

Innovative Approaches to Co-operation in Health Care and Social Services

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Introduction

In recent years, the health care and social service sectors have experienced a significant increase in the number and forms of co-operation. At the same time, the financial volume of these sectors has grown worldwide at a fast pace, a phenomenon which is often described in a simplified way as the "cost explosion" in the health care sector. In the world's largest national health sector, the USA, the financial volume is estimated at 14.5 per cent of GDP, while on average the total health expenditure is estimated at 9 per cent of the world's GDP, with great variations between developing and industrialised countries. Most countries of the world have seen a growing trend in employment in this sector; it was estimated in 1992 to employ 35 million people worldwide. As well as the increase in employment, the structure of employment is also changing considerably. Among the reasons for these changes, the main factor seems to be demographic pressure consisting - depending on the region - either of population growth or substantial changes in the age structure of the population.

An analysis of the impact of various forms of co-operation in the health care and social services sectors has to distinguish between the expectations of the persons concerned and those of the state. The analysis of both sides may, however, lead to the conclusion that there is an intersection of interests and a potential for partnerships between both sides. This paper intends briefly to describe some different co-operative approaches in various countries. It then uses these to illustrate how co-operation has an impact on:

- The quality of, and access to, health care and social services
- employment and working conditions of personnel in these sectors
- the general level of employment at local and national levels
- the expectations of the state and the citizens of a country regarding the health and social system
- the identity and functioning of such co-operatives.

According to the definition of the World Health Organisation, health is a state of physical, mental and social well being. In this regard, the rapid increase of health care costs, accompanied by pressure to keep down the level of public and private expenditure on health care, have led to a greater awareness of the inter-linkage between social services and health care. There is a growing belief that improved social services can stem the steady growth in costs of health care, since it is assumed that social problems often underlie certain health risks such as stress and drug abuse. Thus, in many countries there are public programmes emphasising preventive and primary health care, including better awareness of the dangers of HIV, drug and alcohol abuse, and more healthy lifestyles based on nutrition and exercise. The result has often been an integration of the programmes and work of the social services and health care sectors. For the purpose of this paper, therefore, both sectors will be considered jointly. Also, for the purposes of the paper, the various forms of co-operatives will be understood in line with the definition of the International Co-operative Alliance (ICA) and the International Labour Organisation (ILO). Despite some nuances, the ICA and ILO both see co-operatives as associations of persons who have voluntarily joined together to achieve a common end through the formation of a democratically controlled organisation, making equitable contributions to the capital required and accepting a fair share of the risks and benefits of the undertaking in which the members actively participate. Such co-operatives may also be named self-help organisations (SHO) and mutuals.

Examples of co-operation in health care and social services

The most comprehensive description and analysis of the various forms of co-operation in health care and social services was published in 1997 by the United Nations (UN) Department for Policy Co-ordination and Sustainable Development¹. Besides numerous examples and worldwide statistics, the merit of this UN study lies in establishing a typology of different forms of co-operation. The study distinguishes between those co-operatives whose operational goals are solely concerned with health care and social services and those which include such activities in their multipurpose functions or give support to health care and social service co-operatives. The study also introduces the distinction between organisations that are operated by the users of the services and those run by the providers or by both. Many of these approaches have only emerged in the last decade and the assessment of their success is still preliminary. Other forms of co-operation can look back on a century of history

and can be called "innovative" in view of their creative development and the fact that their success became known to larger circles only in recent times. Nevertheless, there are also forms of co-operation which are not yet reflected in this study, since they have developed in response to more recent health care sector reforms. Examples of the various forms of co-operation will be described in this paper and will serve as illustration of the impact of co-operation on health care and social services.

Japan: Health Co-operatives²

Japan has the most extended and developed co-operative system in the health care sector. The system emerged in the beginning of this century first within the agricultural co-operative movement and later also in the urban consumer co-operative movement. Due to a lack of a national social security system until the early 1960s, the poorer section of the population had no access to the mainly private medical services, and thus out of their needs created the co-operative movement in the area of health care. With the later introduction of a general social security system covering the whole national population, it was expected that the activities of health co-operatives would become redundant. Surprisingly, this development did not take place, and the health co-operatives have adjusted to the changed situation by putting more emphasis on providing preventive services, treating geriatric and chronic diseases, and on improving the general health of the community. They have made it their task to evaluate living and working conditions, to develop programmes for health education and to propagate healthy lifestyles. Following the restructuring of the Japanese public health and social insurance system in the late 1980s, the co-operatives had to adjust to the decentralisation and reduction of public expenditure on health care. In order to balance the loss of income through payments from the public insurance system for their services, the co-operatives tried to offer increasingly those types of services which were not covered by the public system but for which a demand existed among their members. These services included, in particular, activities for health promotion and medical check-ups.

