IHCO Report 2017

Assessing the worldwide contribution of cooperatives to healthcare

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

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To the memory of † José Carlos Guisado.

EXECUTIVE SUMMARY

The transformation of health care systems: Main trends and challenges

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

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

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

The systems identified are the following:

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

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

Key problems and challenges faces by the health sector

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

difficulty to contain rising health costs.

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

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

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

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

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

The progressive revival of health cooperatives

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

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

IHCO research aims and outcomes

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

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

Research Methods

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

Research findings

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

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

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

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

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

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

* Estimates

** Source: World Bank

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

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

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

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

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

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

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

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

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

health cooperatives tend to fill gaps left by other actors.

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

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

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

Mutual aid societies

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

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

Worker and producer cooperatives

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

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

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

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

User cooperatives

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

Inclusive-multi stakeholder cooperatives—Community-based cooperatives

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

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

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

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

Cooperative competitive advantages in the health domain

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

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

Increase accessibility of health services

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

Capture and meet new needs arising in society

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

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

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

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

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

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

Support organizational innovation

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

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

Country case studies based on selected types of health cooperatives

Belgium: Mutual aid societies

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

Brazil: Unimed, the largest health cooperative in the world

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

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

Canada: Examples of health cooperatives from Canada

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

Japan: Health and elderly care cooperatives

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

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

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

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

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

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

Closing remarks and perspectives

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

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

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

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

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

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

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

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

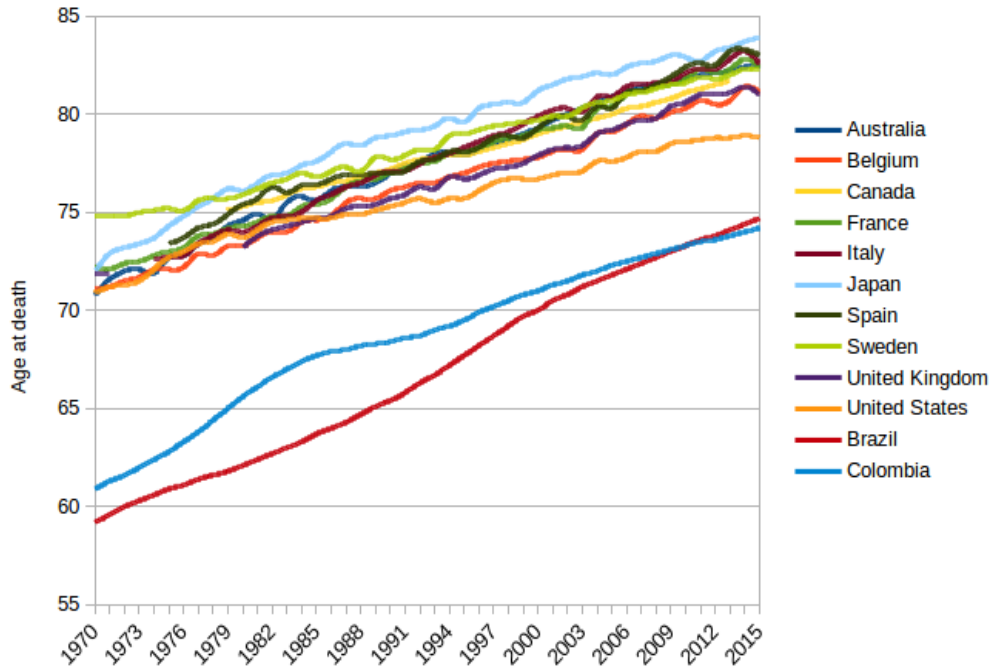
The economic literature corroborates that the health domain typically faces several potential market failures, such as the inability to pay for services and the information asymmetry between the insurers and the insured and between patients and physicians. This explains the dominance of non-profit organizations,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

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

of private health systems with only basic health services being ensured by public policies targeting low-income groups. As highlighted by this report, mutual societies and cooperatives cover diverse roles and have different relevance in each health system.

