An excerpt from:
Better Health & Social Care: How are Co-ops & Mutuals Boosting Innovation & Access Worldwide?
An International survey of co-ops and mutuals at work in the health and social care sector (CMHSC14)
Volume 2: National Cases

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

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HEALTH SYSTEM

Health care in the United Kingdom is a devolved system, meaning that England, Northern Ireland, Scotland, and Wales have their own systems of publicly-funded health care. Even if there is some variety in these systems, each country provides public health care free of charge to all UK permanent residents. The system has been paid from general taxation since its implementation in the 1940s (based on the Beveridge Report). The private health care sector is smaller than the public one. Over the last years, however, a huge top-down reorganization has altered the way the National Health Service (NHS) in England organizes service. New organizations have been established, like the Clinical Commissioning Groups (CGGs), which oversee the delivery of most of the hospital and community NHS services in the local areas for which they are responsible.

Prior to the establishment of the NHS, health care and social services were provided by a combination of philanthropic organizations, State poor-law institutions, and working class self-help and mutual aid (mainly friendly societies, cooperatives, and trade unions).[2] Friendly societies, the most widespread type of organization, provided mutual insurance and in some cases, medical coverage.

The first cooperatives and trade unions appeared over two centuries ago and often used friendly societies as a legal structure. Their impact on health care provision was minimal, however.

Population (in thousands): 62,783

Population median age (years): 40.07

Population under 15 (%): 17.54

Population over 60 (%): 23.06

Total expenditure on health as a % of Gross Domestic Product: 9.4

General government expenditure on health as a % of total government expenditure: 16.1

Private expenditure on health as a % of total expenditure: 17.5

In the UK, cooperatives do not have a single legal structure. Co-operatives UK, the leading trade association for cooperatives there, defines the cooperative as a form of mutual aid association: "Mutuals are organisations majority owned and controlled by their members on a fair and equitable basis. Co-operatives are part of this family of businesses alongside building societies, mutual insurers, and employee owned businesses. What distinguishes co-operatives is their adherence to a set of internationally agreed [International Co-operative Association, ICA] values and principles]."[3] The recent rise of social business, public service mutuals, and employee-ownership, due to David Cameron's "Big Society" program, and the historic lack of a single legal structure for cooperatives, has contributed to the emergence of a diverse landscape of cooperatives and mutuals in the UK.

Six legal forms have been used to register cooperatives:[4] Society (Co-operative Society or Community Benefit Society), Company Limited by Guarantee (typical form for the non-profit sector), Company Limited by Shares, Community Interest Company Limited by Guarantee, Community Interest Company (CIC) Limited by Shares, or a Limited Liability Partnership. A significant number of health care and social care organizations are registered as Community Interest Companies. This legal form, introduced in 2004, is designed for social businesses. It imposes an asset lock and a requirement to confirm and report upon a community-driven purpose. Membership and representation are not mandatory in a Community Interest Company, but they can be implemented.

In 2012, health and social care cooperatives (including daycare, nurseries, foster care, and other types of social care services not included in this study) represented 1.8% of the total turnover of the cooperative economy and 5.5% of the total number of cooperatives in the UK.[5] Whereas the UK health and social care economy increased by 19.2% 2008-2010, the cooperative health and social care sector slightly decreased over the same period (-0.7%).[6]

HEALTH COOPERATIVES

Health care and social care cooperatives did not emerge in the UK until the second half of the 20th century. Producer-owned cooperatives were the principal organizational form of cooperatives that developed in the 1980s and 1990s. The emergence of health cooperatives was a response to health care reforms and a desire on

the part of general practitioners (GPs) to join together and share their out-of-hours (OOH) duties. (Until 1995, GPs were responsible for providing care to their patients around the clock.) Beginning in 1995, it became increasingly common for OOH GP practices to be based on the model of the worker cooperative.