The number of health co-operatives has continued to increase in recent years. For example, there were 125 health co-operatives registered within the Japanese Consumer Co-operative Union (JCCU) in 1998, compared to 118 in 1995. They operate 80 hospitals and 246 clinics with about 13,000 beds. The co-operatives employ about 20,000 persons, out of whom 1,600 are physicians

and 9,000 nurses, and 95 per cent of the total income is derived from payments by the public social security system for services provided by the co-operatives; in 1998 this amounted to 22,7 billion Yen. Regarding the organisational structure of these co-operatives, the Han Groups are of particular interest. They are member groups from within the health co-operatives; at least three members of the same local area get together to monitor and to improve their health situation and therewith contribute to the achievements of the co-operative's general objectives. In the context of these Han Groups, extended educational activities in various areas take place. Membership in Han Groups is not obligatory (about 30 per cent of health co-operative members are organised in such groups), however, they facilitate members' participation in medical treatment and in the management of their health institutions.

The health institutions belonging to the agricultural co-operatives, to which practically all rural households adhere, are even more extensive: in 1995 they owned 115 hospitals, 57 clinics and rural health centres with about 38,000 beds. Employment counted for 38,000 persons, with 3,200 physicians and almost 19,000 nurses. These institutions are organised under the umbrella of the "National Welfare Federation of Agricultural Co-operatives". The health SHO are named "Koseiren". They work together with an insurance system of mutuals and seek nowadays collaboration with local authorities to which the responsibility for health care has been devolved in the course of the decentralisation of public authorities. The co-operatives have contributed significantly to the development of health care and social services in the rural areas.

Brazil: UNIMED co-operatives of the providers of health care services³

The largest system of medical provider co-operatives is to be found in Brazil: UNIMED. The beginnings go back to the year 1967, when it was decided to extend the social security system to the whole population. Since the financial resources of the state were not sufficient to fulfil its legal obligations, the state offered all private employers a 5 per cent topping-up of the minimum salary of their employees if enterprises made available health care services to their workers and their families. This situation led many private providers to enter the health care market, which was previously dominated by the public service. At that time, the first UNIMED co-operative was founded by physicians in search for health care that would foster the ethics and social role of medical science, and protect the liberal practice of this profession and quality of service.

In 1999, 95,000 doctors (about one third of the country's physicians) were members of UNIMED. About 366 primary "worker co-operatives" count among their members independent physicians as well as group practices. The co-operative system, which also operates 42 hospitals, provides services to about 11 million people. Currently, the co-operatives provide their services in 4,000 municipalities (about 80 per cent of the whole country). The "UNIMED Co-operative Business Complex", as the system calls itself today, also includes 120 loan and credit co-operatives (UNICRED - providing credit to the providers and the co-operatives), 15 user co-operatives (USIMED - providing medicines at reduced prices, home care and a range of medical and health care services) and supporting insurance companies known as UNIMED Seguradora which are among the 10 leading health insurances of Brazil. The UNIMED system has also expanded into partnerships beyond the Brazilian borders, and its model is used also in Paraguay and Colombia to create provider co-operatives. The services are also rendered to Brazilian UNIMED members during their stay in these countries.

United Kingdom: Co-operative health care and social services⁴

Since the 1990s, an increasing number of co-operatives in the United Kingdom (UK) provide health care and social services. This development is mainly due to outsourcing in the area of social services where services had previously been delivered by public providers. Contracts to purchase such services are concluded with local governments or institutions of the national health system. Even though many medium sized providers enter this new market, it also appears to offer sufficient scope to small individual providers and groups of providers to make available the large variety of services required. Following the "Griffith Report" in 1988 and the Health Services and Care in the Community Act in April 1993, health care policy has shifted from care in large institutions to community based services. The responsibility for health care services has been transferred from the Department for Social Security to the local authority social services departments, which in turn have undergone major restructuring and decentralisation for this purpose. Besides other providers, co-operatives have mainly focused on child care, and the care of the mentally ill and physically disabled people.

In these areas, co-operatives have also developed partnerships with voluntary organisations, particularly those between housing co-operatives and home care organisations. In many cases, health care personnel have established worker co-operatives with the hope of obtaining service contracts from the local authorities. Frequently,

such smaller groupings face considerable difficulties to participate in contract tenders, as administrative requirements are often complicated. Regarding the remuneration of health care and social services personnel, there are many arguments for and against rates of pay which correspond to the respective public service pay. In most cases, local authorities' rates are used as benchmarks for payment, however, co-operatives seem to pay below these rates.