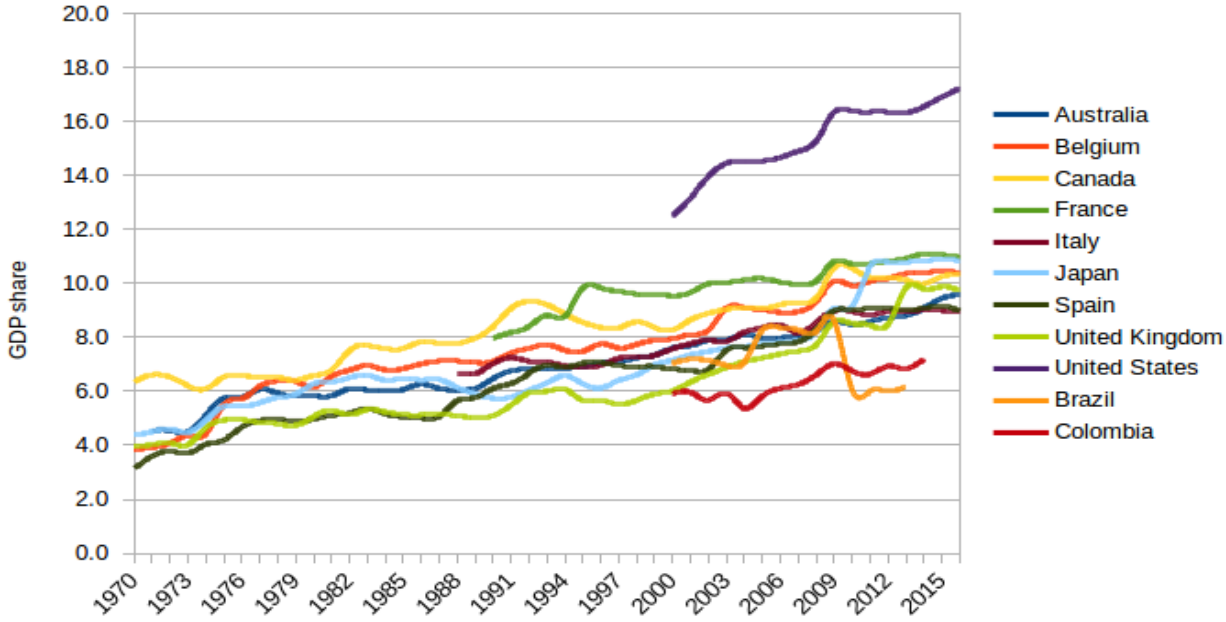
Over the past few decades, tension has been growing in health systems worldwide, mainly due to the dramatic growth of the imbalance between the demand for and the supply of health services. The demand for health services has been boosted mainly by extended life expectancy and people's increasing attentiveness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

Figure 1. Life expectancy at birth



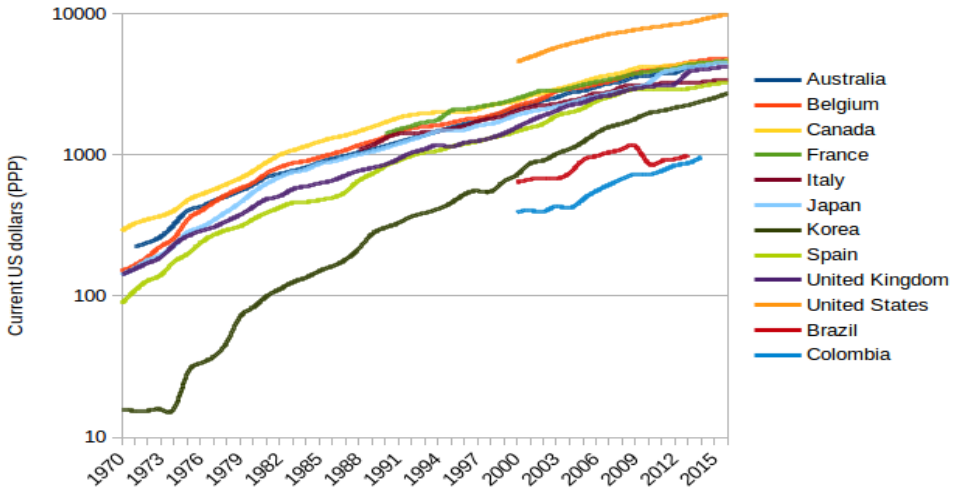
Source: OECD, 2017

Figure 2. Health expenditure (% of GDP)