GP Practices are family doctors who join together to create a practice contracted for its services by the National Health Service. OOH GP Practices provide primary health care services in the evenings and weekends as well other community health care services. They can also offer telephone advice, home visits to patients, and primary care centres with or without walk-in services. By the late 1990s, OOH GP cooperatives had become a popular form of self-organization for doctors, with about 300 organizations across the UK and 30,000 doctors in the early 2000s.[7] However, in 2004 a reform shifted the out-of-hours services away from doctors to Primary Care Trusts that commissioned services locally.[8] With this transfer of service responsibility to diverse providers (including the private sector), GP cooperatives declined. Many physicians opted to relinquish the responsibility of 24-hour care; some GP cooperatives found themselves underpriced by the private sector.[9]

This new context led to a transformation of the sector: some GP cooperatives remained or joined other cooperatives to create bigger entities (e.g., Local Care Direct, which formed from the merger of seven GP cooperatives in 2004).[10] Other GP cooperatives expanded to include a wider range of provision. The majority either disappeared or consolidated. Social enterprises specializing in OOH services and other community health services emerged as well.[11]

A social enterprise is an organization with social aims which reinvests its financial surplus in the enterprise. Some social enterprises in the health care sector follow the membership and governance model of cooperatives, and for this reason were included in this survey. The recent rise of social enterprises in the health care sector is due mainly to the NHS' reform agenda to use the private and third sectors to deliver public services.[12]

One interesting initiative promoted by the NHS in 2010 gave Primary Care Trust staff the option to set up social enterprises and favour community-based approaches to health care. This initiative (presented through the programme "The Right to Request") was a way to encourage staff creativity and local community responsibility.[13] It enabled NHS staff to create mutuals and spin out of the public sector. The government's support of independent, employee-owned enterprises led to a rapid expansion of public service mutuals which follow some of the principles of cooperativism (e.g., user/producer ownership, reinvestment of surplus).

This study identified 20 health cooperatives in the UK. A majority are member-based and -governed social enterprises or non-profits and put a strong emphasis on the role of the members in governance. Eleven of these organizations are producer-based cooperatives (either individual workers or GP practices are members) while nine are based on multistakeholder memberships (e.g., workers, GP practices, users, other local organizations).

The cooperatives provide and combine a diversity of health and social care services: out-of-hours services, emergency care, primary care, minor surgery, dental care, NHS 111 service,[14] and preventive primary care (vaccinations, prenatal care, weight loss, tobacco use, etc.). Nine organizations provide out-of-hours services along with other medical care.[15] Some cooperatives possess their own facilities, like primary care centres, GP-led centres, and walk-in centres (which do not require appointments). One cooperative operates a wholesale pharmacy business.

With 187,000 to 1,500,000 potential users in their respective areas, the cooperatives included in this study vary greatly in size. The oldest organizations are also the largest: usually GP cooperatives that expanded and consolidated into broader social enterprises after 2004. Some of these organizations are public health mutuals or former NHS Primary Care Trusts, like Central Surrey Health and SeQUol.

Health Cooperative Data

Number of cooperatives	20
Types of cooperative	Producer (11) Multistakeholder (9)
Number of members	Over 3,320 members, according to the data collected for 10 out of 19 cooperatives
Number of employees	About 6,280 employees, according to the date collected for 11 out of 19 cooperatives
Users	About 9,484,652 potential users, according to the data collected for 16 out of 19 cooperatives
Facilities	27 Primary Care Centres, 3 walk-in centres, 6 GP-led Practices, 4 community hospitals, 1 pharmacy, according to the data collected for 16 out of 19 cooperatives
Services offered	Illness prevention Wellness and health promotion Treatment and cure Rehabilitation
Annual turnover	About $330,579,000 USD (198,010,914 GBP) according to the data collected for 16 out of 19 cooperatives

Case Study

The mission of **Willow Bank Partnership CIC** is "to promote and improve for the public benefit the health, life-chances and economic and social well-being of people living and working in areas where the Company operates." Its main activity is the delivery of health care services in the community, delivering care which addresses the determinants of health, often in partnerships with other organizations which share Willow Bank's values and social purpose.

Willow Bank was formed in 2006 in response to the Department of Health's Social Enterprise Pathfinder initiative. At that time the team were employed by the NHS to deliver primary care services to vulnerable people: the homeless, substance misusers, and others who had difficulty engaging with traditional GP practices, for example. Under the Pathfinder scheme, the staff, together with two partners, Stoke-on-Trent Gingerbread (a local charity specializing in supporting homeless single parents) and Change Through Partnership (UK) Ltd (former NHS senior managers) formed the social enterprise using cooperative principles. Over 9,000 patients are registered at Willow Bank in 2014 – a significant growth since 2006 when 2,500 patients were using its services.

