

Health co-ops around the world

**Global Background and
Trends from a Health and
Social Care Perspective**



Coordination of the global project

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Introduction

Health co-ops around the world are a series of publications showing the contribution of health co-ops in the health system from a national perspective. The project has been conducted under a mandate of the International Health Co-operative Organisation (<http://www.ica.coop/ihco/>).

Each case includes a snapshot of the national health system, information on the presence of health co-operatives and practical references. It is based on a survey conducted in 2007 with the kind collaboration of many people involved in health co-ops and other relevant organisations located in targeted countries. The series includes the following national cases:

- ✓ Canada
- ✓ United States of America
- ✓ Benin
- ✓ Uganda
- ✓ Mali

The relation between this research project and the very important study conducted in 1995 and 1996 by the United Nations (published in 1997 under the name *Cooperative Enterprise in the Health and Social Care Sector A Global Survey*), as well as the methodological framework are presented in the document:

- ✓ Global background and trends from a health and social care perspective.

All the cases can be downloading free of charge at:

<http://www.usherbrooke.ca/irecus/publications-irecus/autres-publications>



Prologue

The International Health Co-operative Organization (IHCO) launched its study on health co-operatives around the world in 2007. The project is dedicated to health and social care co-operatives and focuses specifically on health services offered under the co-operative model, with a more general look at social care co-operatives where relevant. The project aims to disseminate information on health co-operatives, give greater visibility to the role co-operatives play in the health and social care sectors in various countries, and to promote their development. The results of the research are presented in a series of country case studies illustrating the state of health co-operatives within national health care systems.

This document is meant to provide readers with background information to facilitate the understanding of the country case studies in which the health co-operatives have developed. It defines the concept of health co-operative and provides a review of the conclusions of the first ever global survey on co-operatives in the health sector published in 1997 by the United Nations, “*Cooperative Enterprise in the Health and Social Care Sectors – A Global Survey*” which paved the way for the IHCO 2007 study. It also illustrates global developments, trends and issues concerning co-operatives in the health sector and how they have evolved since the 1990’s.

Furthermore, this document outlines the methodology and framework used to produce the case studies on the state of health co-operatives in various countries.

Introduction

The contribution of co-operatives in the area of health promotion was formally recognized in the 1997 Jakarta Declaration on Leading Health Promotion into the 21st Century. This declaration called upon the World Health Organization (WHO) to engage co-operatives in the advancement of priorities for action in health promotion¹.

Also in 1997, the United Nations (UN) published a survey entitled “*Cooperative Enterprise in the Health and Social Care Sectors*”². It presented the most comprehensive portrait of health and social care co-operatives ever produced³. For the first time, this publication offered a broad view of the richness and diversity of co-operatives operating in health and social care, the trends in the development of institutions supporting the co-operative movement in this sector, an examination of the different benefits for various stakeholders (such as users and providers) and a compelling reflection on the components of a strategy for thorough engagement by the co-operative movement in this field.

¹ Committee for the Promotion and Advancement of Co-operatives (COPAC) (1999) « The Contribution of Co-operatives to the Implementation of the World Summit for Social Development Declaration and Program of Action », Conference Room Paper: First Session of the Preparatory Committee for the Special Session of the General Assembly on the Implementation of the Outcome of the World Summit for Social Development and Further Initiatives, New York, <http://www.copacgva.org/wssd99.htm#health>.

² This survey has been originally released in English and then, translated in French and Spanish.

³ At a limited scale, some portraits have been done previously. For instance, Comeau and Girard (1996), after stated on the Welfare-State crisis, described 11 national cases, which combined information on the health system (management, funding, deliveries) and the characteristic of health co-ops evolving in the system. Comeau, Yvan and Jean-Pierre Girard (1996) « Les coopératives de santé dans le monde: une pratique préventive et éducative de la santé », Montréal, *Cahier de recherche 074*, Chaire de coopération Guy-Bernier, Université du Québec à Montréal, 138 p. <http://www.chaire-ccgb.uqam.ca/fr/recherche/74.pdf>.

The UN 1997 survey helped promote knowledge of health and social care co-operatives and served as a means of breaking down isolating walls between them. It provided a broad review covering co-operatives whose business goals are primarily or solely concerned with health and social care and also co-operatives whose business goals do not include health or social well-being but might include the provision of operational support to health and social care co-operatives. The conclusions of this survey which served as the base for the IHCO study will be discussed further along. At this point however, it is important to define the concept of “health co-operative” in order to foster a common understanding. This implies defining what a co-operative enterprise is, as well as the particularities relating to its sector of activity in this case health.

Defining Health Co-operatives (HC)

What is a Co-operative?