Source: OECD, 2017

Figure 3. Health expenditure (per capita)



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

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

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

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

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

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

Key problems and challenges faced by the health sector

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

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

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

Gaps in health service delivery have various implications:

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

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

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

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

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

The progressive revival of health cooperatives

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

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

Chapter 2. IHCO research aims and outcomes

Research aims

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

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

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

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

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

Research Methods

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

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

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

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

Table 2. ISIC rev. 4 in the health sector

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

Data analysis was based on the collection, aggregation and synthesis of already existing data, statistical and research reports, scientific papers, online databases and data provided directly by the organizations studied. Several possible data sources, both statistical and administrative, were taken into consideration. These included:

[2] https://unstats.un.org/unsd/cr/registry/isic-4.asp

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

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

Table 3. Data sources

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

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

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

[3] www.bccm.coop
[4] www.inami.fgov.be/fr/Pages/default.aspx
[5] www.mc.be
[6] www.ocm-cdz.be
[7] www.ophaco.org
[8] www.rais.gov.br/sitio/index.jsf
[9] www.ic.gc.ca/eic/site/693.nsf/eng/h_00037.html
[10] www.confecoop.coop
[11] www.cncres.org
[12] www.istat.it
[13] www.bvdinfo.com/en-gb/our-products/data/national/aida
[14] www.sncf.coop
[15] www.bvdinfo.com/it-it/our-products/company-information/national-products/sabi
[16] www.scb.se/en_/Services/Statistics-Swedens-Business-Register/
[17] www.uk.coop

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

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

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

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

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

Worldwide analysis of healthcare systems

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

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

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

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

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

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

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

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

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

Table 4. Classification of national health systems

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

Health cooperatives are widespread in all countries studied

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

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

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

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

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

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

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

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

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

* Estimates

** Source: World Bank

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

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

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

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

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

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

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

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

Table 6. Role of health cooperatives in the studied countries

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

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

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

Table 7. Health cooperative models in the studied countries

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

United Kingdom	General practice activities	Private insurance

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

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

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

Worker and producer cooperatives

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

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

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

Workers from many of these organizations have started to reactivate their services, in some cases, thanks to the help of the communities of reference. For instance, we have identified 15 such worker-recuperated enterprises.

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

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

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

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

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

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

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

User cooperatives

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

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

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

Agricultural cooperatives

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

Mutuals

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

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

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

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

Inclusive-multi stakeholder cooperatives—Community based cooperatives

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

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

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

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

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

Health cooperatives are on the rise

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

Chapter 3. Cooperative competitive advantages in the health domain

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

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

Increase accessibility of health services

Cooperatives are, in many instances, set up specifically to increase the accessibility of health services to poor stakeholders and marginal or peripheral communities, thus significantly contributing to reducing health inequalities. In these cases, health cooperatives provide poorer stakeholders or the entire community with the opportunity of transacting on favourable terms with the organization. The cooperative ‘open door’ principle is, in this respect, crucial to ensuring greater participation among

interested stakeholders. These types of health cooperatives are more often supported, if not set up, by volunteers.

Capture and meet new needs arising in society

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

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

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

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

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

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

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

Support organizational innovation

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

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

Closing remarks and perspectives

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

The widespread and global development of health cooperatives confirms the key role played by the various cooperative forms in empowering users, especially the most disadvantaged ones. There is also a growing tendency to move towards a multi-stakeholder model, where various typologies of stakeholders are involved in the governing bodies of the cooperatives. At the same time, there has

been an important emergence of organizations that perform like cooperatives, though they are not legally designated as cooperatives. This is the case, for instance, of associations in many countries, which could easily shift towards a stronger entrepreneurial stance and assume the cooperative form. This evolution has happened in Italy, thanks to a particularly enabling environment.

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

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

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