely to be greater than the surplus to be expected from the activities of component co-operatives and the union itself, at least during its early phases of development, greater use might be made of preferential support from SEWA's own co-operative bank, from other co-operative banks and thrift and savings co-operatives, and from State and Union level co-operative development banks and agencies and co-operative insurance enterprises.

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(b) With mutual organizations

Mutual organizations and co-operative enterprises in health and social care have a common history. As a result of the particular circumstances in each national society either one or the other has become predominant. However co-operatives and mutuals have collaborated frequently in the insurance sector, and there would seem to be much to be gained from extending this collaboration to service delivery. In many conditions, health and social care co-operatives might act as the operational partner of mutual associations.

(c) With the public sector

In a number of countries, in recognition of the fact that health and social care co-operatives have been proven to be an effective means for the provision of health and social services, formal partnerships have been developed with them at national and local levels by the public agencies responsible for health and social care.

In some instances such co-operatives are perceived as implementing agencies, sharing with public agencies the task of providing adequate and appropriate health services. They receive public funding in order to operate. This arrangement is made when beneficiaries are unlikely to be able to meet costs themselves. For example, in Italy in 1993 reliable estimates indicated that about 13 per cent of public spending on social welfare, including health services provision, took the form of financing "social co-operatives" (of which only between 10 and 15 per cent were health co-operatives).

The significance of social co-operatives had been acknowledged by adoption of national law 381/91, which recognized their status and rights. Article 1 of this law stated that the purpose of "social co-operation" was to "pursue the general interest of the community in the human enhancement and social integration of citizens". Adoption of this law expressed the growing awareness of "social co-operation" as a viable formula which could be applied to the "depublicization" of social services, and which would guarantee social protection for all citizens and thereby able to create "that welfare community that was considered the only viable alternative to indiscriminate privatization and residual social policies". The crisis in management and financing of social welfare programmes by the state had forced public

administrators - sometimes unwillingly - to delegate certain services to social cooperatives as well as to non-co-cooperatively organized private sector enterprises and associations.

However, there had been increasing recognition of the fact that "social co-operatives" were forms of organization outside the public sector which combine entrepreneurial energy with democratic participation and administrative transparency. The direction and administration of the co-operative not only responded to the basic principles of the co-operative movement, but was open to the normal legal monitoring applied to any business enterprise, from the point of view of its financial management, and as an employer (by the Ministry of Labour), but also by the agencies responsible for health and social welfare. 298/.

This partnership required some adjustment in the basic operating principles common to all co-operative enterprises: neither provider members nor user members contributed to the capital of the enterprise, this being provided largely from "subsidiser members", likely to be not individuals but institutional or "legal persons", whether public agencies or private not-for-profit or charitable organizations.

The following options appear to be available:

(i) privatization or "cooperativization" of public sector institutions: (e.g. community health centres and clinics; possibly even hospitals; certainly certain programmes of a promotional and preventive nature; certain social service institutions.

(ii) contracting out services which are currently the responsibility of the public sector to non-public sector co-operatives;

In Sweden, both options have been attempted: in some neighbourhoods, communities, or larger administrative areas, local government authorities, together with representatives of the existing co-operative movement (e.g. housing or insurance co-operatives) have examined the establishment of user-owned co-operatives. At the same time, local government authorities have experimented with transfer of certain institutions to the co-operative ownership of the professional staff.

It would appear possible also to develop secondary co-operatives whose members would include primary co-operatives as well as public sector institutions and also private for-profit sector institutions. This could be undertaken not merely at local and sub-regional but at regional and even national levels: this would require collaboration between apex co-operative organization and the responsible higher level government agencies.

With respect to collaboration with governmental agencies responsible for health matters, it would appear necessary that permanent and formal means be established for the exchange of views, development of common guidelines and planning operational collaboration. Regular liaison with regional and national offices and programmes of WHO and UNICEF should be another function of the tertiary organization of health and social care co-operatives and that responsible for overall co-operative engagement in health.

In Sweden the experimentation which took place during the early 1990s, which had involved promotion of both user- and provider-owned co-operatives by local government authorities, in collaboration with national level co-operative housing organizations and insurance enterprises (HSB and Folksam) and their local members, did not proceed very far. Some initiatives never moved beyond the planning stage. By early 1996 there was in fact some backlash, with some of the recently formed co-operatives, particularly those which were provider-owned, undergoing pressure to return to the public sector.

In 1994 also local government policies in respect to the establishment of provider-owned day care co-operatives changed, after which there was almost no further development in this type of co-operative. 299/

D. Strengthening institutions and procedures within the international co-operative movement in support of the formulation and implementation of national strategies

1. Institutional arrangements

There would appear to be much to gain from the establishment of a global specialized co-operative body representing and supporting health co-operatives and the broader efforts of the international co-operative movement to bring about improved health in the societies where they operate. Establishment as a specialized body of ICA would be one, and probably the most appropriate, solution.

The functions of such a body would mirror at the international level those already suggested in respect to the national level body, including building partnerships with the international representatives of the major stakeholders. Of major importance would be application for permanent consultative status with WHO and UNICEF.

Among actions which could be taken immediately would be to send the report and proceedings of the Forum to WHO, UNICEF, the World Bank, the regional development banks and UNDP. The United Nations Department for Policy Coordination and Sustainable Development has incorporated the findings and recommendations of the Forum in the present review. This in turn will be summarized in a chapter on the co-operative health and social care sector within a comprehensive study of the contributions of the international co-operative movement to the goals of the United Nations (to be published in 1996) and also in the next report on co-operatives to be transmitted by the Secretary-General of the United Nations to the General Assembly at its Fifty-first session (also in 1996). By this means the potential of co-operatives within the health sector can be brought to a wide international audience, including the Governments of States Members of the United Nations.

2. Technical assistance

It would be important also for this international body to assume responsibility for the promotion and harmonization of technical assistance within the international co-operative movement, including the establishment of a network of "centres of excellence" which would undertake the essential developmental research: evaluation of experience, appraisal of chances for replication, preparation of guidelines, organization of information networks and regular exchanges of specialists. Steps might be taken to facilitate the provision of assistance by the more developed health and social care co-operatives, such as those in Brazil, Japan, Spain and the United States, to co-operatives elsewhere.

Special attention might be given to promoting the concept of health and social care co-operatives in the transitional economies. This would require collaboration with the co-operatives themselves, as well as with the established institutional structures for technical assistance within the international co-operative movement. It might be also possible to place health co-operative advisers in each of the ICA's Regional Offices (that for

the Americas has already undertaken activities in the area of health co-operatives).

X. CONCLUSION: A POTENTIAL STILL TO BE REALIZED

Co-operative enterprises operating in the health and social care sector are, like all co-operatives, obliged to achieve financial viability in the market. They have to secure an income greater than their expenditures, otherwise they go out of business. Consequently, they are obliged to use management practices as effectively as any enterprise in the market economy: they cannot risk being anything but efficient. They offer good organization, the constant search for new ways of intervening in order to better respond to social need, and the assumption of the associated risks and responsibilities by those involved. Because of their highly democratic nature and accountability to their community base, the risk of their deviating from pursuit of their original goals, or of failing to react to new conditions, is minimized. Because of their business experience, they are often more likely to be efficient than charitable, voluntary and other "not-for-profit" associations. For these reasons they are frequently more efficient than components of the public sector engaged in the same activities: they move forward from the standardised, not-innovative and inefficient approach that often characterises public sector services.

Because of the special requirements of services provided in health and social care, the particular organizational structure of a co-operative enterprise places it at an advantage compared to both public sector and private for-profit sector enterprises. Participation by customers (users, clients, patients) in the identification of goals and in the design of operations is particularly valuable in these sectors - and is a resource which can be fully utilized by co-operative organization, whereas the organizational structures of both public agencies and for-profit enterprises are hostile to an effective participation by citizens in the identification of their goals and in the management of their activities.

Similarly, meaningful dialogue between users and providers, patients and doctors, clients and social workers, is an essential element in successful operation of enterprises in the health and social care sector. Motivation for such dialogue is minimal in the public sector and in private for-profit sector environments: but is an intrinsic feature of co-operative organizational structure which allows such collaboration to pay off in successful operation and in the satisfaction afforded to both providers and users.

Moreover, the co-operative enterprise, because firmly based in the communities in which it operates, can call upon community resources, such as volunteers, and community support, as expressed in effective partnerships with other citizen's organizations and local government authorities. The co-operative form of organization provides to purely social associations a means of economic empowerment, and hence more likely translation of aspirations into reality. By means of controlling their own business enterprises groups of citizens no longer have to rely upon either public agencies over which they have no control, or for-profit enterprises for whose services they have to pay. The commitment to sustainability, to a continued presence differentiates the co-operative enterprise from that governed by considerations of investor satisfaction, which can close or relocate in response to processes entirely external to the community.

For all of these reasons co-operative enterprises have an important role to play in the future development of mixed health and social care sectors in most types of societal situation. This is true in developed market economies experiencing adjustment in the roles and shares allocated to the public, private not-for-profit and investor-driven for-profit sectors. It is the case

also in the transitional economies engaged in the reconstitution of their health and social care sectors after the retreat of the former monopoly constituted by state and parastatal sectors. It is true in the developing economies also engaged in adjustment in the roles and shares of public, communal, mutual, not-for-profit, and for-profit sectors. While there is little doubt that in most countries highly varied structures will be the norm, there also seems little doubt that the particular characteristics of co-operative enterprise, which give it a very substantial potential, if realized, will be translated into a significant role for co-operative enterprise in health and social care, analogous to the major significance of co-operative organization in the economies of many developed market economies.

The question remains one of finding the most effective means whereby the clear potential may be fully realized, and within as short a period as possible. Co-operatives are not elements within a monolithic system capable of an easy coordinated activity: not at the local level, not within any national society, and not at the global level. But the co-operative movement possesses already significant institutional means whereby progress in the health and social care sector may be promoted vigorously. There are sufficient examples of "best practice", a number of important initiatives, and an environment highly favourable to the entry and expansion of innovative approaches.

Achievements will result only from the energetic initiatives of individuals engaged in real-world situations in each community. From what is known of the development of co-operative enterprise in these sectors, it was such local initiatives that transformed potential into actuality - but in most cases also there was an element of external catalytic intervention and support, both directly, and indirectly in the form of improving the entrepreneurial environment, working to establish a "level playing field".

The resources needed to promote and support rapid further development of co-operative enterprise in health and social care are already available to the co-operative movement and to actual and prospective partners - which include governments and inter-governmental organizations, other components of the social economy or "third sector", private for-profit enterprise, and, most importantly, perhaps, the energies of individuals and communities seeking an organizational means whereby they can participate and contribute with some prospect of achieving their goals.

A. Factors relevant to realization of the potential for further effective engagement in health and social care

In Chapter VII the principal determinants of effective engagement by the co-operative movement in these sectors was examined in respect to a number of distinct types of society, defined, very broadly, in terms of the nature of the combination of determinants and the consequent configuration of the "space" available for co-operative enterprises. Chapter VIII set out the benefits to a number of stakeholders of the existence of a co-operative form of organization of enterprise in health and social care, in each of the same distinct types of society. Implied were the potentials for establishing strategic alliances between co-operative enterprises and other stakeholders. Chapter IX examined a number of the organizational procedures and institutional arrangements which might be necessary in order to being about a more comprehensive, integrated and effective engagement by the co-operative movement in the health and social care sector.

In the present chapter, the implications of the situations described above will be examined in the context of the societal circumstances associated with each of the distinct types of society previously identified, and specifically

in the context of prospects for expanded co-operative engagement in health and social care. A number of aspects will be considered:

- the opportunities for expanded engagement by co-operative enterprises offered by probable adjustments in the organization of the health and social care sector, and specifically by changes in the extent of public sector responsibility and the degree of effectiveness of public sector delivery;

- the potential for expansion of the co-operatively organized sector from the organizational base constituted by existing co-operatives engaged in health and social care;

- the potential for formulation of comprehensive strategies for enhanced co-operative engagement in health and social care suggested by recent trends in informal and formal discussions within the co-operative movement, and in preliminary activities which might form the basis for further policy development and operational collaboration between relevant components of the co-operative movement;

- the current capability of tertiary level institutions in the co-operative movement whose function would be to bring interested parties together in order to formulate a comprehensive strategy. Questions which need to be considered might include: is there a national co-operative apex organization? are there apex organizations in each of the principal sectors capable of engagement in health and social care (e.g. agriculture, retail, insurance, health and social care itself)? if there is no national apex organization for the whole co-operative movement, then what if any are the structures used to facilitate collaboration or interaction between different components? what is the condition of co-operative development finance institutions? what is the status of research and development institutions, co-operative media, education and training ?