Italy: Social co-operatives⁵

Italy serves as example of an approach which endeavours to combine at the same time public and private interests as well as those of the users and providers through so called multi-stakeholder co-operatives. The Italian Co-operative Act of 1991⁶ provides for co-operative membership with diversified interests that may also include local governments as members. It is important to note Italian tradition in this respect since the constitution of the country already stipulates the solidarity of every person to another and to the community in general. Since the law is relatively recent, an assessment of the practical impact of these forms of co-operatives has to be undertaken with caution. Traditionally, Italy has had an extensive movement of worker co-operatives that have reacted to the crisis of the welfare state at local level. A considerable number of these provide social services and some also health care services. Among the various activities of social co-operatives, three main types may be distinguished (according to the regional law of Trentino-South Tirol):

- (a) "Integration Co-operatives" which offer employment to physically and mentally handicapped persons;
- (b) "Social Services Co-operatives" established by professional care workers which offer services on contact to local authorities or to users and their relatives; and
- (c) "Community or Social Co-operatives" providing welfare services and employment projects to disadvantaged groups with a large variety of membership which also include voluntary organisations, financing agencies, or public support institutions. Such co-operatives are normally small and they are organised in two federations with almost 2,000 member-societies. In total, they provide employment to about 40,000 people in Italy.

Germany: Quality circles of physicians

Germany has, compared to other countries, no significant tradition

of health care co-operatives.⁷ Apart from three pharmacist co-operatives and five physician co-operatives, no other co-operative health care activities are known. Nevertheless, other forms of self-help initiatives of users of social and health care services have developed rapidly in the last two decades. These self-help groups seek to find joint solutions for their health and social needs. In Hamburg alone, the number of such groups is estimated to be about 1,400⁸ and the total number in Germany is estimated in 1999 to be 70,000 to 100,000⁹. Such groups are often the only form of self-help known to the public. Although they contribute to the promotion of public health, they are usually not created primarily to overcome economic problems of users and providers and do not necessarily fall clearly within the definition of co-operative. Therefore they are not discussed in this paper.

In recent years, there have been a number of pilot projects in Germany which have promoted co-operation between the social security system and independent doctors associated in "quality circles". The objectives of such informal groups are to develop methods for cost containment and to test the financial efficiency of medical treatments. In the State of Hessen, about 1,000 out of 8,000 independent physicians have agreed to participate in such quality circles within the last five years.¹⁰ The public health insurer (AOK) has developed a software programme for monitoring alternative therapies, and to share with the physicians 40 per cent of the savings which the insurer expects to achieve. Such group initiatives to improve the quality of the services through quality circles (and therefore to improve the efficiency of the health system) exist also in other federal states of Germany and in Switzerland¹¹.

*France: Mutual health insurance*¹²

Mutual assistance associations or "mutuals" have developed in many countries based on the same ideas and for the same purposes as co-operatives, although in a different legal form. In many countries, a basic difference lies in the form of ownership. Unlike the co-operative, the mutual has no social capital and does not pay dividends. In the case of liquidation, the mutual's assets may often not be distributed among the members. Even though both organisational forms have kept their historical distinction, they have today established between them strategic partnerships. The ICA has admitted mutuals as members in their International Co-operative and Mutual Insurance Federation (ICMIF). In France, the first special legal code for mutuals was established already back in 1898. In the early 1990s, about 6,000 of such associations existed

in the country with 12.5 million members and 27 million insured persons. They are organised in the "Fédération nationale de la mutualité française" which covers about 60 per cent of the market for complementary health insurance. In addition to insurance services, these associations provide health care and social services through 1,300 enterprises. Their total turnover accounts for 6 billion French francs and they employ about 20,000 persons. They include 42 hospitals, 295 optical centres, pharmacies, home care and special housing for elderly or disabled persons as well as leisure and vacation centres. The mutuals supplement the French social security system. Of special importance is the insurance for public service personnel and students. In most cases, the mutuals insure persons of the same professional category or inhabitants of a certain area. The members pay either a fixed amount or a certain percentage of their income.

The experience of the French mutuals often serves as an example in proposing the introduction of "community based" health insurance in developing countries. Though this idea is frequently supported in their technical co-operation programmes by governmental and non-governmental organisations with great enthusiasm, there are also voices who warn against the spontaneous introduction of such systems. Without a solid financial basis and without evaluation of the willingness and capacity for financial solidarity of the respective community, such models may quickly turn into failure for all parties concerned.

