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Health and Care Sector and the Social and Solidarity Economy

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Abstract

This paper is about the recognition of SSE in the health and care sectors and their value-added. Step by step, from 1920, it tracks the long process of recognition of such organizations by international organizations including the UN. Since 1997, health cooperatives have received a lot of attention as a result of 3 international reports. Therefore, their benefits are well described, including their important innovative practice, their capacity to unite various stakeholders and their presence among a variety of healthcare systems. As a result, cooperatives in other fields of care, for instance, early childhood education, disability, and long-term care have received less attention, despite a recent report released by the International Labor Organization in 2016 offering a first view of the subject. Unfortunately, there is no global study of the role of other forms of SSE in this field. Nevertheless, two specific references are quoted in the field of childcare and nursing home or seniors' homes showing the best quality of services of non-profit organisations or public service in comparison to for-profit organizations.

Keywords

governance; health and care sector; partnership; participation; innovation; quality of services

Introduction

This article concerns the social and solidarity economy (SSE) in the health and care sector. It encompasses a wide range of activities, including healthcare and medical treatment, childcare, early childhood education, disability and long-term care, and eldercare. The information derives from various studies and reports at the international level and focuses on the actions of co-operatives and mutual aid organizations (which seem to attract more interest than associations or non-profit organizations) to show the positive consequences that they generate for members, workers, and community needs, instead of short-term financial gain (also see the entry “Cooperatives and Mutuals”). Higher quality of services, improved access to services, lower delivery cost, empowerment of various stakeholders, maximized social impact, strengthened links with the community, and good wages are among these benefits (also see the entries “Social service and SSE” and “Social policy and SSE”). The entry also takes into consideration matters of governance: stakeholder participation, community engagement, and accountability.

All too often, the health and care sector are seen only through two lenses – that of public organizations or for-profits. This article, therefore, is intended to provide a clear and updated view of the role of a third actor, which, while it shares the notions of the common good and general interest with public organizations, can mobilize many stakeholders, and identify innovative ways of addressing such important societal challenges as the escalating care needs of an ageing population, or better, more affordable child care resources for young families. It also has the capacity to hybridize resources that emanate from the market, from state transfers and from volunteering. In short, SSE in this area by no means resembles a one-size-fits-all approach that is so common in public services, paying little or no heed to differences between urban and rural contexts, socio-economic status, etc. In contrast to for-profit organizations (FPOs), SSE organizations and enterprises (SSEOs) in the health and care sector are not driven solely by financial considerations, but instead, offer ways to instrumentalize financial resources for the purpose of serving the needs of their members and the well-being of the community. In this regard, surpluses often will be reinvested to strengthen an organization’s financial base or to improve or expand services, rather than to enrich shareholders (See the entries “Social policy and SSE” and “Social service sector and SSE”)

Note that, notwithstanding the important contributions they make to the health and care sector, this article does not address the role of individuals or families who are supporting people with health issues, nor associations whose purpose is to support individuals suffering from specific health problems (e.g., cancer, Alzheimer’s) or to advocate on their behalf (e.g., HIV AIDS), nor the work of diverse foundations.

Health and Care Sector and the Social and Solidarity Economy

The recognition of SSE from an international perspective is not new. The year following its establishment (1920), the International Labor Organization (ILO), under the leadership of its first general director, Albert Thomas, set up a cooperative department and hired a French co-op specialist, Georges Fauquet, to be its first director. In 1945, the year of its founding, the United Nations (UN) reached out *to establish a mutually beneficial partnership with the international cooperative movement* (UN 1997, iii). It granted the International Cooperative Alliance (ICA) consultative status with the Economic and Social Council of the United Nations, the highest recognition that the UN awards to non-governmental organizations. However, for the health and care sector, recognition took a long time.