- recent trends in the positions of governments, and of other stakeholders, in respect to the possibility of an expanded role of co-operatively organized enterprise in these sectors; trends in the perceptions and policy positions of citizens and the various types of their representative organization; and trends in the perceptions and policy positions of other stakeholders.

B. Possible developments within principal types of national societal conditions

1. Welfare states in Europe, and in Canada and Israel

(a) Opportunities for expanded engagement by co-operative enterprise offered by probable adjustments in the health and social care sector

While it is probable that there will occur significant adjustments in the public sector, the implications for an increased co-operative engagement are likely to vary. Certainly in Italy and to some extent also in the United Kingdom recent adjustments have opened up very considerable opportunities for the private sector, particularly in social care, and to some extent co-operative enterprises have been able to enter this new market. In Sweden, in contrast, although some experimentation took place, in effect the public sector has not withdrawn significantly and opportunities for private sector, including co-operatively organized development, have been smaller than at first anticipated.

Moreover, adjustments in the public sector which expand the scope for private sector development need not necessarily result in greater

opportunities for co-operative enterprise: citizens and enterprises may prefer other forms of mutual aid, or private for-profit enterprises in the health and social care sector, may be energetic enough to seize most newly created opportunities by means of their greater capital resources, including their ability to advertise.

Nevertheless, in most of these societies opportunities for expansion of enterprises outside the public sector are likely to be considerable, and opportunities for co-operative participation in this new market substantial. The need to find the very specific niches where co-operatives rather than other types of organization or association are most appropriate, and most capable of success, is likely to keep development to a steady rate of expansion, rather than to generate a rapid transformation.

(b) Potential for expansion from the current base constituted by co-operatively organized activity in health and social care

Until very recently in Beveridgean conditions the universality of public sector responsibility for both insurance and service delivery constrained direct co-operative engagement - there are very few user-owned health co-operatives, and few provider-owned co-operatives (and certainly no large secondary networks). Co-operative insurance enterprise is substantial and has the capability to expand into health insurance and a more diversified coverage of risks of conditions requiring social care. Some development in these areas has already taken place.

Co-operative pharmacies are well developed in some countries. Retail and housing co-operatives are particularly well established. The former have much experience in improved nutrition and preventive health. The latter have already served as a base for establishment of social care co-operatives, and are well placed to function as a base from which to develop user-owned health co-operatives. Co-operative banks and savings and credit systems are well placed to finance further engagement in these sectors by all types of co-operative enterprise, as well as to serve as distributors for health insurance provided by co-operative insurers. There is very considerable scope for expansion of worker-owned co-operatives manufacturing goods for, or providing services to the health and social care sector, including labour-contracting co-operatives. There are also many opportunities for establishment of secondary co-operative networks owned by health and social care enterprises, particularly those co-operatively organized, in order to provide support services.

In Bismarkian conditions mutual organizations providing insurance, and then various types of services, were able to occupy substantial components of the sector. Here there is also considerable scope for co-operative expansion, but possibly in closer alliance with mutuals and other elements of the social economy.

In almost all of these countries the organizational superstructure of the co-operative sector is well developed: general and sectoral apex organizations and research and development institutions have considerable resources. Additional considerable resources for research and development exist outside the co-operative sector itself in universities and other institutions.

Consequently, there appears to be a very substantial resource base for early and rapid expansion of co-operatively organized enterprise in health and social care. This is likely to vary between countries, and even between regions within each country. It will require a careful assessment of potential and selection of areas in which effective expansion is best assured in order not to waste resources, and to generate as quickly as possible successful enterprises which can be used as models. There would appear to be much to be gained by selective alliances with local governments, trade unions,

and other occupational and community-based associations. These might extend to the joint operation of facilities such as community health and social care centres, specialist clinics, and residential institutions. As these innovations become better known, it seems likely that there will be much scope for a gradual transfer from public to co-operative institutions.

There is much scope also for further extension of the work at regional level already in progress, and for partnerships between co-operative and other social economy movements and the institutions of the European Union.

(c) Recent developments in consideration by the co-operative movement of further engagement in health and social care

In Sweden co-operative insurance and housing enterprises have negotiated with local governments for the transfer of some functions from the public to the co-operative area. In Italy such a partnership is already well established, at least in certain regions. In France the "mutualité" has been for many decades a full partner with the public sector at national level.

A number of other initiatives suggest future directions for co-operative engagement. In the United Kingdom a member of the legislature (Member of Parliament), and member of the Co-operative Party, Mr. Alf Morris, launched an initiative, in collaboration with The Co-operative Bank, at the 1995 Co-operative Congress, held at Edinburgh. By early 1996 a number of proposals for specific activities and programmes had been made by interested parties. It was the general consensus that these were encouraging, but that development toward a direct co-operative engagement in the health and social care sector would be a gradual process, and that there could be no "Co-operative Quick Fix". 300/

Mr. Morris opened the International Health and Social Care Forum held in September 1995 at Manchester, United Kingdom, and drew the attention of participants to the fact that co-operative engagement in health and social care had preceded nationalized systems. In the mid-1990s co-operative ideas and practices that had been put into practice earlier were being reborn as citizens found that their needs were not being met by the welfare state system. Mr. Morris proposed creation of a framework for co-operative health and social care based on multi-social-service centres in which co-operative enterprises, voluntary organizations and co-operative insurance enterprises would collaborate. 301/

This approach has been complemented by initiatives taken by the United Kingdom Co-operative Council which have succeeded in persuading the ministry responsible for health to commission research into some aspects of co-operative organization in health and social care.

Even though initial steps have been taken, it would seem important that co-operative movements in these countries take urgent steps to review the entire range of possible ways in which each component of the movement can more effectively contribute. This will require the commissioning of research, consideration of how in purely operational and business terms these goals can be achieved, and energetic development of institutional means for collaboration. Such actions appear to be at a very early phase, as yet, but there are no significant constraints on adoption of a much more dynamic approach - important if other stakeholders are not to take advantage of developments and occupy the newly available market space.

(d) Recent developments in the positions of governments and other stakeholders in respect to co-operatively organized engagement in health and social care

In the majority of countries Governments are strongly interested in innovative partnerships with organizations in the non-public sector, provided that these will have the effect of resolving current problems and meeting individual and societal needs in health and social care. Attitudes to co-operative forms of organization, as opposed to other social economy institutions, or to private for-profit enterprise, are likely to vary between countries, but there would appear to be good prospects for greater interaction with the co-operative movement in most countries. This tendency is likely to be enhanced by proof of the effectiveness of co-operative approaches, and by presentation of well-developed strategies showing a coherent and comprehensive engagement by all of the relevant components of the movement throughout the wide range of areas in which they are capable of effective operation.

Dissemination of best practice, a responsibility of national and international co-operative organizations, would appear to be the best way to overcome the caution of some national and regional governments. Of major importance will be lobbying for adjustments in legislation to allow for the full realization of the potential of co-operative forms of enterprise in the health and social care sector.

2. The United States

(a) Opportunities for expanded engagement by co-operative enterprise offered by probable adjustments in the health and social care sector

The distribution of responsibilities and functions is highly complex: the public sector is significant but made complex by the variety of different functions of national, regional and local governments. The private for-profit sector is very substantial and energetic. Scope for community based and citizen owned enterprise is very considerable, with already significant co-operative enterprise. There is keen political and public interest in improvement of the health and social care sector, and continuous adjustment which constantly offers new opportunities for co-operative engagement.

(b) Potential for expansion from the current base constituted by co-operatively organized activity in health and social care

Co-operative forms of organization in the health and social care sectors are already very substantial, but fragmented functionally and locationally. They occupy niches within a complex mixed system which includes substantial public as well as private for-profit investor driven components. Only in the provider-based support area, and in respect to enterprise-based insurance have national organizations developed. They are conspicuously absent in respect to the regionally concentrated well-developed user health co-operative movement.

There is a well-developed national apex organization, which has recently established an enhanced research and development facility, and there are a considerable number of university-based research institutions. The institutional capability available for promoting broader partnerships between different components of the co-operative movement is very substantial.

Given the complexity of the distribution of responsibilities between public and private sectors, and the energy of the private for-profit sector, it would seem that, although scope for further co-operative engagement is very considerable, it will develop in a highly differentiated manner, as opportunities emerge and as the movement is able to respond promptly and effectively.

(c) Recent developments in consideration by the co-operative movement of further engagement in health and social care

Although the national co-operative apex organization supports all types of co-operative organization in this as well as other sectors, there is not as yet any comprehensive strategy for promoting more effective and harmonised co-operative engagement in health and social care. Possibly the establishment of the new research and development facility, the CLUSA Institute for Co-operative Development, in January 1996 will provide an opportunity for investigating precisely what form such a strategy might take in the very specific circumstances of the United States.

(d) Recent developments in the positions of governments and other stakeholders in respect to co-operatively organized engagement in health and social care

In recent discussion of reform in this sector the national (federal) government made an energetic case for forms of co-operative organization of enterprise-based health insurance. Because there was an inappropriate element of public sector involvement, however, this was not considered an appropriate approach by the co-operative movement itself.

3. Japan

(a) Opportunities for expanded engagement by co-operative enterprise offered by probable adjustments in the health and social care sector

During the last decade significant retrenchment in the national social security system has occurred. This has affected in particular older persons, who already constitute a substantial proportion of the population. Scope for provision by co-operatives in both insurance and service delivery, and in respect both to health and social care, is very considerable - and the two already established health co-operative systems have expanded their activities, particularly to provision of combined health and social care to older persons.

(b) Potential for expansion from the current base constituted by co-operatively organized activity in health and social care

The existing user-owned health and social care co-operative systems are well-established, although still catering for only part of what might be considered the potential market in urban areas. Their activities have been constrained recently by the fact that their members rely on the social security system for funds with which to pay their co-operative for services they consume: as these have been significantly reduced, many co-operatives are in financial difficulty.

Co-operative insurance enterprises are strongly established, and have very considerable financial resources. It would seem possible for them to provide not only health and other social insurance to all members of the co-operative movement, but to provide substantial capital for the further expansion of health and social care co-operatives.

(c) Recent developments in consideration by the co-operative movement of further engagement in health and social care

The two user-owned health and social care co-operative systems are extremely active, not only in improving the effectiveness of user participation and in diffusing the concept of healthily living, but also in lobbying at national level for substantial change in the entire structure of health and social care in Japanese society. They have been energetic also in promoting the concept of co-operative engagement in health and social care internationally. However, there would seem to be much scope for further alliances with the co-operative insurance sector, with fisheries co-operatives

and with housing and worker co-operatives, in order to promote a comprehensive co-operative health and social care system.

(d) Recent developments in the positions of governments and other stakeholders in respect to co-operatively organized engagement in health and social care

Although Governments, at least until recently, supported the traditional approach to health and social care, which emphasized cure and rehabilitation of ill persons, rather than broad preventive approaches, there does not appear to have been any strong opposition to health and social care co-operative enterprise, and no such opposition can be anticipated in the near future.

4. Latin American countries

(a) Opportunities for expanded engagement by co-operative enterprise offered by probable adjustments in the health and social care sector

Although conditions are diverse, the general trend in most of these countries is toward improving the effectiveness of what might be described as a partial Bismarkian system. Increasingly comprehensive national social security systems are being introduced, which provide for a very wide range of health and social care service delivery. As has already happened in a number of countries, provider-owned health co-operatives will be accredited as providers under these systems, assuring them a significant clientele.

At the same time, varying approaches are being made to improvement in the provision of services to the least advantaged sections of the population, including reconstruction of the now overwhelmed system of religious and philanthropic hospitals and social care institutions. There would appear to be very considerable scope for development of "interested party" owned health and social care co-operatives, on the Italian model, with the participation of co-operative insurance enterprises, and in collaboration with trade unions and mutual associations.