An internationally recognised definition of a co-operative enterprise is provided by the International Co-operative Alliance (ICA) in its *Statement on the Co-operative Identity*⁴. This definition has served as a base for defining co-operatives in various policy documents of the UN, the International Labour Organisation (ILO) and in various national laws.

“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.”⁵

This definition is accompanied by the core values of self-help, self-responsibility, democracy, equality, equity and solidarity, and a series of principles that apply to co-operative organizations:

1. Voluntary and Open Membership
2. Democratic Member Control
3. Member Economic Participation
4. Autonomy and Independence
5. Education, Training and Information
6. Co-operation among Co-operatives
7. Concern for Community

According to the ILO, this ICA Statement along with the UN Guidelines on Co-operatives⁶ and ILO Recommendation No.193⁷-which contain the co-operative values and principles - form the essence of a *public international co-operative law*⁸ and should therefore be respected in national co-operative legislations. However, the enforcement power of this law has been questioned due to the fact that the ICA is a non-governmental organisation, and that guidelines and recommendations do not yield an official commitment on the part of governments. Nevertheless, the ILO also states that even sceptics

⁴ See Statement on the co-operative identity in annex for full description.

⁵ ICA, <http://www.ica.coop/coop/index.html>, viewed on 13/02/2007.

⁶ UN Guidelines on Co-operatives (2001), <http://www.un.org/documents/ecosoc/docs/2001/e2001-68.pdf>, viewed on 27/02/2007.

⁷ ILO Recommendation 193, (2002), <http://www.ilo.org/ilolex/english/recdisp1.htm>, viewed on 27/02/2007.

⁸ Henry, Hagen, (2005) « Guidelines for Cooperative Legislation - second, revised edition », International Labor Organization, First published -1998, p.5.

must recognize that co-operative values and principles correspond to at least a public international *customary* law because they are generally recognized.

The ICA definition and principles can therefore serve to determine whether an organisation can qualify as a co-operative. The following interpretation of the ICA definition found in “Co-operatives and the Millennium Development Goals” (2004)⁹, further accentuates what can and cannot be considered a co-operative:

“This definition emphasizes that co-operatives are *independent of government* and not owned by anyone other than the members. They are *associations of persons*, which can mean individual people but also ‘legal persons’, organizations that may themselves have members. They are *united voluntarily*, and so people should be free to join or leave. This means that village or neighborhood associations that include all people in an area, whether or not they want to be members, are not really co-operatives. Co-operatives are designed to meet their *members’ needs*; philanthropic organizations that are set up primarily to meet the needs of others are not co-operatives. Nor can a co-operative be diverted into meeting needs that have not been sanctioned by the members, without it ceasing to be a co-operative. They are distinguished from shareholding firms by their *democratic nature*, with voting rights being assigned by person rather than by size of shareholding. In this sense they are ‘*not for profit*’, *but they do produce surpluses* that can be distributed to their members in the form of a patronage refund.”

What is Health?

Another element to be fleshed out is the concept of ‘health’. A generally recognized definition adopted by the WHO¹⁰ is as follows:

“Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”

This definition has not been amended since 1948; however it has suffered criticism. Niyi Awofeso¹¹ (2005) explains that critics question whether the state of health, as defined, is sustainable due to the word “complete” and whether this definition might correspond more closely to happiness rather than to health. Other commonly accepted definitions of health take into consideration such variables as age, culture and personal responsibility, which can influence ones health over time, as well as contemporary issues such as human rights. Finally, some push the concept of health beyond personal wellbeing to include that of the community. Awofeso believes these concepts could prove useful for updating the WHO definition in the 21st century.

⁹ Birchall, Johnston, (2004) « Co-operatives and the Millennium Development Goals », Cooperative Branch & Policy Integration Department, International Labor Office, Committee for the Promotion and Advancement of Co-operatives, Geneva, p. 6.

¹⁰ The bibliographic citation for this definition is: Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948. The definition has not been amended since 1948.

¹¹ Niyi Awofeso: Associate Professor, School of Public Health and Community Medicine, University of New South Wales, Sydney 2052, Australia (email: niyi.awofeso@justicehealth.nsw.gov.au). Awofeso, Niyi, (2005) « Re-defining ‘Health’ », http://www.who.int/bulletin/bulletin_board/83/ustun11051/en/, viewed 06/02/2007.

Other elements to take into consideration when defining health are the determinants of health as presented by the WHO¹². It is stated that:

“Many factors combine together to affect the health of individuals and communities. Whether people are healthy or not, is determined by their circumstances and environment. To a large extent, factors such as where we live, the state of our environment, genetics, our income and education level, and our relationships with friends and family all have considerable impacts on health, whereas the more commonly considered factors such as access and use of health care services often have less of an impact.”¹³

The determinants of health include:

- the social and economic environment,
- the physical environment, and
- the person’s individual characteristics and behaviors.