A UN report (1997) is called upon for the following information:

In 1987, the Interregional Consultation on Developmental Social Welfare Policies and Programmes (Vienna, 7-15 September 1987) adopted the Guiding Principles for Developmental Social Welfare Policies and Programmes in the Near Future (E/CONF.80/10, chap. III), which were subsequently endorsed by the General Assembly in its resolutions 42/125, 44/65 and 46/90. The Guiding Principles noted that:

A basic principle and objective of social welfare policy is to promote the widest possible participation of all individuals and groups, and greater emphasis needs to be placed on translating this principle into practice. This may be achieved through new partnerships in the field of social welfare policy, providing opportunities for greater involvement of beneficiaries, individually and collectively, in decisions concerning their needs and in the implementation of programmes, including community-based programmes (para. 27)

Social welfare is the concern not only of governments but also of numerous other sponsors. Non-governmental and voluntary organizations, trade unions, cooperatives and community and social action groups are major sponsors of social welfare programmes that must be recognized, supported and consulted (para. 54).

There are advantages to such a diversity of sponsors and approaches including the potential for more precise identification of needs, innovation in strategies, generating broader participation and the involvement of more resources. This may result in a need for better coordination of diverse activities and programmes and for a clearer definition of areas of responsibility and function to achieve the optimal effect (para. 55).

Included in the global agenda and general Guiding Principles was the following:

Within the framework of national laws, there is a need to strengthen the role and contribution of non-governmental and voluntary organizations, private entities and people themselves in enhancing social services, well-being and development (para. 64 (h)).

The Copenhagen Declaration on Social Development, adopted at the World Summit for Social Development (Copenhagen, March 6-12, 1995), called upon states and governments to make better use of resources allocated to social development, including the contribution of cooperatives for the attainment of social development goals (Commitment 9 (h)) (United Nations, 1995, p. 16).

The United Nations itself responded to this call in a practical fashion by conducting and producing the first global survey on the role of cooperatives in the health and social care sector. Undertaken prior to widespread Internet access, the report was first released in 1997 in English (which was followed by two additional versions in Spanish and French the following year). The purpose of the survey was “to clarify prerequisites for the further development of the health and social care component of the international cooperative movement, largely by means of its own resources, but also with the possible support of relevant agencies of national, regional and local governments and the relevant specialized agencies and bodies of the United Nations system.”

A milestone document in the long process of gaining international recognition of SSE in the health and care sector, the survey provided updated descriptions of coops active in the

sector and an initial typology: producer, consumer, or multi-stakeholder coops; their levels of activity (first level, second level, etc.); and their various health approaches (promotion, prevention, curative, rehabilitation). In addition, the survey suggested strategies by means of which coops in this sector could gain better recognition from other key stakeholders (unions, state, etc.)

Drawing on responses from existing health cooperatives worldwide, the survey explained in straightforward language the value-added of the co-op model in terms of a variety of dimensions key to health and social care, including participation, motivation, and partnership. Due to the special requirements of health and social care services, the organization of a cooperative enterprise places it at an advantage relative to both public sector and private for-profit-sector enterprises. Of particular value is the participation of customers (users, clients, and patients) in the identification of goals and in the design of operations.

This survey also served as a reminder that the very first health cooperative (with its own clinic and hospital) was launched early in the 20th century by a multi-functional agricultural cooperative in Japan to help its members avoid long journeys from the countryside to urban areas for medical consultation. This medical cooperative network, alongside a second, urban cooperative established under the leadership of the Japanese Consumers Cooperative Union, “stress preventive health and healthy living. They have extended services from the medical to social medicine and social care, particularly for the elderly, given the demographic ageing of the Japanese population” (UN 1997, p. 167).

While not mentioned in the 1997 report, the 1978 Alma-Ata Declaration of the World Health Organization (WHO) focuses on the importance of individuals and community participation in primary health care. The Declaration states that it:

...requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate... (WHO VII, 5).