There is a clear unmet need for effective health and social care systems for the low- and the middle-income majority of the population. Public systems were never intended to meet more than a small proportion of such demand: religious and other philanthropic organizations are now unable to meet the needs of all the disadvantaged sections of society. In some cases an energetic private for-profit sector exists, but is not concerned with the lower-income sections of society. Consequently, there is a very substantial potential for co-operatively organized enterprise.

(b) Potential for expansion from the current base constituted by co-operatively organized activity in health and social care

In Brazil the Unimed system, particularly since its recent extension to the promotion of user-owned co-operatives, and its engagement in reconstruction of community-based health and social care systems largely catering for lower income sections of society, has already established something approaching a comprehensive co-operative health system. This could be expanded further by acting as the base for larger involvement in social care.

In some of the other countries, a base for setting up a similar system, although possibly less unified and comprehensive, exists in the growing collaboration between co-operative and mutual insurance enterprises, provider-owned health co-operatives and other co-operative organizations interested in providing to their members health and social care benefits. Such a system has been set up recently in Colombia. The co-operative base is possibly not so advanced in certain other countries, but is adequate for an early replication of the Colombian model, modified to fit local circumstances.

In certain countries, such as in Uruguay, the basis is rather different: although mutuals are well developed, co-operatives in insurance and health are not. Nevertheless, significant co-operative movements exist, and could provide a base for exploration of a modified form of the Colombian or the Brazilian model - the latter more likely in those countries in which Unimed has already had considerable contact with interested parties.

(c) Recent developments in consideration by the co-operative movement of further engagement in health and social care

In Brazil Unimed has already developed a strategy for a national health and social care system within which both provider-owned and user-owned co-operatives will constitute significant components. The country's new constitution, which came into force in October 1988, determined that there should be a "Unified and Integrated Health Care System (SUS)", by which the Government would function solely as a provider of resources which would be channelled through the not-for-profit sector (co-operatives and philanthropic organizations): in mid-1995 the philanthropic organizations, "Santas Casas de Misericordia" (Holy Houses of Charity) provided 65 per cent of all patient beds in the country, and Unimed a little over 30 per cent.

Unimed proposed that the Government should be the provider of health care insurance in an amount equivalent to between 10 and 12 per cent of GNP, thereby giving proper coverage to the entire population. The system of health and social care service delivery should be based upon functional regions (metropolitan regions and counties, but not municipalities), allowing for the most efficient utilization of resources. Within these functional regions a coordinated system of hospitals and other facilities operated either by philanthropic or co-operative organizations would provide services to all persons requiring attention. Regional health councils would supervise the financial component of the system.

Users would play an equal part with providers in operating the system through their membership in Usimeds (user-owned health co-operatives). By means of close working relations between provider-owned and user-owned components of the co-operative system (Unimed/Usimed) it would be possible to operate efficiently saving about 30 per cent of current costs.

A proto-type of such a system, termed a "Community Co-operative Health Care Insurance Programme" was being developed in mid-1995 in Penápolis in the State of Sao Paolo. It involved 60 doctors and a local population of 80,000. 302/

In Colombia the co-operative movement has supported recent collaboration between a co-operative insurer, provider-owned health co-operatives and enterprises in other sectors, in the setting up of a comprehensive system. Elsewhere, movements are not known to have moved toward specific actions leading to such systems.

(d) Recent developments in the positions of governments and other stakeholders in respect to co-operatively organized engagement in health and social care

Governments in some countries appear to be supportive of co-operatives taking over from the public sector: this has been the case in Colombia. This may well extend to support for co-operative alternatives to the public sector in health and social welfare. Unimed reports that the Brazilian Government has shown considerable interest in the development of its experiment in community-based co-operatively organized health systems designed to replace or complement the religious and municipal systems.

5. Middle-income countries in Asia

(a) Opportunities for expanded engagement by co-operative enterprise offered by probable adjustments in the health and social care sector

Public sector responsibility for the majority of the population is likely to be revised, even if only gradually, as it becomes evident that resources are insufficient either to meet needs fed by demographic expansion and changes in aspirations and expectations. Private for-profit provision for the upper-income minority is likely to maintain or expand its status as the middle class expands. The area in which co-operative forms of organization might be effective is very large in most of these countries.

(b) Potential for expansion from the current base constituted by co-operatively organized activity in health and social care

In most of these countries the base established by co-operatives directly engaged in health and social care, or in co-operative insurance enterprises providing health insurance, is still weak. A more substantial base exists in the often well-developed co-operative organizations in other sectors, notably in agriculture and fisheries.

(c) Recent developments in consideration by the co-operative movement of further engagement in health and social care

In Malaysia, exceptionally, the co-operative movement, including specifically the co-operative insurance enterprise, has set in place the basis for a national co-operative health system. Elsewhere, there appears to have been little such consideration.

(d) Recent developments in the positions of governments and other stakeholders in respect to co-operatively organized engagement in health and social care

Governments have not appeared to have recognized the potential of co-operatives in health and social care. Their inability to meet expanding demand and new threats to health are becoming increasingly apparent, but has not yet been accompanied by realization that much can be achieved by communities themselves taking the matter into their hands.

The Government in Malaysia took much of the initiative in promoting the establishment of a co-operative health system. Elsewhere, although Governments are closely involved in promoting co-operative movements, it does not appear that they have given consideration to co-operative engagement in the health and social sector.

6. Least-developed countries

(a) Opportunities for expanded engagement by co-operative enterprise offered by probable adjustments in the health and social care sector

In most of these countries a minimal health and social care structure was maintained until the early 1980s by diverse mixes of public, philanthropic and indigenous systems. The last decades of economic, environmental and political disaster, the expansion of HIV/AIDS and recent structural adjustment programmes have combined to severely disrupt the previous inadequate structures.

(b) Potential for expansion from the current base constituted by co-operatively organized activity in health and social care

In many of these countries co-operative movements were severely damaged during the period of their exploitation and distortion as de facto elements of parastatal structures. In some countries this experience has not yet been overcome: elsewhere, the process of deregulation and privatization has opened up opportunities which are being followed energetically.

Direct engagement in health and social care by co-operative enterprises exists only in isolated cases, and there are no support co-operatives or insurance co-operatives providing health insurance. The consumer-owned wholesale and retail co-operative movement is not strongly developed, and hence there is little scope for adjustment toward improved nutrition. Housing and community development co-operatives are more widely developed, and some opportunity for their adoption of health and social care objectives exists - indeed has been taken. Possibly the largest potential exists in agriculture and fisheries, where supply, processing and marketing co-operative organizations owned by large numbers of small-producers are significant. There is much scope here for attention to safe food supply. This co-operative sector might also move more energetically into promoting establishment by its member co-operatives of community-based health and social care programmes and facilities: indeed there are some moves already in this direction.

Co-operative insurance enterprises are relatively well established in some of these countries, and there would appear to be much scope for provision of health insurance alliance with other components of the co-operative movement.

National and apex co-operative organizations, and associated development financing, research and development institutions, are weak in many but not all countries. There appears to be much scope for larger attention to health and social care in those countries with strong and innovative movements - their experiments could then be replicated as co-operative movements in other countries become stronger. There is much scope for international assistance, within the co-operative movement, but also as a component of intergovernmental and other assistance. This has already begun: for example in the alliance of the ILO with a Belgian non-governmental organization.

Thus considerable opportunities appear to exist for a selective approach, taken at first where conditions are relatively favourable, and where experiments may be successful. The role of regional and international co-operative organizations in promoting engagement in health and social care would be important, substituting for national apex organizations where these are insufficiently developed. Such efforts are likely to be most successful if integrated at the global level with the programmes of health sector organizations themselves, both non-governmental and governmental. Indeed this has begun already with the programme of the ILO, which focuses on health and social care co-operatives and associated insurance co-operatives. There might be scope to complement this with a broader strategy aimed at agriculture and fisheries, housing and community development, and savings and credit movements.

(c) Recent developments in consideration by the co-operative movement of further engagement in health and social care

Although there have been numerous local and spontaneous experiments in co-operatively organized health and social care in many of these countries, there is little evidence as yet of consideration by the larger co-operative movements, particularly those in agriculture, banking, credit unions and housing-community development. Nor have the apex organizations which exist in some countries taken into consideration the potential which appears to exist. This is no doubt the result of the very severe environment faced by most co-operative organizations.

The existence of these constraints suggests that the responsibilities of the international co-operative movement, supported by intergovernmental organizations, are likely to be even greater than in other types of society.

Co-operative movements at national and regional levels in these countries are at an early phase in restructuring following the very adverse effects of their relationships with Governments during the period of too intrusive official policies in respect to co-operatives. With much support from the international co-operative movement, and by means of their own energies, apex co-operative organizations, as well as co-operative development, training and financing institutions are now becoming stronger.

The task of reconstructing co-operative movements within the many sectors where they have strong potential is a very considerable one, and leaves relatively few resources available for so new an area as health and social care co-operative engagement. Nevertheless, it appears that at least some national organizations recognize that this is an area where efficient co-operative organization can be valuable to the entire co-operative movement, given that it will address problems of immediate and priority concern to a high proportion of the population. If successful it will go far in dispelling unfavourable perceptions.

(d) Recent developments in the positions of governments and other stakeholders in respect to co-operatively organized engagement in health and social care

The position of Governments is in many cases positive, and strengthened constantly by the successful taking by co-operatives of opportunities opened up by withdrawal of the public sector from many sectors. The example of health co-operative development in Benin is highly promising: forms of "interested parties" health and social care co-operatives - which would include users - could be promoted from a highly innovative "pre-co-operative" community base. They would operate within the framework of new forms of partnership with the public sector.

Even though the advantages - or necessities - of privatization are acknowledged, there is some caution in respect to changes, particularly in health, but also in some social services, still felt to be an area in which there is a limit to public sector withdrawal. This affects to some extent perceptions of the potential role of any type of private enterprise, including co-operatives, in these sectors. Nevertheless, given the obvious need for the application of additional resources and innovative approaches, it would appear that there is no major opposition to experiments in partnerships between public and co-operative sectors.

While trade unions, farmers' associations and other associations of self-employed workers suffered also from the constraints of excessive governmental intervention, they are also now re-organizing and gaining in experience and resources. Recently, they have been joined by women's organizations and environmental organizations as expressions of the strengthening of civil society. As in most countries, their exists a strong potential for the development of partnerships between such organizations and the co-operative movement. Given their interest in improvement in the conditions of their members in such basic areas as health and social care, there is much scope for joint action - with co-operatives coming to be acknowledged as the organizational form adopted by the movements in order to best meet their members aspirations. Such alliances are beginning to take shape in a number of these countries.

Given the constraints upon their professional and financial prospects imposed by the broad economic conditions of most of these countries, it would appear likely that professionals would not oppose affiliation with user-owned

health co-operatives and co-operative insurance enterprises, and might find membership of provider-owned co-operatives, operating within a broader co-operative system, to be rewarding. There are already a number of examples of partnerships between health co-operatives and health professionals primarily employed in the public sector, and no known instances of opposition - although this may be because health co-operatives are not yet widely developed.

In the future private enterprises might consider that affiliated health co-operatives, rather than their own facilities, would be an appropriate means to improve conditions for labour force and the communities in which they operate.

7. Transitional countries

(a) Opportunities for expanded engagement by co-operative enterprise offered by probable adjustments in the health and social care sector

The dismantling of the former state-controlled and enterprise-based health and social care systems offers very large opportunities for co-operatively organized engagement, even given the rapid expansion of private for-profit enterprises.

Health and social care co-operatives might best serve as catalytic centres, organizing locally available resources, rather than as providers of externally funded services. As means of mobilization and empowerment they are likely to have considerable advantages over externally promoted forms of organization.

The climate for co-operative organization in the health and social care sectors has become much more favourable. The health and social sectors are in the process of complete transformation to an entirely new situation, and one unfamiliar to Governments in most of these countries. On the one hand, this offers substantial opportunities for the innovative approaches of which co-operative enterprises are capable: but on the other hand the responsible authorities are confronted by the difficult task of overseeing the establishment of multi-stakeholder health and social care systems with whose components they are unfamiliar, implying that a new co-operative element, additional to those under consideration, might be viewed as difficult to absorb.