USA: Networks of independent physicians

Without touching on the extended co-operative system of health care and social services in the USA, we will describe briefly the establishment of networks of independent physicians and their origins. Provoked by the introduction of "managed care"¹³ in the American health system, independent doctors increasingly tend to join various interest groups and networks, in order to improve their negotiating power in relation to the institutions financing health care services or vis à vis the so-called Health Maintenance Organisations (HMO). These constitute a large variety of insurance systems that, through global budgets, more or less strictly manage the medical services available to a limited population group¹⁴. Among the more structured forms of HMOs are also co-operatives. For the people enrolled in HMOs, the choice of doctors and of medical treatment is to various degrees limited, and the organisations' finance services to patients through contracts with the physicians. In most cases, these contracts are concluded on "the principle of capitation" whereby the doctors are paid a set

amount per month per enrolled person regardless of the services provided. In 1997, about 92 per cent of the independent doctors in the USA had one or several contracts with managed care companies.¹⁵ These developments have led to independent doctors joining various professional associations and also unions which traditionally were not considered "appropriate" among their professional group, but from which nowadays assistance is expected for "collective bargaining" over their contracts with the HMOs. Group practices sometimes take the form of co-operatives and professional networks, and their numbers have increased as a reaction to the business practices of HMOs.

In August 1996¹⁶, the Federal Trade Commission and the Federal Antitrust Commission issued guidelines in order to facilitate the establishment of networks of physicians without provoking conflict with antitrust legislation. These networks strive at improving the bargaining situation of the doctors in a market dominated by financial institutions or big purchasers of health care services. Such networks are accepted by the anti-trust authorities if doctors work together with the objective to improve the quality of services or to share financial risks. Price fixing agreements can be accepted if there is proof that they are of advantage to the users. The physicians expect an improved bargaining position to give them more independence in deciding on the medical treatment to be made available to a patient.

There are now pilot tests and proposals for such networks in Germany. In Berlin, a network of 570 physicians has been established covering 15,000 patients. These networks often aim at the co-ordination of medical treatment among doctors and the reduction of costs.¹⁷ Already these few selected examples show that self-help in groups (including co-operatives) in the area of health care and social services can develop a large variety of activities and organisational forms. Co-operation can take place through informal groups and networks of providers or in large and structured co-operative enterprises. All forms, whether the result of recent or older initiatives, show a strong trend towards expansion, as does the health care sector in general. In this sector, regulation is considered indispensable and management therefore faces considerable limitations. Nevertheless, it appears that there is a growing need for co-operation, and considerable creativity is underway to develop various co-operative forms.

The impact of co-operation on access to, and the quality of, health care and social services

In most countries the national health system is mainly a public

institution, however, the biggest private sector share in a national health system exists in the United States. Private health expenditure there constitutes more than half of the total national expenditure on health. In many countries, co-operatives of the users of health care services have developed mainly in situations when the access to and quality of public health care services have not been satisfactory. Like other private providers, co-operatives have begun by developing activities in those areas where the public providers have left gaps. When health care services or the finance of such services are provided by co-operatives, separate questions have to be answered, since health care and social services are of general or public interest and equal and universal access to them are considered indispensable. Thus, there is a question to be answered: *Do all inhabitants or citizens of a geographical area have access to the services when they are needed?* User co-operatives, on the basis of the co-operative principle of open membership, have to make sure that everyone who wishes can become a member and that financial barriers to becoming a member have to be removed (eg through the gradual accumulation of co-operative shares). Provider co-operatives have to ensure that all population groups have access to the services. Moreover, the question has to be put: *are the state or private providers obliged to offer the same services to persons who not are members of the co-operatives?*

In the case of co-operatives in the health insurance sector, it is also of concern whether an insured group is big enough to spread the health risk economically. The experience with privatising the health care system in Chile, in which private companies and a big co-operative (the Instituciones de Salud Previsional - ISAPRE) were involved, has shown that private insurance has the tendency to exclude certain population groups; mainly poorer sections and those exposed to higher health risks. These groups have therefore to be covered by the public health system. The costs incurred for the whole public system are in Chile estimated to be higher than those before the privatisation¹⁸.

A further issue to be considered is the following question: *Are the services which are provided by the co-operative subject to the same quality standards and controls as applied to other health care and social services providers?* As in other sectors serving the well being of society, co-operatives have to come within the oversight and regulation of the state and of professional associations, so that the technical standards of health care and social service co-operatives correspond to those of other providers. Additional to this oversight and regulation "from above and outside", the co-operative has to face control "from below and inside" through its

own members. Experience, particularly in Italy and the UK, has shown that smaller self-help organisations are more likely to enable members to be involved in such participation in the orientation of the organisation. On the other hand, the bigger and financially stronger co-operative organisations have better possibilities to hire professional technical and managerial personnel. A possible alternative may be to improve member participation in bigger co-operatives through internal subgroups. The example of the health organisations in the Japanese consumer co-operative system may serve here as illustration, since the Han Groups seem to provide the good effects of small self-help groups.