Unfortunately, from a global perspective, WHO has never devoted attention specifically to the contribution of SSE to the health and care sector. However, regarding certain concerns, such as health promotion, it does recognize the role of civil society organizations.¹

Nearly 20 years later, under a mandate from the 2014 International Cooperative Summit, a second global survey was conducted. Its purpose was to discern how these organizations improve access to health care, and the innovations they bring to the sector. Entitled *Better Health & Social Care: How are Co-ops and Mutuals Boosting Innovation and Access Worldwide* (Girard, 2014a & 2014b), this survey covered cooperatives and mutuals in 59 countries from every part of the world. It illustrated innovative practices, for instance, fruitful partnerships between coops and public entities, and initiatives to reach isolated or marginalized populations or to address issues of gender. As the executive summary states:

¹ For example, the NGO Alliance For Health Promotion has been in official relation with WHO since 2015. See Alliance for Health Promotion, <https://allianceforhealthpromotion.org/>

- Health cooperative contractors provide high quality, efficient services for Costa Rica's social security system.
- Continuum of care offerings by diverse types of cooperatives in Italy.
- The Espriu Foundation network in Spain runs hospitals in collaboration with the government. This has led to cost savings for the national health system and to higher satisfaction among users.
- Cooperatives provide options for innovative Personal Health Record platforms in Finland.
- Mutuels provide health care to indigenous people in Paraguay.
- Women's Health Cooperative has become a model of community empowerment due to its provision of easily accessible and affordable health care services in Tikathali village in Nepal.
- Thanks to a fruitful partnership with a Public Health Regional Centre and municipal housing office, a home care cooperative in Canada provides overall service to seven homes for the elderly and six homes for the disabled (Girard 2014c).

In addition to such little-known but interesting practices as the paramedic workers cooperative network in Quebec (Canada), the survey put on the radar the unique value-added of the co-op model: its capacity to respond to members' needs. In case after case, cooperatives active in some other sectors became engaged in health and social care as a practical response to members' expectations. For our purposes here, let two examples suffice. In Ethiopia, Oromia Coffee Farmers Cooperative Union uses part of their surplus to invest in improved health facilities, including Health Post and Occupied Medical Equipment, which reach thousands of beneficiaries. In Oruro, Bolivia, due to the poor treatment that members received in public health institutions, Cooperativa Multiactiva Corazón de Jesús established a health centre staffed by a doctor, an orthodontist and two nurses (Girard 2014b, p. 17). Similarly, the survey revealed many instances in which various kinds of cooperatives (agriculture, financial, workers, etc.) and mutuels (insurance) had invested in educational material regarding good health practices.

The most recent global study on the role of healthcare cooperatives was initiated in 2018 by the International Health Cooperative Organisation (IHCO) and the European Research Institute on Cooperative and Social Enterprises (Euricse). They agreed to jointly develop a multi-annual research initiative² on the contribution of healthcare cooperatives to improve people's health and well-being around the world. They aimed to publish an annual report containing—for a progressively larger number of countries—both quantitative and qualitative analyses of healthcare cooperatives and mutual organizations as well as the systems in which they operate.

The first year of the research study focused on 15 countries, all of which have structured healthcare systems: Argentina, Australia, Belgium, Brazil, Canada, Colombia, France, Italy, Japan, Malaysia, Singapore, Spain, Sweden, the United Kingdom, and the United States. For each country, Euricse developed a profile of the main features of healthcare cooperatives vis-à-vis the health care system. In-depth case studies of these cooperatives were provided for Belgium, Brazil, Canada, Italy, Spain, and Japan. Healthcare cooperatives of various types were investigated (cooperatives of health practitioners, mainly doctors; user/patient cooperatives; and multi-stakeholder cooperatives), as well as

² This 2018 report appears to be the only research generated by this IHCO-Euricse partnership as of November 2021.

cooperatives active in other sectors, such as agricultural cooperatives also providing health services.

Using both quantitative and qualitative methodologies, the researchers noted:

that health cooperatives exist in all of the healthcare 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 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 helped shape the role of cooperatives within the healthcare domain in different ways across countries (IHCO/Euricse 2018).