(b) Potential for expansion from the current base constituted by co-operatively organized activity in health and social care

In some of the countries in transition from socialist central-planned regimes the former "parastatal collectives" known as co-operatives are still not completely restructured (that is, either converted to genuine co-operatives, or transformed into private for-profit enterprises, or terminated). However, even in these countries early experiments in establishing genuine co-operatives - in agriculture, savings and credit, banking, housing - have been made already. Elsewhere co-operative movements are already significant, formed either by full conversion (e.g. of agricultural supply and marketing enterprises, housing collectives, wholesale and retail distribution systems) or by newly established components, such as those in savings and credit and in banking.

Health and social care co-operatives and co-operative pharmacies exist only in isolated cases. The few co-operative insurers do not offer health insurance. There are no support co-operatives. Direct engagement in health and social care by these organizational forms would require development from virtually zero. However, the surviving and only partly converted "medical co-operatives", or health departments of enterprises, including co-operative

enterprises, are significant in a number of countries, although in some cases forming part of a still incompletely transformed "parastatal collective" system. There would appear to be some potential for their re-invigoration and possible restructuring as user-owned health co-operatives within the consumer co-operative movement.

Still substantial in a number of countries are the wholesale and retail co-operative systems, with associated processing of foods. These still supply significant proportions of households in some countries. It would seem possible to introduce within these co-operatives a greater emphasis upon safe foods, nutritional education and healthy living. There might well be problems in securing acceptable supplies, but given the ability of producer-owned agricultural co-operatives in some of these countries to convert successfully from former collectives and to secure new markets, there is some opportunity for commercial alliances between retail and agricultural co-operatives in developing improved food supplies. Indeed, given the competitive conditions which face co-operative retailers, an emphasis of this type might well prove to be attractive to consumers, restoring a positive perception of co-operative enterprise as part of the market economy and also a valuable means for improvement in the quality of life.

Housing co-operatives may retain a significant position in many of these countries: the experience of conversion from former enterprise-tied housing to co-operatives in the eastern laender of Germany suggests their important continuing role. Extension of their activities to social care and health would appear possible and desirable as an opportunity for improving the co-operative image. Given their dimensions, and the fact that previous neighbourhood services, utilities and infrastructure were integrated within them, it would seem an area with very considerable potential for setting up community-development co-operatives, user-owned community health clinics and various forms of social care co-operatives.

In the short time since transition began in many of these countries savings and credit co-operatives have shown considerable ability to secure members and to expand. It might be possible to use these as bases for introducing to their members and the communities in which they operate innovation in the organization of health and social care co-operatives and linkages with insurers.

Research and development, media, education and training and national level apex organizations within these new co-operative movements are still at early phases of development - if existing at all. However, to some extent these weaknesses are compensated by the substantial technical assistance received from co-operative movements in other parts of Europe and North America. This is very considerable already in support of co-operatives in these sectors, mentioned above, where some early consideration of greater emphasis on health and social care would appear not only possible, but important means to strengthen the new image of co-operatives.

Provider-owned health co-operatives may have earned for themselves a degree of public opprobrium additional to perceptions of co-operatives as components of former parastatal collective structures. However, given the very poor conditions of the health sector in many countries there is certainly a large potential for their appearance. Some interest has been shown, for example, in Latvia, in the Unimed model, which would certainly fill a very large need in some circumstances.

Social care co-operatives that are owned by a number of "interested parties" would appear to have good prospects in at least some of these countries - in this area at least the co-operative image is unsullied, given the valuable contributions of enterprises which retained considerable genuine

co-operative character, such as those in which significant proportions of persons with disabilities were members in countries such as Poland.

The establishment of user-owned health co-operatives is likely to depend upon purely local circumstances. In almost all cases in other countries this type of co-operative was initiated by groups of interested co-operators, trade unionists, members of farmers' organizations and health professionals. Their efforts succeeded to a significant extent because attempted in a community environment characterized by familiarity with co-operatives as an effective means for mutual assistance. More broadly, they occurred in conditions of strong civil society and advanced civic consciousness. All of these conditions have been severely constrained in the countries now in transition. Certainly the co-operative movement can be considered one of the most effective means whereby civil society can be restored and strengthened - but this is likely to involve a long-term process. Current international efforts to strengthen civic society might be persuaded to support user-owned co-operatives, because they respond to a clear need and if successful would serve as an example of the benefits of mutual assistance at the community level.

Of importance also would be strategic alliances between the new co-operative movements and other stakeholders - many of which, given the seriousness of the situation in respect to health and social care and the dimensions of unmet need - are likely to be interested in working for a co-operative solution.

The scope for all forms of worker-owned support co-operatives and co-operatively organized networks of health facilities is clearly very large given the unsatisfactory supply and operational circumstances in which hospitals, clinics and social facilities must operate, and the deterioration in the supply structures which, although intrinsic parts of the former state structures, have now largely disappeared.

Possibly the most successful approach would be to include within the current technical assistance programmes provided by the international co-operative movement (and supported by Governments and inter-governmental organizations) a component concerned with stimulating interest in contributions to health and social care. It might be argued that this might be an area which would benefit the co-operative image and hence would constitute a valuable support for other areas of co-operative development.

(c) Recent developments in consideration by the co-operative movement of further engagement in health and social care

As far as is known the apex organizations of the new co-operative movements in these countries have not yet considered in a comprehensive manner the possibilities of greater engagement in health and social care.

(d) Recent developments in the positions of governments and other stakeholders in respect to co-operatively organized engagement in health and social care

The position of Governments will be significant, given the relevance of the process of transfer from the public sector, and the strongly held perception that Governments are responsible for such areas as health and social care. The perception of co-operatives is more favourable now than it was earlier in the process of transition, when new Governments perceived co-operatives as unacceptable forms of organization because of the confusion of genuine co-operatives with parastatal collectives. Much effort has been made by the international co-operative movement and the new national co-operative movements themselves to rectify the situation, with some success. New legislation permits, in some cases, supports co-operative development. It might be necessary to introduce further adjustments in legislation in order to

permit co-operative engagement in the health and social care sectors, but this is now more of a tactical than strategic challenge.

Given the very special circumstances of these countries, and their diversity, there is clearly much scope for both policy-oriented and operational forms of research. This could be undertaken by co-operative institutions and those in universities, the public sector and in intergovernmental organizations as part of broader support for further development of the co-operative movement.

For many citizens the term co-operative retains a negative image, not only because of its use to identify the parastatal collectives of the period of central planning, but because of its association with entrepreneurial opportunism during the earlier period of transition. This broad perception is being changed gradually as a result of efforts by the international co-operative movement, and the clearly effective activities of new types of co-operative, such as credit unions. Moreover, some sections of the population have found that co-operative structures are preferable to full privatization, as the experience of production co-operatives in the area of the former German Democratic Republic has shown.

For many citizens, the notion that any institution other than those of the public or semi-public enterprise-based system could be a provider of health or social care is still an unfamiliar one. In particular, it would appear that reliance upon forms of mutual assistance which are made operational only through the commitment by users of their own resources, whether financial or labour or entrepreneurial, is still not a widely accepted approach. This is the case in respect to social care, especially as co-operatives in this area often rely to a substantial degree upon voluntary labour, and to health, where the advanced qualification of personnel and the need for specialized equipment appear to require the attention of much larger organizations than those which individual communities are able to establish.

At present, therefore, citizen perceptions may be more neutral than hostile, and given the need for effective health and social care services, it is probable that communities will be open to experimentation - given the fragility of available good will, however, it would be essential that experiments succeed, which suggests that they be carefully selected and planned.

As in many developing countries where public sector employment of health professionals has been reduced, it is likely that many will no longer find professional and financial security in public employment, and may be more willing therefore to establish their own co-operatives, or to be employed in user-owned co-operatives. While many would prefer to work in the for-profit private sector, it is likely in current conditions that only a small proportion of the population will be able to afford their services. The extent to which enterprises would favour new forms of enterprise responsibility, in particular those including a co-operative component similar to that existing has not yet been tested.

The financial and other support provided by existing co-operative enterprises is not available from national sources in most of these countries, although the scope of international technical assistance makes up in part for this. This is likely to be a major constraint upon engagement by the new co-operative movements in health and social care, suggesting that international help incorporate a component geared specifically to health and social care.

C. Possible international developments

1. Within the international co-operative movement

Recent progress made toward establishing a specialized body of ICA responsible for health co-operatives, both user-owned and provider-owned, as well as recent prominence given to this type of co-operative in a number of publications including the ICA's Review of International Co-operation and the Plunkett Foundation's "The World of Co-operative Enterprise 1996", is clear evidence of the growing attention being given to this sector of the international co-operative movement.

However, it appears that the close functional relationship between health and social care, recognized in the two international fora held in 1992 and 1995, has received less attention in the most recent developments, which have been concerned entirely with health. Moreover, the major significance of co-operative insurance enterprises in respect to health and other forms of social insurance, as well as the importance of the contributions of other co-operative sectors, notably agriculture, retail and housing, has not been reflected in any broad strategic approach by the international co-operative movement.

One of the themes of this global review has been that the entire co-operative movement is already engaged considerably in contributing to health and social well-being, and that its very large potential can be realized only by means of a comprehensive and coordinated strategy, within which health and social care co-operatives themselves will play an important but only partial role.

2. Within intergovernmental organizations

Intergovernmental organizations interested in the promotion and support of co-operatives, or the development of partnerships with the international co-operative movement, comprise an only partially coordinated system. While WHO and UNICEF have central responsibilities for health, they have little experience of co-operative forms of organization.

The United Nations Secretariat includes institutional structures for policy coordination, including that in respect to partnership with the international co-operative movement, but separate components of the Secretariat are responsible for such areas as housing and community development, and the consumer movement, while other specialized agencies are responsible for such relevant areas as agricultural co-operatives. The ILO has the broadest mandate for promoting and supporting co-operatives, and has recently begun a major programme concerned with health, social care and insurance which is the most coordinated approach to the topics covered in this global review yet undertaken by any part of the United Nations system.

There would appear to be an urgent need for coordination between the international co-operative movement, and the intergovernmental system: possibly this can be achieved most effectively through such existing machineries as the Committee for the Promotion and Advancement of Co-operatives (COPAC), which brings together the ICA, the International Federation of Agricultural Producers, the World Council of Credit Unions, ILO, FAO and the UN, as well as the International Union of Food, Agricultural, Hotel, Restaurant, Catering, Tobacco and Allied Workers' Associations (IUF).

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ANNEX I. COUNTRY PROFILES

These profiles are intended to provide basic information for each country where health and social care co-operatives are known to operate. The following countries are included:

Africa

- Benin
- Niger
- Senegal
- South Africa
- United Republic of Tanzania

Asia and the Pacific

- Australia
- India
- Japan
- Malaysia
- Mongolia
- Myanmar
- Philippines
- Republic of Korea
- Singapore
- Sri Lanka

Latin America

- Argentina
- Bolivia
- Brazil
- Chile
- Colombia
- Costa Rica
- El Salvador
- Haiti
- Panama
- Paraguay
- Peru

Western Asia

- Israel
- Lebanon

North America

- Canada
- United States of America

Europe

- Belgium
- Czech Republic
- Finland
- France
- Germany
- Italy
- Poland
- Portugal
- Romania
- Russian Federation
- Spain
- Sweden
- United Kingdom of Great Britain and Northern Ireland

At the time of writing a reference was known to health co-operatives in Mexico, but further information was not available. An unconfirmed address was: Dr. Armando Guerrero Villareal, President, Sociedad para la atencion medica de las organizaciones sociales, S.C., Leon Gto (?), Mexico.

Country profile: **Argentina**

A **provider-owned** health co-operative was recently set up in a regional centre, San Miguel de Tucuman. **Research** is being undertaken by the Gabinete de Estudio y Promoción del Cooperativismo Sanitario at Buenos Aires.

Contact:

Dr. Miguel Ang Melano, President,
Cooperativa de Residentes y Especialistas COOPRES
Santiago del Estero 998
4000 San Miguel de Tucuman
Tel: (54.81) 222.094/225.183; Fax: (54.81) 224.956

Federacion Argentina de Mutuales
de Salud (FAMSA)
Parana 426 70.H
1017 Buenos Aires
Tel: (54.1) 476-3465; Fax: (54.1) 374-7170

IDELCOOP
Gabinete de Estudio y Promocion del
Cooperativismo Sanitario
Av. Ravadavia 2358 50 B
Buenos Aires
Tel: (54.1) 954-3671; Fax: (54.1) 954-3672

Country profile: **Australia**

There are unconfirmed references to health co-operatives existing in New South Wales, but it was not possible to obtain further information.