It also should be noted that new models of quality control in SHO or networks of service providers are being developed. These also involve the patients, as in a pilot project in Switzerland of general practitioners.¹⁹ The involvement of users and citizens in health care and social services varies considerably. The above mentioned UN study on Co-operative Enterprise in the Health and Social Care Sectors endeavours to provide an idea of the perceptions of different actors in various geographical regions.²⁰

Impact of co-operation on the employment and working conditions of personnel

The employment and working conditions in co-operative health care and social services are not only relevant for employees, but also have an impact on the general situation of these highly labour-intensive sectors.²¹ Hence, international and national labour standards and labour relations policies consider the working conditions of health care personnel vital to the quality of the services.²² Co-operatives of users normally conclude labour contracts with technical and managerial personnel according to the prevailing labour law and collective bargaining procedures. Even though non-governmental organisations (NGOs) are sometimes convinced that working and employment conditions have less priority than the good cause for which the organisations are working, such organisations cannot circumvent the provisions of labour law. Another question which remains to be examined is the unionisation and co-determination (collective involvement) of health care and social workers in such co-operatives, since these aspects impact considerably on working conditions.

Compared to the situation of user co-operatives, the case of provider co-operatives needs more detailed examination. The situation is often complex. The personnel who are hired by a co-operative are certainly, as in the above mentioned case, subject

to the current labour law. The Italian social co-operatives are obliged to apply even to voluntary unpaid collaborators the same legal provisions as to paid employees, especially in view of occupational safety and health regulations. On the other hand, members of provider co-operatives (worker co-operatives) are often classified as independent workers. In this case, the provisions of labour law which apply to employees are applicable to the members only in respect of occupational safety and health, social security and health insurance.²³ Also, this form of co-operative may face particular financial problems. Due to the limited financial reserves of such co-operatives, the members often accept income and working conditions that do not reach the standards applied to employed health care and social service personnel. Moreover, provider co-operatives have to face the question whether members' income is sufficient to interest qualified persons to join and to remain in their co-operative. This is of concern to technical and managerial staff. Co-operative members might also have motives other than financial ones to join and to remain, but for the sustainability of the co-operative it is important that the members do not have to seek other sources of income that would further weaken the financial situation of the co-operative. If such a co-operative also employs non-members, rather complicated situations of co-determination and labour relations are to be expected.²⁴

The contribution of co-operation to local and national employment

The impact of co-operatives on employment, and the factors influencing this impact, are documented in a great deal of literature. Sufficient financial and human resources, an appropriate organisational structure and a sympathetic policy environment appear to be the main conditions serving to benefit local and national employment.²⁵ The fact that co-operatives contribute to improving the employment situation is widely recognised, but there is little known on the extent of their contribution. For the purpose of this analysis, direct job creation (for employees of co-operative enterprises and for members of production co-operatives) would have to be distinguished from the indirect impact on employment which derives from the fact that self-employed workers and small entrepreneurs are often only able to be active economically through the structure of their co-operatives.²⁶ A comprehensive study on different forms of co-operation in Europe and their impact on employment was carried out in 1996 by Hans Westlund and Stig Westerdaahl of the Swedish Institute for Social Economy²⁷. With support from the European Commission, they examined 20 cases

from almost all countries of the European Union. Among these cases were self-help organisations active in social services. The impact on employment was rated in all cases to be positive and particularly high in the area of social services. In some cases, the growth rates of employment were spectacular, even though the absolute figures may not appear very high since only 20 individual cases were investigated. These high growth rates are surprising, as this development coincided with a general decline in employment in the EU during the 1990s. Strong growth has been related by the study to strong local links of the SHO in those areas that were neither covered by public nor other private providers. In the view of the study, the participation of voluntary workers has been of financial advantage to the SHO. However, the study did not include any cases in the area of health care.