Each of these three reports shows the capacity of cooperatives and mutuals to be implemented and run under a variety of healthcare systems, those that are almost exclusively public as well as those that mix public and private healthcare provision. But such an observation should not lead us to underestimate the challenge that cooperatives face if they are to gain full recognition from the State. The reports also demonstrate the remarkable diversity of the cooperative model, ranging from small clinics to substantial networks of cooperatives that own and operate clinics, hospitals, and research centres. Take, for example, the world's biggest health co-op network, UNIMED do Brasil, an organization that encompasses nearly one-third of the country's doctors. There is also room for cooperative pharmacies, including primary level user-owned and secondary-level cooperative networks of pharmacies, like the Association of All Pharmacists Cooperatives in Turkey (TEKB).

Finally, even if the need for health facilities is huge in many parts of the world, the first two reports highlight how underdeveloped health cooperatives are in low-income countries, especially in Africa. That raises many issues, including a lack of knowledge of the cooperative model, but also a lack of a legal framework to support such a model.

Since the UN's 1997 survey, coops and mutuals engaged in the health and social care sector seem to be receiving more and more attention. What, then, about the more global notion of "care," for instance childcare and eldercare? To address this issue, in 2016 two agencies of ILO, the Cooperatives Unit (COOP) and the Gender, Equality and Diversity Branch (GED), decided to jointly undertake *a global mapping of the provision of care through cooperatives*.

As the report's introduction explains:

Across research and practice literature, various case studies have been set forth, providing a foundational understanding of the functions of care cooperatives and the barriers they face. These studies, however, tend to focus on childcare and, to a lesser extent, eldercare, mostly discussing cases from Western Europe and North America. As such, the broader understanding of care cooperatives across geographic regions and populations has been lacking (Matthew et al. 2016).

The report uses the following definition of care:

Looking after the physical, psychological, emotional and developmental needs of one or more other people, namely the elderly, children and people living with disabilities, physical illness and/or mental illness.³

The mapping primarily uses two sources of information: an online survey (the survey sample consisted of 182 survey respondents from the care sector and cooperative movement, of which 55 percent participated in the English version of the survey⁴), and key stakeholder interviews. The aim of the research was to:

- Determine the landscape of cooperatives that provide care, including their beneficiaries, members, objectives and scope;
- Ascertain the legislative, social and economic contexts that drive care through cooperatives;
- Identify the challenges and opportunities that cooperatives face in initiating and sustaining care provision and decent employment;
- Determine the resources that cooperatives need in order to be viable care providers, enterprises and employers;
- Assess how well cooperatives affect the livelihood of care beneficiaries, workers and the larger community, compared to private and public care provision options; and
- Determine whether and under which form care cooperatives are registered.

The findings of the research in many respects lend support to the results of reports previously cited in this entry:

- Cooperatives are emerging as an innovative type of care provider, particularly in the absence of viable public or other private options;
- Cooperatives generate access to better terms and conditions of work in the care sector (e.g. access to benefits, more bargaining power, regularized hours)—especially for female employees.
- Compared to the public, other private and even non-profit care providers, cooperatives provide care in distinct and preferred ways;
- Cooperatives foster interdependency in care by privileging equitable inclusion and democratic decision-making across the care chain. As such, care workers, care beneficiaries and their families, and other stakeholders have a voice in the nature of the service provided and the operation of the care provision enterprise.

Two other observations are in order. The authors argued that “the cooperative approach to care is distinct from public, other private and even non-profit providers.” Why? “When the seven cooperative principles are engaged, cooperatives foster interdependence rather than dependence in caregiving by privileging voice and inclusion.” This refers to the cooperative identity, values and principles that were adopted at the congress of the ICA in Manchester in 1995.⁵

The authors also recognized that *more evidence and data are needed in order to move forward*, for example, *more information on the social and economic impacts of care*

³ Adapted from ILO (2015). *Women and the Future of Work: Taking Care of the Caregivers*.