Contact:

Mr. David Griffiths, Secretary
Co-operative Energy, Ltd., and
Director, Co-operative Federation of Victoria, Ltd.,
71 Franciscan Avenue, Frankston, Victoria 3199
Australia

Mr. Graham Monday, Chief Development Officer, or
Mr. Jayo Wickremarachchi, Development Officer,
Registry of Cooperatives,
New South Wales

Country profile: **Belgium**

A system of **primary user-owned pharmacy** co-operatives is well established, and has a national tertiary organization, Office des Pharmacies Cooperatives de Belgique (OPHACO). This organization has provided technical assistance for the purpose of promoting co-operative pharmacies in the Czech Republic.

Health insurance is provided by the **co-operative insurance** enterprise P&V Assurances s.c., owned by co-operative organizations, trade unions and mutual organizations. One part of the P&V group consists of the Multipharma co-operative pharmacy chain. P&V Assurances s.c. is a member of the Insurance Intelligence Group established by ICMIF to examine possibilities for further engagement by co-operative insurance enteprises in health and social care.

The Comite europeen des cooperatives de production et de travail associe (CECOP) is located in Brussels, and has a department responsible for the promotion and support of health co-operatives.

Contact:

Mr. William Janssens, Vice-President,
Office des Pharmacies Cooperatives de Belgique (OPHACO),
Route de Lennik 900, 1070 Brussels,
Tel.: (32-2) 529 92 41; Fax.: (32-2) 520 29 92

M. Jacques Forest, President,
P&V Assurances S.C.,
151 rue Royale, B-1030 Brussels
Tel.: 32 2 250 91 11; Fax.: 32 2 250 91 40

M. Didier Wafflard,
Contact person for ICMIF Insurance Intelligence Group,
P&V Assurance s.c., 151 rue Royale, B-1030 Brussels
Tel.: 32 2 250 91 11; Fax.: 32 2 250 91 40

Mme Jeanine Devuyst,
Contact person for ICMIF Insurance Intelligence Group,
Association of European Cooperative and Mutual Insurers (ACME),
Galilee Building, Avenue Galilée 5, Bte 19, B-1210, Brussels
Tel.: 32 2 250 94 99; Fax.: 32 2 250 96 00

Monica Menapace,
Comité européen des coopératives de production et de travail associé
(CECOP),
rue G. Tell, 59, B-1060 Brussels
Tel. (32/2) 537 57 40; Fax. (32/2) 537 09 17; E-mail CECOP@geo2.poptel.org.uk

Country profile: **Benin**

Since 1991 10 **primary level provider-owned** health co-operatives in the form of community health clinics have been set up with support from the Government, the World Bank, UNDP, WHO and the International Co-operative Alliance (Regional Office for West Africa). Providers comprise recently graduated health professionals (doctors, midwives and health assistants) formerly unemployed because of retrenchment in the public sector. The Sikecodji Co-operative Health Clinic in a suburb of Cotonou is the prototype of these co-operatives.

The International Labour Organization has included within a provisional list of social services that might be organized on a mutual basis, and which it might support in collaboration with the Belgian NGO Wereldsolidarieteit (World Solidarity: WSM), support to health co-operatives, in partnership with national organizations.

Contact: Dr. Edwige Adekambi,
Sikecodji Co-operative Health Clinic,
Cotonou, Benin

Mr. Ada Souleymane Kibora, Regional Director
International Co-operative Alliance,
Regional Office for West Africa,
Immeuble de la CAISTAB - 7th Floor
01 BP 3969 Abidjan 01, Cote d'Ivoire
Tel.: (225) 21 43 27
Fax: (225) 22 15 21
Email: aci@africom.com

Mr. Joseph Fazzio, Chief,
Co-operative Branch,
International Labour Organization,
4, route des Morillons,
CH-1211 Geneva 22 Switzerland,
Tel.: (41 22) 799 61 11
Fax.: (41 22) 799 85 72

Country profile: **Bolivia**

In the mid-1980s it was reported that there were eight **health** co-operatives, presumed to be **user-owned**, in operation. In the late 1970s it had been reported that there were a number of **primary level provider-owned health** co-operatives in operation. More recent information is not available.

The International Labour Organization has included support to primary health co-operatives, in partnership with national trade union organizations, within a provisional list of social services that might be organized on a mutual basis, which it might support in collaboration with the Belgian NGO Wereldsolidarieteit (World Solidarity: WSM).

Contact: At present no national apex co-operative organization is a member of the International Cooperative Alliance. Responses to requests by the Secretary-General of the United Nations for information on co-operatives, transmitted to the Government of Bolivia, have been prepared by the Universidad Catolica Boliviana, in which there appears to be a co-operative research programme. Information dated August 1991 is as follows:

Dr. Luis F. Ocampo, Director,
Instituto de Capacitación y Asesoramiento INCA - DEC,
Casilla 4805, La Paz, Bolivia

For the ILO programme the current contact is:

Mr. Joseph Fazzio, Chief,
Co-operative Branch,
International Labour Organization,
4, route des Morillons,
CH-1211 Geneva 22 Switzerland,
Tel.: (41 22) 799 61 11
Fax.: (41 22) 799 85 72

Country file: **Brazil**

Since 1993 a number of **user-owned health** co-operatives (Usimed) have begun to operate. They have been promoted by the national tertiary organization of **provider-owned health** co-operatives, Unimed do Brasil (Confederaçao Nacional das Cooperativas Medicas - National Confederation of Health-care Co-operatives). This has developed rapidly since its foundation in 1967 in Santos, and is now located in almost all States of the country, with 304 primary health co-operatives whose members totalled 73,000 doctors, over 30 per cent of the national total. About 8,000,000 individuals were preferred users, the majority through health insurance contracts provided by their employers. All these "enrollees" were able to obtain services from any member primary co-operative, and also from doctors in Argentina, Paraguay and Uruguay through special agreements made with provider organizations there.

The first primary health co-operative to set up its own hospital was that in Brasilia, in 1983: in mid-1995 there were 19 such co-operative hospitals, with 14 others under construction. The system also operated 14 X-ray laboratories, 22 clinical analysis laboratories, three diagnostic centres and 66 mobile first aid units, as well as road, helicopter and river ambulances capable of reaching most parts of the country.

In order to serve the needs of the system, Unimed has established a number of specialist subsidiary enterprises, all forming part of the Unimed Multicooperative Business Complex. They include Unimed Participaçoes, a holding company which oversees the operations of Unimed Aseguradora, an insurance subsidiary; Unicred, a savings and credit system with additional banking functions which undertakes financial services for the entire system; Unimed Systems, which develops, supplies and manages data and other management operations for the system; Unired, a satellite data communication network; and Unimed Produtos e Serviçios Hospitalarios, which provides technical and management advisory services and logistic support, including bulk purchasing and production of generic drugs, for the system. In addition a Unimed Study Centre Foundation provides management and business training and carries out scientific and technical research.

Contact: Dr. Edmundo Castilho, President,
Unimed do Brasil (Confederaçao Nacional das Cooperativas Medicas)
Alameda Santos, 1827 - 15 andar - CEP 01419 002 (909)
Sao Paulo, Brazil
Tel.: 55 11 245 9700; Fax.: 55 11 245 9990
Tel.: 55 11 253 6633; Fax.: 55 11 253 6656

Country profile: **Canada**

In 1995 there were 37 **user-owned health** co-operatives of the community health clinic type, operating in all Provinces except New Brunswick and Newfoundland. In Saskatchewan a Community Health Co-operative Federation operates as a tertiary organization at provincial level. The two national apex co-operative organizations have been active in arguing for inclusion of a role for health co-operatives in national and provincial health and social security systems. There are no known **provider-owned** or **joint-owned health** co-operatives. A secondary **health service support co-operative** provides bulk purchasing services to health facilities in Quebec. Five worker-owned ambulance service co-operatives operate in Quebec. **Research** on health co-operatives is being carried out at the University of Quebec at Montreal, and had been supported previously by the national co-operative apex organizations. There is no national tertiary organization of health co-operatives.

Most co-operative health clinics provide social care for the elderly, and some for other disadvantaged sections of their communities. **User-owned social care** co-operatives are well developed, particularly child-care and nursery co-operatives, and home service co-operatives for the elderly. A national tertiary organization was set up in Toronto in May 1993: the Association of Canadian Childcare Cooperatives. Other co-operative sectors contributing to social care include the housing co-operative movement. Funeral co-operatives are well developed, particularly in Quebec and the Atlantic Provinces.

Health insurance is provided to members by a number of **co-operative insurance** enterprises, two of which are owned by the savings and credit co-operative movement. The CUMIS Group Ltd. serves primarily members from the Anglophone community; the Desjardins-Laurentian Life Grouping Inc. (Group Vie Desjardins-Laurentienne inc.) serves memebrs of the Mouvement des caisses Desjardins, primarily from the Francophone community. The Co-operators Group Ltd., also provides health insurance. It originated in a grouping of agricultural producers' co-operatives and savings and credit co-operatives.

Contact:

Community Health Services Association (Regina) Ltd.,
3765 Sherwood Drive, Regina, Saskatchewan S4R 4A9
Tel.: 543 7880

Community Health Services (Saskatoon) Association Ltd.,
455 Second Avenue North, Saskatoon, Saskatchewan S7K 2C2
Tel.: 1-306-664-4243; Fax: 1-306-664-4120

Tignish Co-operative Health Centre,
PO Box 129, Tignish, Prince Edward Island, Canada
Tel: (902) 882-2020; Fax: (902) 882-3595

New Ross Health Co-operative,
New Ross, Nova Scotia, Canada

Professors Yvan Comeau and Jean-Pierre Girard,
Chaire de coopération Guy-Bernier,
University of Quebec at Montreal,
Case postale 8888, succursale Centre-Ville,
Montreal, Quebec H3C 3P8, Canada
Tel.: (514) 987 3550; Fax.: (514) 987 8564

Mr. Ed Klassen, President,

Canadian Co-operative Association,
Suite 400, 275 Bank Street, Ottawa, Ontario K2P 2L6,
Tel.: (1-613) 238 67 11; Fax.: (1-613) 567 06 58;
E-mail: ccaott@web.apc.org

Mr. Majella St.Pierre, President,
Conseil Canadien de la Cooperation,
450 rue Rideau, Suite 201, Ottawa, Ontario, K1N 5Z4,
Tel.: (1-613) 789 54 92; Fax.: (1-613) 789 07 43

Mr. Murray Fulton, Director,
Centre for the Study of Co-operatives,
University of Saskatchewan,
Diefenbaker Centre, Saskatoon, Sask. S7N 5B8,
Tel: (1.306) 966-8509
Fax: (1.306) 966-8517

Mr. Maurice E. Therrien
Executive Director; Secretariat aux Coopératives
930, avenue Carling, piece 467
Ottawa, Ontario K1A 0C5
Tel: (1.613) 759 7195; Fax: (1.613) 759 7489

M. Gilles Jumeau, General Secretary,
Desjardins-Laurentian Life Group Inc.,
200, Avenue des Commandeurs, Levis, Quebec, G6V 6R2,
Tel.: 1 418 838 7870; Fax.: 1 418 833 5985

Mr. James M. Barr, Senior Vice President, Corporate Relations,
The Cumis Group Ltd.,
PO Box 5065, 151 North Service Road, Burlington,
Ontario L7R 4C2
Tel.: 1 905 632 1221; Fax.: 1 905 632 9412

Mr. Terry Squire, President and Chief Executive Officer,
The Co-operators Group Ltd.,
Priory Square, Guelph, Ontario N1H 6P8,
Tel.: 1 519 824 4400; Fax.: 1 519 824 0599

Country profile: **Chile**

There are no known **user-owned health** co-operatives. The **provider-owned health** co-operative, Cooperativa de Servicios de Proteccion Medica Particular Ltda. (Promepart), provides services to users who are for the most part enrollees in enterprise-based health insurance plans. As an "Institucion de Salud Previsonal (ISAPRE)", the co-operative also serves other individuals and households who choose to withdraw from the national health insurance scheme and make their own arrangements for health insurance and care. PROMEPART/ISAPRE has become one of the largest health providers in the Santiago Metropolitan Region.