In some countries, there are special government sponsored schemes to support initiatives of self-help organisations to create employment. For example in Spain, unemployed persons can use the payments they receive from their unemployment insurance to acquire membership and shares in worker co-operatives. In Italy, under the new co-operative law local governments may become "financing members" of social co-operatives with the goal to benefit the impact on the local employment situation. In some developing countries, co-operative organisations have served to absorb retrenched public service personnel or (as in Egypt) to offer self-employment to unemployed university graduates. In Benin, in 1991 medical graduates who faced a recruitment stop in the public health system after completing their studies established co-operative clinics to employ themselves. Ten co-operatives were created, with 10 to 12 provider-members in each. This project was proposed by the State and supported by the World Bank and World Health Organisation. Management training was later provided by the Regional Office of the International Co-operative Alliance (ICA). This initiative did not only offer jobs to health care personnel, it also inspired others who were affected by the austerity measures of the state to opt for co-operative solutions to secure their employment.²⁸

Besides the issues of employment, consideration also needs to be given to working conditions and terms of employment, and to the type and quality of jobs which are being created through SHO initiatives.

Co-operation in health care and social services: the state's perspective

Beyond the traditional responsibility of the state to assure national health care and social services, its changing role in society today

has to be considered. Since the 1980s there has been a worldwide trend to limit the functions of the state and to restructure its institutions. The model of the "lean state" is widely discussed and has often led to the conviction that the obligations of the state are to be reduced to a minimum - with all its consequences for public budgets and public employment. Facing the dimension of this trend and the social and economic consequences of cutting public services and functions, the World Bank felt it necessary in 1997 to give a more balanced picture of the state's role in social and economic development in its World Development Report. In the report, the World Bank underlined the central role of the state in economic and social development as a partner and catalyst to others rather than being the sole provider of services.²⁹

The necessity and importance of the state's activities are also recognised in the European Union. The access of all citizens to "services of general interest" (often described as services in the public interest), including health care and social services, is given high priority.³⁰ Due to budgetary constraints and structural adjustment, the state is, however, often forced to limit the delivery of such services. Nevertheless, the need for certain basic and essential services "of general interest" does not necessarily disappear if the state reduces its support. Therefore, in a process often described as privatisation, the communities at local and national levels are looking for new models to finance, provide and regulate the services of general interest. The basic operating principles of such services are: continuity, equal access and universality. There are various ways of organising the delivery of these services, reflecting different geographical, and technical circumstances, political and administrative settings, cultural and social traditions. Although the services are of public interest, they do not necessarily have to be provided by public institutions. The operators can be both public and private providers, in either competitive or monopolistic situations. The EU Commission lists among the providers private companies, public agencies, and public-private partnerships. These different organisational structures make it necessary to speak of services of general interest rather than of public services. The provision of such services is regulated by public authorities to various degrees, depending on the characteristics of each particular sector³¹.

Co-operatives play a specific role in the privatisation of services of general interest, since they facilitate the partnership with public institutions due to their joint responsibility and solidarity with the community. As can be seen from the example of the Italian social co-operatives, such partnerships can even be institutionalised by

local governments becoming members of this type of co-operative. However, the condition for privatising the provision through co-operatives is, as in the case of other private providers, that services can be provided in a more cost effective and efficient way, while the quality remains equal. The method of privatisation is certainly of relevance to its success, since it has been frequently observed that a change in ownership may not achieve the same effect in different market situations that may be either competitive or monopolistic. Also, the social dialogue between providers, employees and users has an impact on the success or failure of privatisation. Often these conditions favour privatisation through co-operatives, since they will mostly not be in a position to be the only supplier, but rather supplement others in the market place. In addition, they have a long tradition of social awareness and dialogue. What might be more unfavourable is the fact that co-operatives in a number of countries have no tradition in the area of health care service. In these countries, it might be more appropriate for privatisation to be linked to traditional forms of voluntary mutual aid or other organisations in the non-profit sector.

Regarding mobilising external finance, co-operatives face limitations on access to commercial banks. However, due to their organisational structure they are often in a position to activate members to contribute to the financing of services (mobilisation of internal finance). In this way, public health expenditure can be supplemented. Beyond financial considerations it should be noted that modern health policy attributes great importance to preventive health care and the involvement of patients and users. Co-operatives can enhance such involvement in an organised and participatory way more effectively than public or other private providers. It is for this reason that they are often supported by public authorities in countries like Italy and the UK. The expectations which users and potential users of services have from different forms of co-operation play a vital role in spreading the co-operative idea within this sector. In Germany, such expectations have led to widespread and diversified networks of citizen initiatives and self-help groups. They are the expression of a "new solidarity"³², an answer of civil society to new situations and needs. It would go beyond the scope of this paper to discuss in more detail the complexity of this "new solidarity" in western European countries.