Given that the WHO is the specialized agency on health matters of the United Nations as governed by 193 Member States, the WHO definition of health along with the determinants of health will be the reference for this study.

What is a Health Co-operative?

One of the definitions of health co-operatives provided by the UN in its 1997 Survey which best describes the way the concept was interpreted to undertake the present IHCO study, corresponds to health co-operatives as defined in category 1.1 of the survey:

Health co-operatives¹⁴:

“These are co-operative enterprises whose business goals are solely concerned with health and social care but more precisely, co-operative enterprises providing health services to individuals (health co-operatives).”

An exploration of other existing definitions of a health co-operative turned up this well-rounded version proposed by the “*Conseil québécois de la coopération et de la mutualité*¹⁵” (CQCM) (2005) – the Quebec (Canada) co-op and mutual apex organizations – in a document outlining its position on matters regarding co-operatives and health:

... “It is a collective enterprise that produces services to promote, maintain and improve the health and living conditions of communities while involving its members in the organisation of services through decision-making. The co-operative is based on democratic participation, equality, and collective management. These conditions can

¹² WHO, <http://www.who.int/hia/evidence/doh/en/>, viewed on 09/02/07. Similar to this reference, the European Commission shows that health determinants are based on a variety of factors: «personal behaviour and lifestyles; influences within communities which can sustain or damage health; living and working conditions and access to health services; and general socio-economic, cultural and environmental conditions». http://ec.europa.eu/health/ph_determinants/healthdeterminants_en.htm.

¹³ Some studies show that access and use of health care services represent only 20% of individual health.

¹⁴ United Nations, (1997) « Co-operative Enterprise in the Health and Social Care Sectors – A Global Survey », New York, p.4.

¹⁵ Conseil québécois pour la coopération et la mutualité, (2005), « Positionnement et orientations du Conseil de la coopération du Québec en matière de santé », p.10. Freely translated from French by Geneviève Bussière.

potentially lead to social transformation and improvement of health in order to fulfill the needs of the community.”

This definition expands on the one offered by the 1997 UN Survey in that it defines the bases of the co-operative organization, collective enterprise, democracy, collective management, etc, as well as identifying the specific nature of a health co-operative which is to produce health related services.

Another element to take into consideration in defining health co-operatives is the type of co-operative ownership model under which they operate. This has an impact on the service provision and the orientation of the enterprise.

Types of Co-operative Ownership

The International Co-operative Alliance states, that as business enterprises co-operatives can be defined in terms of three basic interests: **ownership, control, and beneficiary**¹⁶. In the UN Survey, for each category of health co-operative, a distinction was made regarding the type of ownership: **user-owned, joint user and provider owned or provider owned**.

These categories demonstrate to what degree members administer and have control over their health. For example, user-owned and joint user/provider-owned co-operatives encourage a greater involvement on the part of members with regards to decisions that concern them.

The IHCO study refers to health co-operatives according to three ownership models:

1. User-owned co-operatives
2. Multi stakeholder co-operatives
3. Provider-owned co-operatives

User-owned Health Co-operatives

« Health Co-operatives: A Viable Solution to the Current Crisis in Health Service Delivery » by Kristen Sinats¹⁷ (2001) provides the following definition of a health co-operative operating under the user-owned model:

“User or client-owned health co-operatives are set up by individuals in the same community to help them meet their own health care needs. Member-users determine goals and practices, hereby enabling ordinary citizens to empower themselves with respect to health care. Members and owners each contribute shares of capital and subsequently contribute to operating costs, usually by prepaid premiums, and appoint managers to negotiate contracts with health insurance and health care providers. Often these co-operatives purchase and operate hospitals and other facilities, and hire professional and other staff. Services range from simple preventative care and basic insurance to advanced curative and rehabilitative interventions.”

¹⁶ ICA, <http://www.ica.coop/coop/index.html>, viewed on 06/02/2007.

¹⁷ Sinats, Kristin (2001) « Health Co-operatives: A Viable Solution to the Current Crisis in Health Service Delivery », Victoria, Occasional paper number 5, British Columbia Institute for Co-operative Studies, University of Victoria, p.9.

Vern Hughes, who was previously Executive Officer of Australia's only consumer-owned primary health care centre adds that apart from the diversity that may exist in consumer (user-owned) co-operatives there are five core features that characterize these organisations: *consumer focussed, consumer governed, financial autonomy, not-for-profit, and community based*¹⁸.