Contact: Sr. Hector Rubio Arenas, President,
Confederaçion General de Cooperativas de Chile (CONFECOOP),
Bulnes No. 107, Depto. 21,
Santiago, Chile
Tel.: 6951856

Country profile: **Colombia**

There are no known **user-owned** health co-operatives. The **provider-owned** health co-operative - Cooperativa Medica del Valle y de Profesionales de Colombia (COOMEVA) - originated in 1964 as a user-owned multi-functional insurance and related services co-operative established by doctors in the provincial city of Cali. It progressively extended its services, including a prepaid health insurance plan in 1973, complemented by a dental service in 1986. This later developed as an autonomous component of the co-operative: "Prepagada Coomeva". By 1995 branches had been established in most parts of Colombia, and membership had been extended from health professionals to all persons in technical and professional occupations. In 1995 COOMEVA established a subsidiary, COOMEVA EPS (Entidad Promotora de Salud), S.A., which began to operate as a provider of health insurance to persons enrolled in the newly introduced national system of health insurance, while PREPAGADA COOMEVA continued to provide private health insurance to higher income households. The co-operative continues as a user-owned multiple insurance (including health insurance) co-operative for middle-income households.

Over one hundred co-operatives, trade unions, mutual societies and parents' associations have established a secondary **funeral co-operative** "Coopserfun" in the Bogota region.

Health insurance is provided by the **co-operative insurance** enterprise Seguros la Equidad Organismo Cooperativo, owned by almost 1,500 primary and secondary co-operative organizations. In 1995 this enterprise initiated a strategic alliance with the provider-owned health co-operative to establish a combined insurance and service co-operative "Coopsalud".

Contact:

Dr. Victor H. Pinzon, General Manager,
COOMEVA,
Avenida 6A Norte, No.22-45, Cali, Colombia
Tel.: (92) 667 2000 or (92) 667 2001
Fax.: 667 5357

Mr. Luis Arturo Munoz Carraso, Chief Executive,
Asociacion Colombiana de Cooperativas (ASCOOP)
Transversal 29 - 35-A-29
11575 Santa Fé de Bogota D.C.
Tel.: (57-1) 268 04 50/ 268 34 92;
Fax.: (57-1) 268 42 30;
Email: sascoop@itecs5.telecomco.net

Dr. Armando Tovar Parada, President or Dr. Javier Montes Mejia,
Confederación de Cooperativas de Colombia (CONFECOOP),
Avenida 19, No.6-68 Piso 16,
Apdo. Aereo 036299,
Santa Fé de Bogota D.C.
Tel.: (57-1) 341 06 86/ 284 34 92
Fax.: (57-1) 341 84 67

Mr. Julio Enrique Medrano Leon, President,
Seguros la Equidad Organismo Cooperativo,
Calle 19, No.6-68 Pisos 10,11 y 12,
Apdo Aereo 30261, Bogotá
Tel.: 57 1 284 1900; Fax.: 57 1 286 5124

Country profile: **Costa Rica**

There are no known **user-owned** health co-operatives. Three **provider-owned** health co-operatives of the clinic type have been established since 1988 (Coopesalud, 1988; Coopesain, 1989; Medicoop, 1992), and a fourth, owned jointly by providers and a number of local community associations (Coopesana) was established in 1993. They have taken over certain of the functions of public sector programmes.

Contact: Professors P.E.Pezza and J.F.B.Bolanos,
University of Rhode Island,
Providence, Rhode Island, U.S.A.

Professors Yvan Comeau and Jean-Pierre Girard,
Chaire de coopération Guy-Bernier,
University of Quebec at Montreal,
Case postale 8888, succursale Centre-Ville,
Montreal, Quebec H3C 3P8, Canada
Tel.: (514) 987 3550; Fax.: (514) 987 8564

Country profile: **Czech Republic**

With the assistance of Office des Pharmacies Cooperatives de Belgique (OPHACO) (see Country profile: Belgium) 10 co-operative pharmacies had been set up by January 1996, and establishment of two more was in preparation.

Contacts: Dr. Ivan Fidler,
Cooperative Association of the Czech Republic,
Tesnov 5, 11001 Prague 1, Czech Republic
Tel: (42-2) 248 104 34/ 248 051 61
Fax: (42-2) 248 107 49

Country profile: **Denmark**

Health insurance is provided by the **co-operative insurance** enterprise AP Pension, owned by the co-operative movement and serving salaried workers employed in co-operative enterprises.

Contact: Mr. Holger Dock, Managing Director,
AP Pension,
Osterbrogade 125, DK-2100 Copenhagen,
Tel.: 45 31 20 58 88; Fax.: 45 31 20 30 00

Country profile: **Ecuador**

Health insurance is provided by Coopseguros del Ecuador Ltda., a **co-operative insurance** enterprise owned by the savings and credit co-operative movement.

Contact: Mr. Sixto Davalos C., General Manager,
Coopseguros del Ecuador, Ltda.,
Edificio Skorpios 5 y 6 pisos,
Alemania y Amazonia 2817 (Esquina),
Casilla 84-B, Quito
Tel.: 593 2 456 080; Fax.: 593 2 448 242

A **social care** co-operative provides a supportive environment for the employment of persons with disabilities, and for provision to them of a wide range of services. The co-operative has taken the lead in lobbying for improvement of the condition of all persons with disabilities in the country.

Contact: No information is available. The co-operative operates under the name ACOGIPRI (Associación cooperativa - grupo independiente para rehabilitación integral).

Country profile: **Finland**

There are no health co-operatives at present, but it is thought that it is only a question of time before they are formed, in view of the impact upon social services and the welfare state of the severe economic conditions. There are six co-operative creches and one cooperative residence for elderly persons

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Contact: Ms. Raija Itkonen,
Finnish Consumer Cooperative Association (FCCA)
c/o SOK Corporation
Fleminginkatu 34, P.O. Box 171, 00511 Helsinki
Tel: (358-0) 188 2227; Fax: (358-0) 188 2228

Mr. Harri Porvali, Managing Director,
Finnish Co-operative Development Centre,
Annakatu 29 A 17,
00100 Helsinki, Finland
Fax: (358-0) 694 6860

Parents of children with severe mental disabilities have established **social care** co-operatives to provide support and services. A national apex organization, Syndicat National des Associations des Parents d'Enfants Inadaptés, has been established.

Mutual assistance organizations complement by means of formal agreements the national social security system, providing health **insurance** and deliver some health and social care services. They combine at the national level in the Fédération Nationale de la Mutualité Française. Although not co-operatives, they share many of the characteristics of health service and insurance co-operatives, and provide a model of how mutual assistance associations of various types can operate in partnership with the public sector at a significant level.

Contact: M. Henri Poizat, Director of International Affairs,
Federation Nationale de la Mutualité Française,
255, rue de Vaurigard, 75719 Paris Cedex 15,
Tel.: 33 1 40 43 32 20; Fax.: 33 1 40 43 35 13

Country profile: **Germany**

In Germany there were in 1994 three **provider-owned** health co-operatives. In 1970 there had been seven. There were two pharmacy co-operatives.

Health insurance is provided by a subsidiary (R+V Krankenversicherung AG) of the **co-operative insurance** enterprise R+V Insurance Group, which developed primarily from the Raiffeisen co-operative movement. It serves members of the savings and credit, bank and agricultural purchasing and marketing co-operative systems, of one or more of which a high proportion of the rural population are members.

Contact: Mr. Hans Dusterwald, Executive Manager,
R+V Versicherung,
Taunusstrasse 1, D-65193, Wiesbaden,
Tel.: 49 611 533 9418; Fax.: 49 611 533 4500.

Country profile: **Haiti**

The International Labour Organization, as part of its programme of support for co-operative development, has promoted the organization by co-operatives of community pharmacies.

Contact: Mr. Joseph Fazzio, Chief,
Co-operative Branch,
International Labour Organization
4, route des Morillons
CH-1211 Geneva 22 Switzerland
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Country profile: **India**

In India a **user-owned** health co-operative movement existed in the 1920s and 1930s, but apparently there was little or no continuity with the contemporary movement. **User-owned** health co-operatives, most of which take the form of co-operatively organized hospitals or clinics, began operation in the early 1960s. They are located primarily in the western and southern States of Maharashtra (where there are 15), Goa, Karnataka and Kerala (where there are 87). Among the best known outside India are the Shushrusha Citizen's Hospital in Bombay and the Indira Gandhi Co-operative Hospital in Cochin, Kerala. While some employ staff doctors, most physician's services are provided by doctors employed primarily in local public hospitals. In Kerala they are strongly supported by the State Government. Spokesmen for the health co-operative movement argue for their significant role in the health sector throughout the country, which remains very strongly based upon public services for the great majority, with a growing private for-profit sector for the urban middle and higher income populations. Individual doctors were largely responsible for promotion of the user-owned health co-operatives. There are neither State nor Union (national) level apex organizations of health co-operatives.

A particularly innovative development has been that of "Awareness (Jagruti) Community Health Programme" which has been set up by the Self Employed Women's Association (SEWA) for the use of its members. The only known **provider-owned** health co-operative is that formed by the community health workers - who are specially trained poor self employed women themselves - who operate within SEWA's programme.

Some of the larger co-operatives in the agricultural sector, notably the sugar producers' co-operatives in the State of Maharashtra, provide health and social care benefits to their members in their own facilities.

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Country profile: **Israel**

In Israel probably the most comprehensive co-operative health system to have existed in any country orginated in 1926 and expanded until by the early 1950s, and thereafter until 1995, when it was fully nationalized, it provided comprehensive health insurance and service coverage to more than 70 per cent of the population. This was provided as a benefit of membership in the national trade union organization, Histadrut, which operated as both trade union and co-operative apex organization, and which included 85 per cent of wage earners and all members of cooperatives.

All members of Histadrut were simultaneously members of and shareholders in a parallel system of co-operative business enterprises, Hevrat Ha'Ovdim, of which one of a number of specialist subsidiary organizations, Kupat Holim, was responsible for provision of health insurance and services to all members of Histadrut.

At its peak, this co-operative health system employed about 30,000 persons, including over 8,000 doctors. It owned and operated more than 1,300 family clinics, which also provided pedicatric care; more than 800 specialized clinics; and 14 major hospitals, including two geriatric hospitals and one psychiatric hospital.

All members of Histadrut were also members of one of seven Pension Funds. These owned holiday resorts operated by Kupat Holim.

In 1995, after a period of intense debate, and with opposition by most of those associated with trade union and co-operatives, the co-operative health system was fully nationalized.

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Kupat Holim
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Country profile: **Italy**

There are about 2,000 health and social care co-operatives, termed "social co-operatives". Although including in their membership some users, almost all are **primary level producer-owned health** or **social care** co-operatives. They employ about 40,000 persons, most of whom are professional personnel and members. Most are associated with one or other of the two major national apex organizations, Lega Cooperative and Confcooperative. The majority have been established since the late 1970s.

Possibly only 13 to 15 per cent were health co-operatiives: the remainder were providers of a wide variety of social care, principally to young persons, persons with disabilities and elderly persons. Members were predominantly providers, both professionals and para-professionals, including both salaried staff and volunteers. In some co-operatives users, notably persons with disabilities employed in "sheltered workshops", were also members, as were persons and institutions providing finance, including local government authorities, with whom there was close collaboration. In 1993 about 13 per cent of public spending on social welfare was allocated to the financing of these co-operatives. Although found in all regions, there was some degree of concentration in Emilia-Romagna and in Toscana.

A national apex organization exists: Consorzio Nazionale della Cooperazione di Solidarietà "Gino Mattarelli". This institution maintains a **research** centre (Centro Studi). **Research** is also being undertaken in the Department of Economics of the University of Trento.

The co-operative **insurance** enterprise, Unipol Assicurazioni, has recently established a health insurance enterprise, Unisalute, which is developing health and social security programmes for members of co-operatives and trade unions as well as health plans for the work-forces of enterprises as a means to supplement public programmes.

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Country profile: **Japan**

Two separate systems of **user-owned** health co-operatives exist. One evolved as part of the consumer co-operative movement and has a primarily urban focus. It consists of "medical co-operatives" which are autonomous community-based co-operatives with their own clinics and hospitals. Its national apex organization is the Medical Co-operative Committee of the Japanese Consumers' Co-operative Union. This organization has been active in the public discussion of national health policy.