⁴ The survey also offers options to answer in Spanish, Italian and French.

⁵ International Cooperative Alliance [Cooperative identity, values & principles](https://www.ica.coop/en/cooperatives/cooperative-identity).
<https://www.ica.coop/en/cooperatives/cooperative-identity>

cooperatives ...if the impact of care cooperatives is to be conveyed to governments, funders and potential beneficiaries.

As mentioned in the introduction to this article, there appears to be no study or report that explores the impact of the three main legal forms of SSEs in the health and care sector from a global perspective. For example, it is only possible to find research focusing on one sector of activity concerning quality in for-profit, non-profit, and public childcare provision. This is the purpose of the *Child Care Briefing Notes* published in 2011 by the Canadian Childcare Resources and Research Unit. Quoting research conducted over the last 30 years in various countries such as Canada, the United States, United Kingdom, and New Zealand, the *Notes* refer to:

observational tools such as the Early Childhood Environmental Rating Scale (ECERS) that measure ‘process quality’ or with indicators of quality: staff training, wages, working conditions, professional development, staff morale, turnover, compliance with regulations, ratios and how funds are used the research examining multiple variables across jurisdictions shows that public and non-profit childcare is significantly more likely to be a better quality than for-profit childcare (Childcare Resource and Research Unit 2011).

In other words, NPOs surpass FPOs in terms of many of the indicators directly impacting the quality of services, such as wages, working conditions, early childhood educator training, staff turnover, staff morale, staff/child ratios and group size.

In their conclusion, the authors supply the following reminder:

Whether childcare is for-profit or public/not-for-profit is not the only policy issue that determines whether children and families get high quality early childhood services. Yet, it is, however, a fundamental choice that influences how well other key structural policy elements—public financing; a planned (not market) approach; well paid, early childhood-educated staff treated as professionals; a sound pedagogical approach; and ongoing quality assurance—function to ensure high quality and equitable access.

From another perspective, the impact of the recent COVID-19 pandemic on morbidity among older citizens in many countries has brought to the forefront of public debate the question of eldercare. Of particular concern are the consequences of the ownership and management of nursing homes (also known as long-term care homes) or seniors’ homes (also known as retirement homes or assisted living facilities) on their residents. Given their focus on maximizing profit rather than on the well-being of their clients relative to other ownership models (public and not-for-profit), how effectively have FPOs involved in this sector managed the consequences of the pandemic?

For sure, amongst the raft of COVID-19 post-mortems coming our way in the near future, we can expect many comparative studies on this issue. In fact, in 2016, a research team from the University of British Columbia in Canada have already released a study that reviewed the link between ownership and care quality. They used the “Bradford Hill’s Guidelines for Assessing Causation”:

These guidelines provide a useful framework for assessing evidence for a causal effect. Specifically, Bradford Hill suggested that nine relevant factors should be considered before concluding causation ... Plausibility ... Temporality ...

Experiment ... Biological gradient or dose-response ... Coherence ... Analogy ... Consistency ... Strength of the association ... [and] ... Specificity. (Ronald et al. 2016).

Using data from Canada and the United States, the authors suggest there is a greater likelihood of inferior care when it is provided by for-profit facilities. And “what is behind this relation between profit and inferior care? One explanation is that there is a trade-off between improving quality (for example by hiring more staff) and generating profit. In other words, where the pressure to make a profit is strong, quality may be sacrificed.” Based on this causal link between for-profit ownership and inferior care, the authors argue that the “precautionary principle should be applied when developing policy for this frail and vulnerable population.”

It is evident that more research needs to be done on the value-added of SSE in the health and care sector, particularly in the care sectors, including association legal form. However, based on what we know from the 1997 report, there is some evidence related to the quality of service, sensitivity to stakeholders empowerment and community link. Paying more attention to a country’s spending, in particular, the health and care expenses will converge focus towards the way health and care services are delivered. We can expect that this, in turn, will contribute to a better in-depth understanding of SSE in this field of activity.

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