Multi Stakeholder Health Co-operative

Multi stakeholder co-operatives (MSC) are known under different names worldwide. For example, such co-operatives take on the name of social co-operative in Italy¹⁹, collective interest co-op society (société coopérative d'intérêt collectif) in France, solidarity co-operative (coopérative de solidarité) in the province of Québec – Canada²⁰ and, in the UK and various other countries, they are called multi-stakeholder co-operatives. As worldwide expert in co-op Hans Münkner²¹ quoted (referring to MSC),

“Interest in this new form of co-operative society has led the promulgation of new laws or the amendment of existing co-operative laws in Italy (1988, 1991), Canada (1997), Portugal (1998) and France (2001). In other countries, MSCs are established under current co-operatives law (Germany), under special laws for community benefit organisations (UK), non profit associations, societies with social objectives (Belgium) or under general law (Denmark).”

Co-operatives UK, a national association of co-operative enterprises, defines multi-stakeholder health co-operatives as organisations that bring together service users, staff and the wider community for the delivery of care services²². They are characterized by the fact that diverse stakeholders such as users, workers, volunteers, benefactors and representatives of public bodies are members of the organisation and are involved in the management (Carlo Borzaga²³ 1996). The base of the concept is that for a co-operative to be considered multi stakeholder, it must have two or more categories of members.

Provider Owned Health Co-operative

As for provider owned health co-operatives, Nayar and Razum (2003)²⁴ state that they are composed mostly of health professionals or entrepreneurs who are looking to widen the range of services offered or to minimize costs related to administration, supply purchases and technical services. Members cover operating costs through the subsequent premiums that they pay after having provided initial shares. According to the COPAC (1999)²⁵, various advantages are related to this type of organisation such as bulk purchasing, shared administration and technical services and the fact that different health

¹⁸ Hughes, Vern, http://www.australia.coop/dp_health.htm, undated, viewed on 29/01/2007.

¹⁹ Wikipedia, (http://en.wikipedia.org/wiki/Social_co-operative, viewed on 15/02/2007).

²⁰ Conseil Québécois pour la Coopération et la Mutualité (2005) « Positionnement et orientations du Conseil de la coopération du Québec en matière de santé ».

²¹ Münkner, Hans (2004) « Multi-stakeholder co-operatives and their legal framework » in Borzaga Carlo and Roger Spear (eds) *Trends and challenges for Co-operatives and Social Enterprises in developed and transition countries*, Trento, Edizioni 31, p. 49- 81.

²² Co-operatives-UK, (<http://www.co-operatives-uk.coop/live/welcome.asp?id=1193>, viewed on 01/02/2007).

²³ Borzaga, Carlo (1996) « Stakeholder co-operatives in European welfare », *SOUNDINGS* a journal of politics and culture, issue 4 – The public good, Autumn.

²⁴ Nayar, K., Rajasekharan and Oliver Razum (2003) « Health Co-operatives: Review of International Experiences », *Croatian Medical Journal*, 44:568-575, p. 569.

²⁵ COPAC (1999) “The Contribution of Co-operatives to the Implementation of the World Summit for Social Development Declaration and Programme of Action”, Conference Room Paper: First Session of the Preparatory Committee for the Special Session of the General Assembly on the Implementation of the Outcome of the World Summit for Social Development and Further Initiatives, New York.

professionals can come together in one network in order to offer a stronger and more diverse range of services within a community.

With regards to these three possibilities of co-operative ownership, the International Health Co-operative Organisation (IHCO)²⁶ defines itself as a:

“...sectoral organisation of the ICA which brings together co-operatives within the ICA membership that provide health care to their members or that provide self-employment for health professionals (doctors, nurses, etc.) or integrate consumer and producer co-operatives.”

This illustrates the application of the term “health co-operative” to define all co-operatives in the area of health care services regardless of the type of ownership that they operate under.

For its study on health co-operatives around the world, the IHCO chose to adopt a definition of a health co-operative that brings together various elements such as, co-operative identity, focus on health services and ownership model.

“A health co-operative is an autonomous, collectively and democratically-controlled enterprise whose main purpose is to satisfy the needs of its members through the provision of services to promote, maintain and improve health and living conditions or through the provision of self-employment for health professionals. It can be owned and managed by users or providers of the health services, or a combination of both and can also include members from the wider community.”

Defining Social Care Co-operatives

As did the 1997 UN Survey, the IHCO study on health co-operatives also refers, although to a lesser extent, to social care co-operatives. A social care co-operative is one whose original and current primary or sole function is to provide social care services to users, those who are in need of that care²⁷.

The relevance of presenting information on these co-operatives in a survey dedicated to health related services can be found in the WHO determinants of health which were presented earlier. Social care cooperatives can have an impact on the health of individuals who benefit from their services.