The consequences for co-operative identity and operations

Many of a co-operative's positive effects have to be related to the identity of owners and users and the strong cohesion among the

group of members. If the services - such as in the health care sector - have to be made available to all population groups including non-members, the co-operative identity and operations might be in danger. Co-operatives could develop into so-called "market cooperatives" where the members do not feel any more that they are co-owners and co-responsible but rather that they are payers for goods and services as in any other enterprise. This is certainly the case with many members of the French mutuals or of the American and Argentinian electricity co-operatives, examples of other services of general interest. Members are often even not aware that they are part of a co-operative. In view of the co-operative identity, it should also be examined whether a close relationship of the co-operative to the local government (as in the case of the Italian social co-operatives) might provoke the well-known dangers of an "officialisation" of the co-operative. This has particularly long-term implications for the economic survival of co-operatives.

Also, if the provision of services to members is not significantly different from that to non-members, the operations of the co-operative can be affected, since the members might also not develop loyalty to an enterprise that is not offering a distinctive treatment to them. In this context, the question should be asked: which structure is the most conducive to the operations and the economic and social viability of a self-help organisation? Can co-operation be sustainable in informal networks? How can the advantages of small SHOs, based on a strong anchorage in the local community and on participation, be combined with the advantages of big co-operatives and their financial strength? Could the Japanese health co-operatives with their Han-Groups serve as models for other countries? Such questions have already been raised for other sectors of co-operative operations and should now also be raised for health care and social services.

Conclusions

- Provided co-operatives and other private providers are subject to the same public regulations, the technical quality of the services should correspond to similar standards offered by the public sector.
- Due to the particularities of health care and social services, it can be assumed that co-operatives do not provide such services at significantly lower costs than other providers. Any comparative advantage of co-operative health care and social services is not to be expected in this respect.
- The advantages of co-operatives are rather to be expected

from their more responsive relationship to the users and patients.

- The self-determination of users and providers within co-operatives induces more intensive involvement, and thus leads to more demand-driven and responsive services, particularly in health care and social services.
- Co-operatives increase employment opportunities in the area of health care and social services, in contrast to the public services where, in view of the austerity measures of public budgets increases are not to be expected.
- It has been assumed that the state can reduce spending by outsourcing to private providers and co-operatives; concise evidence for this thesis, however, is still due and requires a complex cost-benefit analysis.
- Co-operatives can improve participation of the citizens in preventive health care and thus improve the effectiveness of a modern health policy.
- If the long-term sustainability of co-operatives is not to be endangered through the provision of services of general interest, ways have to be found which maintain the strength of the co-operative identity of users and owners and also mobilise sufficient finance for the operations of the co-operative.

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Notes

- 1 United Nations, Cooperative Enterprise in the Health and Social Care Sectors - A Global Survey, New York, 1997.
- 2 The description of the Japanese situation is mainly based on United Nations, Cooperative Enterprise ..., op cit, pp24-28 and Shuitsu Hino, An introduction to health cooperatives in Japan (JCCU), Paper published by the Health Cooperative Association of JCCU in January 1999.
- 3 The description of the Brazilian provider co-operatives is mainly based on United Nations, Cooperative Enterprise ..., op cit, pp44-45 and information material of Unimed do Brasil.
- 4 The description follows mainly R. Spear et al, Third Sector Care, Co-operative Research Unit, Open University, Milton Keynes, 1994.