Willow Bank's governance structure reflects staff and community interests. A majority of board members are staff directors, elected on 2- or 3-year cycles. There is a director position reserved for patients and founding partners. (At the moment the organization is even chaired by a patient.) All profits are reinvested in the organization or to benefit local communities. Unlike other primary care organizations, which usually are established under a for-profit partnership model, all Willow Bank staff are salaried, including the GPs.

Willow Bank invests a good deal of its time in developing partnerships with other organizations, which in turn makes it possible to trial innovative service delivery models. For example, with partners in the community and with the support of the chair, Willow Bank has been the first in the UK to implement a screening and treatment program for South Asian communities at risk of hepatitis C.

Willow Bank recently won a prestigious grant to explore how services can be commissioned to support the efforts of families to achieve better health and social care outcomes. It is one of the highest achieving GP practices in the city of Stoke-on-Trent in terms of health outcomes.

SOCIAL CARE COOPERATIVES

Although social care can also be provided by health cooperatives (e.g., prevention services, palliative care, etc.), some cooperatives specialize in social care and focus on a target population (e.g., the elderly or people with disabilities) or specific services (e.g., alternative therapy, palliative care).

At the beginning of the 1990s, health and social care services in the UK started shifting away from care in large institutions to community-based services.[16] The NHS and Community Care Act, passed in 1990, stated that local authorities were responsible for assessing and providing social care needs for their populations by purchasing services from the independent sector, rather than by providing care themselves.[17] This legalization "diversified the provision of a wide range of social care services from the public sector to the third sector and the private sector,"[18] which led to the creation of a number of social care cooperatives. According to a recent study on care services in the UK, social care cooperatives represent under 1% of the social care market.[19]

Recently, Scotland and Wales and initiated projects and policy changes to support the growth of social care cooperatives. In 2013, a cooperative development programme was set up in Edinburgh to support Scotland's sector of health and social care co-operatives.[20] In Wales, the Social Services and Wellbeing Act was passed in 2014 to promote and support social enterprises, the third sector, and cooperatives.[21]

This study identified 26 social care cooperatives. About half are producer-based. The other half is characterized by multistakeholder membership (staff, users, and their families can become co-op members). They are organized as social enterprises or non-profits. A majority of social care cooperatives provide domiciliary services to seniors and the disabled: health-related assistance, help with domestic chores, shopping, and washing, for instance. Two of them also provide nursing homes. Therapy services (e.g., alternative therapy targeting children) and acupuncture are two other types of service which these cooperatives provide. They range in size from small organizations with less than 10 members to larger cooperatives with 300 or as many as 800 members.

Social Care Cooperatives Data

Number of cooperatives	26
Types of cooperative	Producer (12), Multistakeholder (14)
Number of members	Over 2,347 members[22]
Number of employees	Over 2,022 members[23]
Users	N/A
Facilities	N/A
Services offered	Illness prevention; Wellness and health promotion; Treatment and cure; Rehabilitation
Annual turnover	Over $56 million USD (34 million GBP)[24]

Case Study

Care Plus Group is a social enterprise that provides adult health and social care services for the communities of northeast Lincolnshire, a "densely populated area but geographically isolated."[25] Care Plus offers nursing services, specialist nursing, palliative care, domiciliary care, psychological services, meals on wheels, employability, and other social care services. It was set up in 2011 as a Community Benefit Society (a form of a cooperative business) and employs over 800 staff.[26]

Care Plus is a multistakeholder cooperative, owned by its staff and stakeholders. Every worker has a vote as do community members. It has an innovative governance structure that reflects the culture change that has seen some public organizations, namely mutuals, shift over to the third sector under the "Right to Request" law: "The culture change [...] involves becoming aware that there is not simply an entitlement to an annual pay increase for continuing to do the same job. If the business is to prosper, pay increases need to be based on an element of performance, cost and efficiency savings."[27] Quality care, cost efficiency, growth, governance and leadership, and an engaged workforce are the six strategic goals of the cooperative.