Conclusions from the 1997 UN Survey²⁸

The UN Survey had identified that different types of health co-operatives were active in at least 43 countries in 1995 (p.70). Approximately 53,000,000 people used the services of these co-operatives, 80% of which were from northern regions such as Japan, Europe, Israel and North America (p.39).

Of the total users of co-operative health services, 75% received services from user-owned health co-operatives. The remainder used the services provided by provider-owned health co-operatives (p.55).

²⁶ International Health Co-operative Organization, <http://www.ica.coop/ihco/index.html>, viewed 16/01/2007.

²⁷ UN Survey, 1997, page 4.

²⁸ UN Survey, 1997, 176 pages.

The 1997 UN Survey results suggested that certain environments were more conducive to the development of health co-operatives, including a sequence of determinants for successful co-operative development in the health and social care sectors. The sequence was presented in such a way that each determinant favouring the successful engagement of co-operatives in the health and social care sectors depended on the existence of the previous determinant. An unfavourable condition for one determinant could limit the opportunity for health co-operative development.

The most important determinants for the development of co-operatives in the health and social care sectors according to the UN Survey²⁹ in sequence are:

- 1) *Extent of public-sector responsibility [in the health and social care sectors]:* The extent to which public coverage and delivery of health and social services is available for the national population determines the space available for co-operatives to insert themselves and successfully operate in these sectors as a non-public enterprise.
- 2) *Policy position of the Government on co-operatives:* If space is available for the development of health co-operatives, then the way co-operatives are perceived by the government, and its policies, legislation and administrative practices are critical.
- 3) *Citizen's perceptions of co-operatives:* If space is available for co-operatives to engage in health and social care and the government's perception of them is at least neutral and at best positive then what becomes important is the way individuals perceive co-operatives as an effective means by which to secure health and social care services not offered by the government.
- 4) *Perceptions of the co-operative movement and availability of capital:* If space is available for co-operative development in the sectors, government perception is not un-favourable and citizens are familiar with the co-operative model then how the co-operative movement perceives the involvement of co-operative enterprises in this sector is of importance. This will influence the support offered by other co-operative enterprises to develop health and social care co-operatives.
- 5) *Perceptions and positions of other stakeholders in health and social care:* This becomes important at the same time as the previous determinant. Other stakeholders that can support health co-operatives or initiate their development include trade unions, professional associations, consumer associations and organizations representing specific interest groups in society such as women, youth, the elderly, etc.
- 6) *Perceptions and positions of health and social care professionals:* The perception and position of health and social care professionals who are not employed by or affiliated with the government becomes important regarding the development of co-operatives in the health and social care sectors. They can be favourable, neutral or unfavourable and even actively oppose the development of co-operatives in the health and social care sectors especially if it can potentially affect their share of the market.
- 7) *Perceptions and position of other stakeholders in society including employers:* Other stakeholders, particularly employers, can have a certain responsibility in the national system of health care with regards to the provision of health and social care insurance and therefore they are also likely to take a position on how co-operative can help them.

²⁹ UN Survey, 1997, page 88.

- 8) *Technical and organizational determinants*: Finally, when all previously mentioned determinants are generally favourable, then such determinant as availability of capital and of technical and managerial personnel familiar with co-operative enterprises becomes relevant.

While taking into consideration these determinants, the UN Survey underlined the importance of their relevance and how it can change over time and from one society to another. Therefore, generalizations should be avoided when using these determinants to analyze the development of health co-operatives and place and time should also be considered. This principle can also be applied when analyzing the benefits of co-operatives in the health and social care sectors to users, providers and society (p.111).

The UN Survey concluded that co-operative enterprises can hold an advantage over public-sector and private for-profit sector provision of health and social care services. For one, co-operatives have to be financially viable to stay in business but they are not profit oriented. They therefore seek efficient management practices.

Second, their democratic nature and accountability to the members reduces the risk that they will deviate from their original goals or that they will not react to new conditions. Also, a valuable asset in this sector of activity is the participation of the users in identifying the goals and the design of operations. Co-operatives are able to fully exploit this resource whereas public agencies and for-profit enterprises are often not open to efficient participation by citizens. The same goes for the establishment of a meaningful dialogue between users and providers of the health and social care services (p.146).

Furthermore, co-operatives are anchored in the communities where they provide services so they can effectively pool resources from it. For example, the creation of partnerships with other community organizations and the local government, as well as mobilizing volunteers and community support. Citizens' control over the co-operative enterprise is empowering. Through co-operative enterprises members can provide themselves with the services they need without relying solely on the public agencies over which they have no control or paying for the services of for-profit enterprises.