A second system evolved within the agricultural co-operative movement and consequently has a rural focus. It consists of medical co-operatives with their own clinics and hospitals which have developed as part of the "welfare federations" set up as secondary level specialized service organizations at the regional (prefectural) level by the multi-function agricultural co-operatives within each region. Its national apex organization is the National Welfare Federation of Agricultural Co-operatives.

Both systems stress preventive health and healthy living. They have extended services from the medical to social medicine and social care, particularly for the elderly, given the demographic aging of the Japanese population. There are no known **provider-owned** health co-operatives, and no autonomous **social care** co-operatives. **Research** is being undertaken by the School of Social Sciences of Ritsumeikan University. Health insurance is provided by a specialized **co-operative insurance** division of the Japanese Consumers' Co-operative Union.

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Country profile: **Lebanon**

No **health** co-operatives are known to exist. A **social care** co-operative system has been set up consisting of **residential** and **sheltered workshop** co-operatives for persons with disabilities.

Contact: No information is available.

Country profile: **Malaysia**

A **secondary provider-owned health** co-operative network, KDM, has operated since 1988. More recently it has collaborated with the consumer co-operative movement, co-operative banks and the Malaysia Co-operative **Insurance** Society in a **jointly-owned** national co-operative system, KOHISAT, which has strong governmental backing.

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Tel.: (60-3) 755 25 77; FAX.: (60-3) 757 59 64

Country profile: **Mongolia**

A single **provider-owned** health co-operative, the Enerel Dental Clinic in Ulan Bator, is a worker-owned dental service provider primary co-operative. Its members are dentists who have studied in Japan. In September 1995 it was reported by the Medical Co-op Committee of the Japanese Consumers' Co-operative Society (JCCU) that the co-operative still faced organizational obstacles.

Contact: No information available, but contact should be possible through the Medical Co-op Committee of the JCCU (see country profile for Japan).

Mr. Barsbold, Chairman,
Central Union of Mongolian Consumers Co-operatives,
120, Sukhbaatar District, Ulanbaatar, Mongolia
Tel.: (976-1) 329 025; FAX.: (976-1) 329 025

Country profile: **Myanmar**

It has been reported by the Japanese Consumers' Co-operative Union that health co-operatives exist, but no information is available. A **social care** co-operative established by retired nurses provides child-care services in Yangon.

Contact: Mr. Myo Myint, Chairman,
Central Co-operative Society,
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Tel.: (95-1) 828 18; FAX.: (95-1) 830 63

Country profile: **Niger**

The International Labour Organization, as part of its programme of support for food security, is encouraging the establishment of ten village pharmacies managed by local co-operatives.

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Country profile: **Panama**

A single **user-owned** health co-operative is known to operate: the COOPASI Health Co-operative at Veraguas. The co-operative did not, in 1992, have its own facilities or professional staff: members have access to facilities in a private hospital as well as services from a panel of doctors. There are no **provider-owned** health co-operatives, but doctors were major initiators of the COPASI co-operative and make up a significant proportion of its members.

Contact: Dr. Adolfo Name, Chairman of the Administrative Council,
COOPASI,
Veraguas, Panama

Country profile: **Paraguay**

It is believed that a **secondary provider-owned health** co-operative **network**, modelled on Unimed do Brasil, has been established recently.

Contact: No information available.
Unimed do Brasil (see country profile for Brazil).

Country profile: **Peru**

Health insurance is provided by Segurosperu, a **co-operative insurance** enterprise owned by a large number of primary co-operatives operating in numerous economic sectors.

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Tel.: 51 14 24810; Fax.: 51 14 331473

Country profile: **Philippines**

In 1992 the national co-operative apex organization, NATCCO, began to promote the establishment of **user-owned** health co-operatives, the first being in the Quezon area. In Mindanao a **provider-owned** health co-operative movement recently began operations. Recently also **user-owned social care** co-operatives have been established, in the form of daycare co-operatives.

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Ms. Aida Manasan,
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Country profile: **Poland**

A user-owned health co-operative system, based on the Yugoslav model, existed during the 1930s. A small number of **provider-owned health** co-operatives continue to operate. A well developed secondary level network of **social care** co-operatives exists in the form of "social employment" sheltered workshops.

Contract:

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Three **provider-owned** health co-operatives operate in the two largest urban areas, Lisbon and Porto. An educational co-operative has established two Higher Institues of Health Sciences, which provide **professional training** at post-graduate, graduate and continuing education levels. An extensive system of **social care** co-operatives providing education, training and protected work-places to persons with disabilities has been set up throughout the country.

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Tel.: 02 317082

Dr. José da Rosa Repolho, President,
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Country profile: **Republic of Korea**

It is reported by the Japanese Consumers' Co-operative Union that health co-operatives exist, but no information is available.

Health insurance is provided to members by the specialized **co-operative insurance** departments of both the National Agricultural Co-operative Federation and the National Federation of Fisheries Co-operatives, whose membership includes a significant proportion of the rural population.

Contract: No information available on health co-operatives. The Japanese Consumers' Co-operative Union (see country profile for Japan) may be able to provide information.

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Mr. Lee Dong Kwon, Director, Co-operative Insurance Department,
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Country profile: **Romania**

A considerable number of **social care** co-operatives provide sheltered workplaces and health and social insurance and other services to members who are persons with disabilities.

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Health services are provided to members and employees of the consumer co-operative movement. In addition to local polyclinics, a hospital, a rest home and four sanatoria are operated.

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Country profile: **Senegal**

In the late 1970s **user-owned** health co-operatives were set up as autonomous primary enterprises sponsored by trade unions and located in the larger enterprises. By 1980 there were 40 such co-operatives, all in the Dakar region. No information is available on subsequent development.

Contact: No information is available.

Country profile: **Singapore**

User-owned health co-operatives have been set up by the National Trade Union Council (NTUC) for the benefit of all members of its constituent trade unions and their dependants. They include the NTUC Co-op Dental Care Society, Ltd., and the NTUC Health Care Co-op, which operates a chain of **co-operative pharmacies** within the NTUC sponsored consumer-owned co-operative supermarket chain "Fairprice". No **provider-owned** health co-operatives are known to exist. NTUC Income, a **co-operative insurance** enterprise established under the auspices of the National Trade Union Council, provides health and other insurance at affordable rates to trade union members.

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Country profile: **South Africa**

It is known that at least one user-owned health co-operative operates in collaboration with the National Consumer Co-operative Union in Marshalltown, and that another (possibly several) health co-operative, also probably user-owned, operates in East London.

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South Africa

Country Profile: **Spain**

The only known **jointly-owned** health co-operative is the co-operative hospital, SCIAS, in Barcelona, sponsored by the regional provider-owned health co-operative, but with members including providers and users, most of whom already having privileged access contracts with the provider-owned health co-operative system.

A distinctive type of **secondary provider-owned health** co-operative network exists. It is derived from pre-co-operative arrangements of a provider-managed/user prepayment type, termed "igualatorios". The health co-operative system is particularly well developed in Catalonia, where the **provider-owned health** co-operative "Autogestio Sanitaria" operates throughout the Autonomous Region. Health professional members interested in family-oriented practice subsequently set up a separate provider-owned co-operative. These providers joined with users to establish the **jointly-owned health** co-operative hospital SCIAS. Within Catalonia, in order to support these separate enterprises, a further secondary co-operative, "ELAIA", has been formed.

A national network of provincial organizations of secondary provider-owned co-operatives exists, "LAVINIA". **Research** is undertaken by the "Fundacion Espriu" in Barcelona, and was previously undertaken by the Gabinete de Estudios y Promocion del Cooperativismo Sanitario.

In Madrid, in close association with the workers' co-operative movement, a distinctive **provider-owned** health co-operative network has developed from an original co-operative formed by the take-over of their work-place by dental professionals. This is CES Clinicas S. Coop.Ltda.

The Mondragon Co-operative Group in the Basque Autonomous Region has a separate subsidiary, Lagun-Aro, which administers health and social security programmes for all individual members of the co-operative enterprises which make up the Group.

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Country profile: **Sri Lanka**

User-owned health co-operatives have developed within the context of a substantial co-operative movement: the first began operations in 1932. Most are hospital or clinic co-operatives, of which the best known outside Sri Lanka are Gampaha Co-operative Hospital Ltd., and Galle District Hospital Co-operative Society Ltd. In 1995 there were 10 such co-operatives in operation.

A number of multi-purpose co-operatives provide health services in small hospitals to which their members have access. There are no known **provider-owned** health co-operatives.

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Country profile: **Sweden**

With retrenchment in the welfare state there has been much interest in the transfer of some of the programmes and facilities hitherto the responsibility of local governments to either **user-owned** or **provider-owned** health and/or social care co-operatives. Such transfers have already been effected in a small number of communities. The national apex organization representing housing co-operatives, HSB: Riksforbund, and the national level insurance co-operative, Folksam, together with the Co-operative Research Institute (KOOPI), developed during the early 1990s a model of consumer-owned co-operative health centres, termed "Medicoop". **Research** is being conducted by the Swedish Cooperative Research Institute (KOOPI), the Department of Business Administration at Stockholm University, and the Agency for Co-operative Development at Goteborg (Kooperativ Konsult).

Both **user-owned** and **provider-owned social care** co-operatives are well developed, totalling about 1,600 in 1995. They included **home care** and **residential service** co-operatives for **persons with disabilities** and **elderly persons**; **child-care** and **nursery** co-operatives. Housing and insurance co-operative movements have strongly supported provision of social care to members, including establishment of separate social care co-operatives. Close collaboration has developed with local government authorities, who are transferring programmes and institutions to both user-owned and provider-owned co-operatives. Health and social care co-operatives **jointly-owned** by providers, users, insurers and local governments are appearing under the name "interested parties co-operatives".

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No **user-owned** health co-operatives are known to exist. **Provider-owned** health co-operatives have begun to appear in some areas. These and both **user-owned** and **provider-owned social care** co-operatives have been supported by the Industrial Common Ownership Movement Ltd. (ICOM), as members of the workers' co-operative movement. Many are termed "**community care**" co-operatives, providing **home-care** and **residential services** to the elderly and to persons with disabilities. **Child-care** co-operatives are increasing in numbers. There are a number of "**sheltered workshop**" or "**special needs**" or "**social employment**" co-operatives for persons with disabilities.

Research has been undertaken at the Co-ops Research Unit at the Open University and at the Centre for Research in Social Policy in the Department of Social Sciences at Loughborough University.

Fourteen consumer-owned retail co-operative societies operate a considerable number of outlets, some in conjunction with optical services. A secondary **pharmacy** co-operative has been formed by 25 consumer-owned primary retail co-operative pharmacies, and has 230 outlets.

The **co-operative insurance** enterprise, Co-operative Insurance Society Ltd., provides health insurance.

The consumer co-operative movement has played a leading role in the retailing of nutritionally correct foods and household safety. A significant proportion of funerals are undertaken by the 25 consumer-owned co-operatives.

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Country profile: **United Republic of Tanzania**

The International Labour Organization, as part of its programme of support for small industrial co-operatives, is promoting health protection for informal sector workers through five co-operatives and associations formed by them.

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User-owned health co-operatives operate in some major urban centres in the North-east, Mid-West and North-west of the country. The largest concentration of the 13 in operation, which includes some co-operatives serving both rural and urban populations, is in the Mid-West, within an area of substantial co-operative enterprise activity. The largest single co-operatives are the Group Health Association of Metropolitan Washington D.C., the Group Health Co-operative of Puget Sound, based in Seattle, Health Partners in Minnesota, and the Health Insurance Plan of Greater New York. They have become recognized as centre of innovative and high quality health care with a strong preventive emphasis. These co-operatives have about one million user-households, including both full members and those enrolled in employment-based health insurance contracts. Most have diverse and innovative social medicine and social care programmes which extend the scope of preventive and rehabilitative care.

A particularly innovative form of user-owned health co-operative, concerned primarily with older users, is the United Seniors Health Co-operative of Washington D.C., which specializes in assisting members by means of computerized data bases to identify and apply for health and social care benefits within public and private programmes for which they are entitled but otherwise unable to access because of insufficient information.

Health co-operatives, together with non-co-operatively organized "health maintenance organizations" to form a national representative organization, the American Association of Health Plans.