- 5 The description follows mainly C. Borzaga and A. Santuari, *Cooperatives and the new social services market*, Review of International Cooperation, Vol.90, No.1, 1997, pp11-17 and R.Spear et al, op cit, p6.
- 6 The Autonomous Region Trentino-South Trol promulgated a regional law on "Cooperatives of Social Solidarity" already in 1988.
- 7 The beginnings and parts of the German social security system (eg "Berufsgenossenschaften") can, however, be closely linked to co-operative ideas. See eg J. Zeche, *Health Care Cooperatives and other Institutions in Germany*, in: E.Düffer (ed), op cit, pp419-422.
- 8 Kontakt- und Informationsstelle für Selbsthilfegruppen in Hamburg (KISS), *Selbsthilfezeitung*, Nr. 72 (Mai/Juni 1999), p10; J. Zerche, op cit, p421 speaks 1994 still of 5,000-10,000 such groups in the entire country.
- 9 J. Matzat, *Geschichte der Selbsthilfe in Deutschland: eine Erfolgsstory*, Oberhessische Presse, Germany, 6 October 1999.
- 10 S. Walter, *Ärzte erhalten Geld für Sparbemühungen*, Oberhessische Presse, Marburg, 27 October 1997.
- 11 Pilot tests with quality circles of physicians and pharmacists in the Canton of Fribourg in Switzerland led to calculations that the health care expenditure in the entire country could be reduced by yearly 72 million Swiss Francs through the results of quality circles, *Tribune de Genève*, 10 March 1999, p12. In the frame of newly created networks, doctors are also obliged to participate in quality circles for training purposes. (See p8 of this paper)
- 12 The description follows mainly United Nations, *Cooperative Enterprise ...*, op cit, pp35-36.
- 13 "Managed care is the general term used to describe an organisational approach to health care and the delivery of medical services that seek to control the costs and quality of health care and to co-ordinate and integrate medical and other health related services" Michael J. Klag (ed), *Johns Hopkins Family Health Book*, 1999, p1409.
- 14 Glen R. Johnson, Marc L.Rivo, *Managed Care in : R.E. Rakel (ed) Essential of Family Practice*, Second Edition, W.B.Saunders Company, Philadelphia, PA, 1997, Chapter 11.
- 15 Cynthia Engel, *Health services industry: still a job machine?*, in: US Department of Labor, *Monthly Labor Review*, Vol. 122, Number 3, March 1999, p8.
- 16 R. Pear, *US issues guidelines to help doctors from health networks*, in: *The New York Times*, 29.8.96 and S. Auerbach, *Doctors gain more freedom from health networks*, in: *Washington Post*, 29.8.96.
- 17 S. Dümpelmann, *Sprechstunde in der Apotheke?* Oberhessische Presse, Marburg/Germany, 19.4.99; B. Zander, *Ärzten ins Netz gegangen*, in: *Stern* (German Weekly) 22/1999, pp194-197. These developments experience specifically the support of the health insurances, see eg *Deutsche Krankenversicherung (DKV)*, *Kundeninformation Ausgabe 1999*, pp10-11.
- 18 Sandra Polaski, *Selected Cases in the Americas*, in: G. Ullrich (ed), *Labour and social dimensions of privatization and restructuring: Health care services*, ILO, Geneva 1998, pp11-43.
- 19 B. Künzi, *EUROPEP, Verbesserung der medizinischen Versorgung unter Einbezug der Patienten*, Workshop-Bericht, Erstes Forum Managed Care Symposium, Januar 1999, pp14-15.
- 20 United Nations, *Cooperative Enterprise ...*, op cit, pp111-133.
- 21 Labour costs can account for up to 75 per cent of total health care expenditure.
- 22 Eg ILO Nursing Personnel Convention, 1977 (No. 157); Report of the ILO/PSI Workshop on Employment and Labour Practices in Health Care in Central and Eastern Europe in Prague, May 1997; ILO Joint Meeting on Terms of Employment and Working Conditions in Health Sector Reforms, Report for Discussion at the Meeting and Note on the Proceedings, Geneva, September 1998.

- 23 For regulations in individual countries see: ILO, *Labour Law and Co-operatives - Experiences from Argentina, Costa Rica, France, Israel, Italy, Peru, Spain and Turkey*, Geneva 1995.
- 24 See eg W.H. Staehle, *Co-determination in Germany*, in: Dülfer, E. (ed), *Handbook of Cooperative Organizations*, Göttingen 1994, pp106-110.
- 25 R. Lindenthal, *Cooperatives and Employment in Developing Countries*, ILO Working Paper on Cooperative Development, Geneva 1994, pp118-125.
- 26 G. Ullrich, *The role of human resource development in employment creation through cooperatives*, in: *Anuario de Estudios Cooperativos*, 1996, Universidad de Deusto, Bilbao, 1997, p195f.
- 27 H. Westlund & Stig Westerdahl, *Contribution of the Social Economy to Local Employment: Research Report*, in: *Anuario de Estudios Cooperativos*, 1996, Universidad de Deusto, Bilbao, 1997, pp237-280.
- 28 United Nations, *Cooperative Enterprise ...*, op cit, p40.
- 29 The World Bank, *World Development Report 1997, The state in a changing world*, Oxford University Press, 1997, pp1-3.
- 30 Commission of European Communities, *Communication of the Commission, "Services of general interest in Europe"*, COM (96) 443, 11.6.96 In Europe, such services strive to serve the public while protecting the environment, enhancing economic and social cohesion, and the promotion of consumers interests and to establish a dynamic market economy and social cohesion among the member states of the EU, p1.
- 31 Commission of European Communities, op cit, p3.
- 32 German literature uses the expression "*neue Gemeinnützigkeit*". See eg Werner Kramer, *Die neue Gemeinnützigkeit*, in: *Hamburger Notizen der Patriotischen Gesellschaft von 1765*, (2/99) März/April 1999, pp3-7.