Finally, the co-operative's anchorage in the community also means that it is committed to sustainability and a continued presence, unlike profit-driven enterprises which can potentially chose to close or relocate due to factors external to the community. In summary, in most societal situations, it is believed that co-operatives play an important role in the future development of mixed health and social care sectors (p.146).

The UN survey proposed a wide array of suggestions as to how to achieve greater engagement from the co-operative movement in health and social care. Certain elements proposed focused on national strategies for the strengthening of co-operative health and social care sectors. Others related to how the international co-operative movement could be strengthened in order to better support national strategies for the development of co-operatives in the health and social care sectors. For example,

“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 in which they operate. Establishment as a specialized body of ICA would be one – and probably the most appropriate – solution (144).”

Founded in 1996, the International Health Co-operative Organization (IHCO) has played a role much like that originally suggested in the UN Survey.

Developments in the Health and Social Care Sectors

Since the mid-90s and the publication of the UN Survey, many developments trends and issues have surfaced internationally with regards to the health and social care sectors.

For one, the contribution of population health to economic and social development was reflected in the Millennium Development Goals (MDG) adopted in 2000 by the United Nations (see annex 2). At least four of the eight Goals deal specifically with health issues placing health as a “goal in itself and a key development input towards other goals”³⁰.

The WHO, as the directing and coordinating authority for health within the United Nations system, stresses the importance of strengthening health systems and making them more accessible as key strategies for fighting poverty and fostering development³¹. Low income countries are afflicted with problems in their health systems but the problems are not exclusive to them. High income countries also face issues of inadequate access to health care for large segments of their population due to a lack of equity. Furthermore, they also face the issue of rising costs in health care caused by the inefficient use of resources.

In response to this phenomenon, the WHO mentions in Report #65 on health sector reform, that “the world experienced a wave of health sector reforms, including reduction in the role of the state and increasing use of market-like mechanisms”³².

Nayar et al (2004) in their article, « *Self-help: What future role in health care for low and middle-income countries* » indicate that many reforms have been encouraging a move towards privatization of medical services – the argument being that the state is often inefficient in the financing and implementation of health programs and that it is not equipped to deal with social sectors such as health. A mix of public and private care is an alternative often suggested with the first insuring primary care and the second taking on the lucrative curative care. However, there are also certain options falling between the fully state-oriented services and privatized care. This is where health co-operatives fit in.

The Co-operative Potential

In an ILO publication (2004) by Johnston Birchall³³ “Co-operatives and the Millennium Development Goals”, the foreword states that:

“With a movement that reaches over 800 million individuals, [...] the co-operative movement can be a key partner to reach the MDG targets. Co-operatives are improving the lives of people by raising their economic conditions, by promoting social integration

³⁰ (WHO - The world health report 2003 - shaping the future Overview: <http://www.who.int/whr/2003/en/index.html>).

³¹ (<http://www.who.int/features/qa/28/en/>, viewed 07/2007).

³² (<http://www.who.int/tdr/research/finalreps/no65.htm>, 2003).

³³ Prof. Johnston Birchall is Senior Lecturer in Social Policy, Stirling University and Senior Associate, New Economics Foundation, UK.

and ultimately creating just those conditions that the Millennium Declaration foresees as being fundamental to building peaceful societies.”³⁴

Along the same lines, in 2004, the ICA and the ILO launched the global campaign “Cooperating out of poverty³⁵”. They exposed the fact that there is revived interest in the co-operative form of organization. Following a resolution that outlines co-operatives as a model to achieve social and development goals, guidelines were adopted by the UN in 2001 on the role of co-operatives in social development (p.8). Furthermore, they argue that “the co-operative enterprise is the only form of organization meeting so fully all dimensions of poverty such as those put forward by the World Bank: *opportunity, empowerment and security* (p.10).”

With regards to the health related MDGs of reduction of child mortality and the improvement of maternal health, Birchall (2004) outlines how co-operatives of various forms are actively involved in the delivery of primary care in various countries (p.29). Additionally, the aging population in many northern countries is triggering the expanded need for care for the elderly. The development of care co-operatives has been a way to answer this need and governments are increasingly entering in partnerships with these co-operatives for the provision of care (p.13).

With regards to the MDG to combat HIV/AIDS, malaria and other diseases, Birchall underlines the important role co-operatives play in education and awareness campaigns to address these pandemics. In addition, in some countries, co-operatives have been organized specifically to address the issue of HIV/AIDS and to deliver care to affected people (p.30).

In light of the reality and potential of co-operatives in health and social care issues, health co-operatives are increasingly becoming nationally significant in many countries³⁶ (COPAC). Some governments have established partnerships with health co-operatives for the provision of health care services and with current reform efforts underway, more governments are considering this type of alliance with co-operatives as a way to effectively meet the health and social care needs of their populations.