Private for-profit business enterprises, in some regions in conjunction with public sector institutions, have themselves set up **group health care purchasing co-operatives** as a means to increase their negotiating power in respect to employee health insurance coverage in the health insurance market. They operated on behalf of about 10 million employees. Three States were experimenting with sponsored health insurance co-operatives for small employers. Innovative forms of health insurance purchasing and management co-operatives, bringing together users, providers and insurers, and using advanced data processing facilities, have begun to appear.

Co-operative enterprises provide health insurance plans for members and employees: some have during certain periods promoted the establishment of user-owned health co-operatives by members and others in the communities in which they operate: this has been the case with the National Rural Electric Co-operative Association.

In rural regions and in inner cities over 800 community-based and partly community-controlled health centres which are funded by Federal and State Governments serve 4.2 million persons, mainly in low-income households, including rural migrant workers. Although not themselves co-operatives they can be considered semi- or proto-co-operative institutions.

While there is no national apex organization of health co-operatives the general co-operative apex organization - the National Co-operative Business Association - and the National Co-operative Bank support health co-operative development, partly by means of representations with the legislature and Federal and State Governments.

Although in the 1980s it was reported that there were many small **primary level provider-owned health** co-operatives, they had not at that time established any formal tertiary organization and no recent information is

available. There are a number of **dental service** co-operatives. The only known **jointly-owned** co-operative enterprise is a recently established health insurance purchasing and management network, "Justcare", whose members include users, providers and insurers.

Independent pharmacies have established **secondary co-operative pharmacy networks** serving several thousand members.

Research has been undertaken at the University of North Carolina, and operational and programme development research is undertaken by the larger user-owned health co-operatives themselves.

Up to the early 1960s a number of trade unions, within the health benefits made available to members, established health centres with a semi-co-operative organization.

Co-operative insurance enterprises owned by, or closely affiliated with, co-operatives provide insurance to about 50,000,000 persons. Health insurance is provided by Amalgamated Life Insurance Company, a co-operative enterprise owned by industry/union "jointly trusted funds" set up originally by immigrant clothing industry workers. In Puerto Rico health insurance is provided by the Cooperativa de Seguros de Vida de Puerto Rico (COSVI), and enterprise owned by the savings and credit co-operative movement.

There are a number of secondary co-operative networks providing bulk purchasing and common services to hospitals and clinics: they are termed "shared service organizations".

An increasing number of **provider-owned social care** co-operatives, including **child-care** and **home-care** co-operatives were being set up. Housing co-operatives for elderly persons are significant, and in other housing co-operatives comprehensive health and social care programmes for the elderly are in operation.

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ANNEX II. USEFUL ADDRESSES

This includes only addresses of international institutions and associated persons. Those for national institutions are provided in each of the Country Profiles.

International Co-operative Organizations

Mr. Bruce Thordarson, Director-General, Mr. Arsenio Invernizzi, Senior Project Analyst and Coordinator of the International Co-operative Health and Social Care Forum, and Ms. MariaElena Chavez-P, United Nations and Development Liaison Officer, **International Co-operative Alliance (ICA)**, 15, route des Morillons, 1218 Grand-Saconnex, Geneva, Switzerland. Tel.: (4122) 929.88.88, Fax.: (4122) 798 41 22, E-mail, icageneva@gn.apc.org

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Mr. Hans Dahlberg, Chief Executive, **International Co-operative and Mutual Insurance Federation (ICMIF)**, P.O. Box 21, Altrincham, Chesire WA14 4PD, United Kingdom; Tel.: (44-161) 929 50 90; Fax: (44-161) 929 51 63; E-Mail: shaun@orchid.income.com.sg.

Mr. Luis A. Perdomo, President, **Confederación Latinoamericana de Cooperativas y Mutuales de Trabajadores (COLACOT),** Avenida 19 No. 13A-12 Of.1301C, Apartado 35940, Bogota, Colombia. Tel: (57-1) 283 58 37/283 59 57; Fax: (57-1) 283 57 96.

Dr. Armando Tovar Parada, President, **Organización de las Cooperativas de America (OCA)**, Carrera 11 No. 86-32 Oficina 101, Apartado Postal 135683, Santa Fe de Bogota D.C., Colombia. Tel: (57-1) 610 32 96/218 12 95; Fax: (57-1) 218 91 30.

Mr. Felix Cristia, Executive Director, **Confederación de Cooperativas del Caribe y Centro America (CCC-CA),** Apartado 3658-1000, San Jose, Costa Rica. Tel: (506) 404 641/404 592; Fax: (506) 404 284.

Mr. Shoji Kato, Chairman, **Medical Co-op Committee of the Japanese Consumers' Co-operative Union**, Coordinator, International Cooperative Health and Social Care Forum, September 1995 and Chairman, Steering Group, Seikyo-kaikan, 4-1-13, Sendagaya, Shibuya-Ku, Tokyo, 151 Japan. Tel.: 03-34 97-9103. Fax: 03-3403-0573.

Mr. Amaldo Silvestre Mallmann, International Director, and Mr. Carlos C. Sandskaer, Coordinator of the First Interamerican Forum on Co-operative Health Care and Related Services, **UNIMED DO BRASIL**, Alameda Santos, 1827, 15. andar, CEP 01419-002, Sao Paulo, SP, Brazil. Tel.: (011) 253-6633, FAX.: (011) 253-6656.888 7465.

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United Nations System

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Mr. Nitin Desai, Under-Secretary-General for Policy Coordination and Sustainable Development, **United Nations Secretariat**, New York, New York, 10017, United States of America. Tel.: (212) 963-5958, Fax.: (212) 963 1010. [Direct to focal point for the promotion of co-operatives: Room DC-2 1348,tel.: (212) 963 2924, Fax.: (212) 963 3062].

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ANNEX III
THE BILL OF PATIENTS' RIGHTS OF THE MEDICAL CO-OP COMMITTEE OF THE JAPANESE CONSUMERS' CO-OPERATIVE UNION, ADOPTED 11 MAY 1991

Democracy in Medical Treatment

As citizens of Japan, we all have the fundamental rights to be respected as human beings and to receive medical treatment without discrimination. With advancement in the pursuit of democracy, the constitutional ideal of the right to lead healthy and culturally fulfilled lives is steadily taking root among the people. From this perspective, people are demanding open, accessible medical treatment, with increased participation from patients. However, the rights of patients have not been fully recognized by the current medical establishment. The situation is far from satisfactory.

Promoting this movement, clearly defining the rights and responsibilities of patients, and the obligations and responsibilities of those in the medical profession, as well as the local and central governments, have become tasks which those in the medical profession and patients can no longer avoid.

Medical Co-operative

A medical co-operative is a voluntary organization set up by citizens based on the Consumers' Livelihood Co-operative Society Law. The objectives of this co-operative are: to have local residents discuss various problems which pertain to their health and lives; to set up an organization to own and operate a medical institution; and to solve problems through co-operation between staffs and officials of the co-operative and those in the medical profession.

Through investing in, and utilizing and managing co-operative movement, co-operative members are responsible for carrying out all activities. With health and medical activities, too, they are not merely recipients of a diagnosis or medical treatments, but are also required to actively take part in these activities.

Medical co-operatives, based on HANs (groups) and individual families, are promoting activities to maintain and enhance health in communities. To remain enthusiastic and to continue leading enjoyable lives, people must change themselves, influence society, and actively co-operate with other people. This is what "healthy living" is all about. Those are the fundamentals of our movement to maintain healthy and happy lives.

Each and every co-operative member has participated and cooperated to make our medical co-op what it is today. There still are some instances where human dignity is not respected. However, we will continue to move forward, placing great importance on the members' participation and co-operation.

The aim of the Medical Co-op's "Bill of the Patients' Rights" is to foster and highly value the well-being of the members. To do this, the members must rigorously analyze themselves.

At the same time, the charter is a declaration of human rights which guarantees that the lives of all co-operative members and local residents are respected and supported by all. The charter also guarantees democracy and participation by residents in medical care.

Rights and Responsibilities of Patients

Patients have the following rights and responsibilities:

- Right to Know

  The right to receive a full explanation and full information, to their own satisfaction, regarding the name and condition of illness (including examination results); prognosis (possibility of developing another illness); diagnosis; treatment and surgery (reason for decision to carry them out, and its details); name of drugs and their effects and side effects; and necessary fees.

- Right to Decide

  After receiving an explanation and the diagnosis, to their own satisfaction, patients can decide for themselves the suitability of the treatment plan and other matters proposed by those in the medical profession.

- Rights Regarding Privacy

  The right to have one's privacy protected and the right not to be interfered with in personal affairs.

- Right to Learn

  The right to learn about their own illness, method of treatment, hygiene, and prevention.

- Right to Receive Medical Treatment
  The right to receive necessary and adequate medical service at any time, in a way that respects their basic human rights. The right to demand improvements in medical security from the government and local municipalities.

- Participation and Cooperation

  The patient's responsibility to protect and develop these rights by cooperating with those in the medical profession.

ANNEX IV
STATEMENT ON THE CO-OPERATIVE IDENTITY OF THE
INTERNATIONAL CO-OPERATIVE ALLIANCE

The International Co-operative Alliance is an independent, non-governmental association which unites, represents and serves co-operatives worldwide. Its main objective is to promote and strengthen autonomous co-operatives throughout the world. Through actions taken at the international, regional and national levels, the Alliance also seeks to promote and protect co-operative values and principles; facilitate the development of economic and other mutually beneficial relations between its member organizations; and further the economic and social progress of people, thereby contributing to international peace and security.

The the end of 1995 the co-operative organizations making up the membership of the Alliance themselves had an individual membership which in aggregate totalled 765,000,000 persons. If the immediate families or households of these co-operative members is taken into account - and taking a global average of four persons per family or household - then a total of 3,060,000,000, or more than half of the world's population, were directly associated with the international movement which the Alliance represents.

At its Thirty-first and Centennial Congress, held at Manchester, United Kingdom, during September 1995, the International Co-operative Alliance adopted a "Statement on the Co-operative Identity". This had been formulated by means of a world-wide review of the values and principles upon which co-operatives base their activities, with the objective of strengthening the identity and role of co-operatives in the global economy.

The text of the Statement on the Co-operative identity is as follows:

Definition

A co-operative is an autonomous association of persons united voluntarily to meet their common economic, social and cultural needs and aspirations through a jointly-owned and democratically-controlled enterprise.

Values

Co-operatives are based on the values of self-help, self-responsibility, democracy, equality, equity and solidarity. In the tradition of their founders, co-operative members believe in the ethical values of honesty, openness, social responsibility and caring for others.

Principles

The co-operative principles are guidelines by which co-operatives put their value into practice.

1st Principle: Voluntary and Open Membership
Co-operatives are voluntary organisations, open to all persons able to use their services and willing to accept the responsibilities of membership, without gender, social, racial, political or religious discrimination.

2nd Principle: Democratic Member Control
Co-operatives are democratic organisations controlled by their members, who actively participate in setting their policies and making decisions. Men and women serving as elected representatives are accountable to the membership. In primary co-operatives members have equal voting rights (one

member, one vote) and co-operatives at other levels are also organised in a democratic manner.

3rd Principle: Member Economic Participation
Members contribute equitably to and democratically control, the captal of their co-operative. At least part of that capital is usually the common property of the co-operative. Members usually receive limited compensation, if any, on capital subscribed as a condition of membership. Members allocate surpluses for any or all of the following purposes: developing their co-operative, possibly by setting up reserves, part of which at least would be indivisible; benefitting members in proportion to their transactions with the co-operative; and supporting other activities approved by the membership.

4th Principle: Autonomy and Independence
Co-operatives are autonomous, self-help organisations controlled by their members. If they enter into agreements with other organisations, including governments, or raise capital from external sources, they do so on terms that ensure democratic control by their members and maintain their co-operative autonomy.

5th Principle: Education, Training and Information
Co-operatives provide education and training for their members, elected representatives, managers, and employees so they can contribute effectively to the development of their co-operatives. They inform the general public - particularly young people and opinion leaders - about the nature and benefits of co-operation.

6th Principle: Co-operation among Co-operatives
Co-operatives serve their members most effectively and strengthen the co-operative movement by working together through local, national and regional and international structures.

7th Principle: Concern for Community
Co-operatives work for the sustainable development of their communities through policies approved by their members.