Pat Conaty describes the governance of Care Plus Group in his recent study of social care cooperatives:

> "Care Plus Group has a two-tier board comprising a Council of Governors responsible for the strategy of the mutual and a board of directors responsible for the operations. [The workers] elect eight staff governors. Two further governors are appointed by the local authority, two governors by GPs and three governors by community group members. The board of directors includes four non-executives (one of whom is the chair) and three executive directors including the chief executive of the mutual. The Council of Governors is the body that both appoints and removes the chair of the board and the other non-executive directors as well. A Community Forum recruits members from service users, carers, volunteers and other local health community people."[28]

PHARMACY COOPERATIVES

Social pharmacies, organized as cooperatives, exist in the UK. The four organizations identified in this study are all part of wider retail groups: The Cooperative Group, The Midcounties Co-operatives, East of England Co-operative Society, and Lincolnshire Co-operative. At the time of writing (May 2014), The Cooperative Group is selling its pharmacy branch, The Co-operative Pharmacy (the largest cooperative pharmacy), due to recent poor financial results.

The four pharmacies are user-based cooperatives. Three of them operate on a mid- to large-scale, with 45 to 750 shops in the UK. The fourth cooperative operates on a smaller scale with eight pharmacies. Over 851 pharmacy cooperatives are active throughout the UK. Two of the cooperatives have an online retail website. Two pharmacies offer their customers private consultation rooms.

Pharmacy Cooperatives Data

Number of cooperatives	4
Types of cooperative	User (4)
Number of members	N/A
Users	N/A
Facilities	Over 851 pharmacies
Annual turnover	Over $1.344 billion USD (805 million GBP)[29]

HEALTH MUTUAL ORGANIZATIONS

Six major health insurance mutuals were identified in the UK. Five are registered as mutual friendly societies, and the sixth is registered as an Industrial and Provident Society. They provide complementary health plans and insurance to 5-6 million customers. They also offer a range of products for individuals and businesses: health cash plans, dental insurance, health plans for the elderly, and personal health insurance. The services covered include in-patient and day-patient treatment, out-patient treatment, cancer treatment, private ambulance, home nursing, therapy, or physiotherapy.

Health Mutual Organizations Data

Number of cooperatives	6
Types of insurance	Complementary (6)
Users	5-6 million
Facilities	1 hospital trust
Annual turnover	About $1.012 billion USD (606 million GBP) in 2012

Case Study

Benenden Health is a not-for-profit business with a membership of around 900,000 people across the UK. It offers health care services that complement rather than replace the care offered by the NHS. In 2013, Benenden Health provided more than $105 million USD (63 million GBP) in health care services to its members. Monthly subscriptions cost only $13.67 USD (8.19 GBP) per person, and

members can request a range of health care services and treatments. There are no exclusions for pre-existing medical conditions and no upper age restrictions.

Benenden Health was founded in 1905 by a post office worker, Charles Garland, in order to help post office employees affected by tuberculosis. Almost immediately, 30,000 fellow workers joined the scheme. In 1907 Benenden Hospital was opened in Kent. In May 2014, a $75.13 million USD (45 million GBP) redevelopment of the same hospital was launched. In January 2013 Benenden Health opened up its membership to any UK resident aged over 16. Previously, members of Benenden Health had to be current or former public sector workers, or members of a range of other eligible organizations.

Being a mutual makes Benenden Health a different kind of health care provider: Benenden Health is not a private medical insurer but a not-for-profit health care organization that provides members with health services that are complementary to the NHS. Members are at the center of Benenden Health and can have a say in how the mutual is run. Benenden members elect delegates at the branch level to represent them at the organization's annual conference, at which the Society's major policies must be approved.

Whenever waiting times in the NHS are too long, members can instead request quicker treatment or diagnosis via Benenden Health. As well as serving its members well, this means that Benenden Health is helping to relieve the rising pressure on the NHS.

SOURCES

[1] A more detailed version of this case is available upon request. Thanks go to the following for their collaboration: Marc Bell, Blandine Cassou-Mounat, Pat Conaty, Geraint Day, Mo Girach, Karen Hassell, Ed Mayo, Martin Shaw, Liz Watson, and the UK Health and Social Care Information Center.

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[14] This is a telephone medical counselling service provided on behalf of the NHS.

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[20] Conaty 2014.

[21] Conaty 2014.

[22] According to the data collected for 10 out of 27 cooperatives.

[23] According to the data collected for 7 out of 27 cooperatives.

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[25] Conaty 2014.

[26] Care Plus Group. 2014. "About us". Webpage. Retrieved May 31, 2014 (http://www.careplusgroup.org/pages/about-us).

[27] Conaty 2014.

[28] Conaty 2014.

[29] According to the data that was collected for two out of four cooperatives.