However, despite the fact that co-operatives have been active in the provision of primary care around the world as mentioned above in the review of the 1997 UN Survey, the extent to which they are involved in the health and social care sectors depends first on the space made available to them in the health system of the country where they operate. This aspect has been taken into account in the development of the IHCO case studies on health co-operatives around the world.

Methodology and Framework for the Case Studies

In order to better understand the role that co-operatives play in the health sector of a country, it was deemed necessary to review the health system of that country. This allows seeing where health co-operatives can fit in, what they can or cannot do given the specific health system context and in what areas they could have a greater impact.

³⁴ Birchall, Johnston (2004) « Co-operatives and the Millennium Development Goals », International Labor Organization, Geneva, page iv.

³⁵ (<http://www.ica.coop/outofpoverty/documents/campaign.pdf>).

³⁶ COPAC (1999), Conference Room Paper, <http://www.copacgva.org/wssd99.htm>.

“It is the sum total of all the organizations, institutions and resources whose primary purpose is to improve health. A health system needs staff, funds, information, supplies, transport, communications and overall guidance and direction. And it needs to provide services that are responsive and financially fair, while treating people decently”.

(WHO: <http://www.who.int/healthsystems/about/en/>)

Since the focus of this study is on health services provided under the co-operative model and not on the analysis of health systems, an extensive review of already existing electronic sources of information on the health systems of various countries was done in order to find the best sources. For each country case study, general information on the health system is provided. The data provided was extracted from pre-existing sources and is meant for information purposes only, to provide the reader with basic knowledge of how health services are delivered from country to country.

The research efforts were concentrated around the WHO sites in an attempt to obtain the most up to date information possible. However, one difficulty encountered is that there is not an integrated source of information providing health systems profiles for all countries. The WHO regional sites each have different formats for presenting information and not all have actually produced narrative health systems profiles for their countries. Also, the data is more or less up to date depending on the source of information.

The most comprehensive, useful, and up to date information on health systems was found on the European Observatory on health Systems and Policies website (www.euro.who.int/observatory). The website provides full country health system profiles, more condensed health systems summaries (10-12 pages) and some snapshots (2-3 pages) of health systems. The website covers all countries of the European continent, as well as others such as Canada, Australia, Israel, and New Zealand. The information is generally up to date, with some country profiles as recent as 2007 and not going back further than 2002 apart from a few exceptions dating to 1999.

The European Observatory also presents “snapshots of health systems” for 16 countries (<http://www.euro.who.int/document/e87303.pdf>). These were of particular interest for this study since they present in a concise manner the essential elements for understanding how the health system of a given country functions.

The model of the European Observatory “snapshots of health systems” was therefore adopted for presenting the health systems in each country case study. The information is presented based on the following key elements:

- 1) Organisational structure of the health system;
- 2) Healthcare financing and expenditure;
- 3) Healthcare provision;
- 4) Development and issues.

Each country is introduced with a map and basic statistics from the WHO international website (<http://www.who.int/en/>). Also, all health system snapshots were complemented with specific data concerning the percentage of GDP dedicated to healthcare and public/private breakdown, as well as physician and nurse density per 1000 population and hospital beds per 10000 populations. This data

was extracted from the World Health Statistics 2007 which present health statistics for the WHO 193 Member States (<http://www.who.int/whosis/en/>).

Framework Adopted for the Case Studies

In order to collect relevant information about health co-operatives in each country, two questionnaires were created. One questionnaire was intended for associations of health co-operatives (federations, apex organizations, groups, etc), and the second questionnaire for individual co-operatives. Variables for analysis were identified and served as the base for the design of the survey.

Variables for Analysing Health Co-operatives

The WHO definition of health and other commonly accepted definitions agreed that being ‘healthy’ goes beyond physical wellness. This is reflected in the different facets of health services provision. Therefore, in analyzing the role of health co-operatives in the health care sector of a given country, an important element considered is the nature of the health services offered. Five types of possible health services were considered:

1. **Promotion:** Health promotion is the process of enabling people to increase control over, and to improve their health. It involves actions directed at strengthening the skills and capabilities of individuals, but also action directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health.³⁷
2. **Preventive:** Program of health care designed for the prevention and/or reduction of illnesses by providing such services as regular physical examinations. This care is in opposition to curative care, which goes into effect only after the occurrence of an illness.³⁸
3. **Curative:** Care by procedures or applications that are intended to relieve illness or injury.³⁹
4. **Rehabilitative:** Services designed to improve/restore a person's functioning; includes physical therapy, occupational therapy, and/or speech therapy.⁴⁰
5. **Palliative:** Care that is given to alleviate the symptoms of a disease without curing it.⁴¹

Another element that was considered is the point of service from where the co-operative delivered its services. These included for example:

1. Clinic or community health center
2. Hospital
3. Home-based health care services
4. Long-term care facilities
5. Ambulance or emergency services

³⁷ World Health Organization: http://www.who.int/hpr/NPH/docs/hp_glossary_en.pdf, viewed on 29/01/2007.

