EURICSE | RESEARCH REPORT

Executive Summary

THE COOPERATIVE HEALTH REPORT: Assessing the worldwide contribution of cooperatives to health-care

coop Health

In Partnership with:
International Health Co-operative Organization (IHCO)

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This executive summary refers to the first edition of "The cooperative health report: 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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In memory of † José Carlos Guisado.

The transformation of health 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 5 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 socioeconomic 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* (% 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 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

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

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.