³⁸ Answers.Com, <http://www.answers.com/Preventive%20care>, viewed on 29/01/2007.

³⁹ Free dictionary, <http://www.thefreedictionary.com/curative>, viewed on 29/01/2007.

⁴⁰ United States Department of Health and Human Services, <http://aspe.hhs.gov/daltcp/diction.shtml#rehabilitations>, viewed on 29/01/2007.

⁴¹ Answers.Com, <http://www.answers.com/topic/palliative-care-in-medicine>, viewed on 29/01/2007.

6. Pharmacy
7. Out of establishment promotion and prevention activities
8. Others

To summarize, for each case study, the following variables were considered in the analysis of the role played by health co-operatives in the health care sector of a given country.

- 1) Three types of co-operative ownership models:
 1. User owned
 2. Multi stakeholder
 3. Provider owned
- 2) Five categories of service provision in the health sector:
 1. Promotion
 2. Preventive
 3. Curative
 4. Rehabilitative
 5. Palliative
- 3) Point of service delivery:
 1. Clinic or community health center
 2. Hospital
 3. Home-based health care services
 4. Ambulance or emergency services
 5. Long term care facilities
 6. Pharmacy
 7. Out of establishment promotion and prevention activities
 8. Other

Data Collection

Much of the research process consisted of extensive web-based searches. In certain countries, collaboration from governmental organizations responsible for co-operatives or other co-operative organizations was obtained in order to collect information on existing health co-operatives. It was an important part of the success of the data collection process⁴².

This study involved the collaboration of important organizations and members of the IHCO, who were responsible for the data collection and production of case studies for their respective areas. The Canadian representative assured the coordination of the entire project as well as the data collection for part of North America (Canada and USA) and Africa.

The case studies provide a window into how co-operatives contribute to the provision of health care services in different countries and different national health care systems.

⁴² We can find the specific acknowledgment in every case study that has been realized in this project.

ANNEX 1

Statement on the Co-operative Identity

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 values 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 capital 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; benefiting 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 to 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, 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.



ANNEX 2

United Nations Millennium Development Goals

What they are⁴³

At the Millennium Summit in September 2000 the largest gathering of world leaders in history adopted the UN Millennium Declaration, committing their nations to a new global partnership to reduce extreme poverty and setting out a series of time-bound targets, with a deadline of 2015 that have become known as the Millennium Development Goals.

The Millennium Development Goals (MDGs) are the world's time-bound and quantified targets for addressing extreme poverty in its many dimensions-income poverty, hunger, disease, lack of adequate shelter, and exclusion-while promoting gender equality, education, and environmental sustainability. They are also basic human rights-the rights of each person on the planet to health, education, shelter, and security.



Goal 1: Eradicate Extreme Hunger and Poverty



Goal 2: Achieve Universal Primary Education



Goal 3: Promote Gender Equality and Empower Women



Goal 4: Reduce Child Mortality



Goal 5: Improve Maternal Health



Goal 6: Combat HIV/AIDS, Malaria and other diseases



Goal 7: Ensure Environmental Sustainability



Goal 8: Develop a Global Partnership for Development

The world has made significant progress in achieving many of the Goals. Between 1990 and 2002 average overall incomes increased by approximately 21 percent. The number of people in extreme poverty declined by an estimated 130 million. Child mortality rates fell from 103 deaths per 1,000 live births a year to 88. Life expectancy rose from 63 years to nearly 65 years. An additional 8 percent of the developing world's people received access to water. And an additional 15 percent acquired access to improved sanitation services.

But progress has been far from uniform across the world-or across the Goals. There are huge disparities across and within countries. Within countries, poverty is greatest for rural areas, though urban poverty is also extensive, growing, and underreported by traditional indicators.

Sub-Saharan Africa is the epicenter of crisis, with continuing food insecurity, a rise of extreme poverty, stunningly high child and maternal mortality, and large numbers of people living in slums, and a widespread shortfall for most of the MDGs. Asia is the region with the fastest progress, but even there hundreds of millions of people remain in extreme poverty, and even fast-growing countries fail to achieve some of the non-income Goals. Other regions have mixed records, notably Latin America, the transition economies, and the Middle East and North Africa, often with slow or no progress on some of the Goals and persistent inequalities undermining progress on others.

⁴³ <http://www.unmillenniumproject.org/goals/index.htm>