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Australia's Leading Co-operative and Mutual Enterprises in 2017

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Tim Mazzarol

Johannes Kresling

Centre for Entrepreneurial Management and Innovation
Phone: +618 6488-3981
Fax: +618 6488-1072
Email: tim.mazzarol@cemi.com.au

General Inquiries:
Email: tim.mazzarol@cemi.com.au

Website: www.cemi.com.au

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AUSTRALIA'S LEADING CO-OPERATIVE AND MUTUAL ENTERPRISES IN 2016

Tim Mazzarol, University of Western Australia (tim.mazzarol@uwa.edu.au)

Johannes Kresling, University of Western Australia (johannes.kresling@uwa.edu.au)

ABSTRACT

This paper reports on a research study that aims to map the size and structure of the Co-operative and Mutual enterprise (CME) sector in Australia. The Australian CME Index (ACMEI) is a longitudinal study that can provide a better understanding of these firms and their economic and social contribution to the national economy. This year the study found a total of 2,134 active CMEs of which 82.5% were co-operatives, 13.2% mutual enterprises, 2.2% were friendly societies and 2% were member-owned superannuation funds. These firms had a combined active membership base of over 29 million memberships, generated more than $113 billion in revenue, managed over $722.2 billion in assets, and employed at least 52,322 people. They encompassed a wide range of industry sectors and provided significant economic and social benefits to their members. The report outlines these contributions and offers case studies of selected CMEs to illustrate these contributions.

Key words: co-operatives, mutual enterprises, Australia, Top 100.

INTRODUCTION

This is the fourth annual report on the Australian Co-operative and Mutual Enterprise (CME) sector and draws on the findings of the previous studies by way of comparison (Mazzarol *et al.*, 2014; 2015; 2016). The study is part of a long-term project, the Australian Co-operative and Mutual Enterprise Index (ACMEI), with the goal of developing a comprehensive understanding of the size, characteristics and impact of the co-operative and mutual enterprise (CME) sector on the Australian economy and society. This work is undertaken in conjunction with the Business Council for Co-operatives and Mutuals (BCCM).

THE EVOLUTION OF AUSTRALIA'S CME SECTOR

Co-operatives existed in France during the middle ages, and in the United Kingdom and Europe from the eighteenth century (Gide 1922; Williams 2007). However, it was the foundation of the *Rochdale Society of Equitable Pioneers* in England in 1844 that marks the creation of the first modern co-operative (Drury 1937; Fairbairn 1994). The legacy of the Rochdale Society was the focus that it had on pursuing both economic and social goals, within a constitutional framework that set down guiding principles to enhance the well-being of its members (Wilson, Shaw and Lonergan 2012).

The founding principles laid out by the Rochdale Society were a comprehensive manifesto that outlined arrangements for the enterprise to engage in a wide-range of economic and social development activities (Rochdale Society 1877). This included the establishment of retail stores to sell food, clothing, books and other goods to members, as well as the purchase of land, and the construction of housing for members. It also included the manufacturing of goods and operation of lands so as to create jobs for members who were unemployed or receiving low wages (Fairbairn 1994). The general principles and values established by the Rochdale Society have, with minor changes, continued to guide the international co-operative movement to the present day (Nelson *et al*. 2016).

FRIENDLY SOCIETIES

Australia was quick to adopt co-operative and mutual enterprise. For example, the first friendly societies were established in Australia in the 1830s, and modelled on their English counterparts, which had emerged in the seventeenth and eighteenth centuries. These comprised *The Independent Order of Oddfellows*, *The Independent Order of Rechabites*, the *United Ancient Order of Druids* and the *Ancient Order of Foresters*. By the 1920s around half the population of Australia were members of a friendly society (Lyons 2001). This included the foundation of the Friendly Society Pharmacies in the 1840s, which aimed to bring down the cost of medicines and offer quality drugs and advice (Green and Cromwell 1984). However, during the Great Depression of the early 1930s, Friendly Societies found it difficult to retain their membership, and in the decades, that followed the number of societies declined (Lyons 2001). Many Friendly Societies converted into mutual health insurance funds, or mutual investment managers. Today there are an estimated 48 Friendly Societies operating in Australia.

CO-OPERATIVES

Co-operatives emerged in Australia during the 1850s, with the foundation of the Brisbane Co-operative Society, a consumer retail co-operative, in 1859 (Balnave and Patmore 2012). Consumer co-operatives expanded throughout Australia in nineteenth century in response to economic booms and busts, with an estimated 152 consumer co-operative societies operating in 1923, with around 110,000 members (Balnave and Patmore 2012). These firms were joined by agricultural co-operatives in dairy and bulk grain handling and storage during the late nineteenth and early twentieth centuries, which experienced rapid expansion in the period following the First World War. For example, by the 1920s, dairy co-operatives accounted for 91% of all butter production in Australia (Fernandez 2014).

During the three decades from 1970 to 1999, the co-operatives sector in Australia experienced both social and economic challenges that led to the demutualisation or dissolution of many co-operatives. The decline of many consumer co-operatives has been attributed to increasing competition from investor-owned firms (IOFs), changing social and demographic characteristics of the community, plus poor management and governance (Balnave and Patmore 2008). In the agribusiness sector the demutualisation of many large grains, meat, fruit and dairy co-operatives has been attributed to a combination of government deregulation, changing market conditions, increased competition and poor governance (Brewin, Bielik and Oleson 2008; Mazzarol *et al.* 2014)

In 1996, it was estimated that there were around 3,000 co-operatives in Australia (Lyons 2001). Today, our estimates suggest that around 1,761 co-operatives are actively trading, with almost all industries represented. During the 1990s the modernisation of co-operatives legislation across all state and territory jurisdictions. The introduction of this legislation and the development of the *Co-operatives National Law* (CNL) under the Australian Uniform Co-operatives Laws Agreement (AUCLA) from February 2012, led to a steady alignment of state and territory co-operatives legislation under this national legislative framework. By 2017 NSW, Victoria, South Australia, the Northern Territory, Tasmania, the ACT and Western Australia had either adopted the CNL or amended their own legislation to bring them into alignment with the CNL (Jacobson 2016). Queensland withdrew from the AUCLA in January 2015, but committed to ensuring that its co-operatives legislation would be 'substantially consistent' the CNL (Apps 2016).

The adoption of uniform co-operatives legislation across Australia under the CNL is important to the future growth and development of the co-operatives sector. Among the key elements that the CNL offers are four provisions. First, the CNL enables co-operatives to operate across multiple jurisdictions without undue compliance costs of having to register in each state or territory. Second, the CNL provides much greater alignment with the national *Corporations Act (2001)*, with more standardised language between the two statutes. Third, the CNL recognises the need for simpler compliance and reporting requirements for small co-operatives, thereby facilitating the establishment and growth of co-operative enterprises (Apps 2016).

Finally, the CNL (like the previous state and territory acts) provides for capital fund raising using a new financial instrument known as a Co-operative Capital Unit (CCU). This hybrid security can be issued to both members and non-members, and even potentially traded on the stock exchange (Apps 2016). However, co-operatives that make use of CCUs in order to raise capital, need to approach this with caution and ensure that governance provisions are applied to ensure that the democratic governance and underlying social and economic purpose of the enterprise are not eroded (Mamouni Limnios, Watson, Mazzarol and Soutar 2016).

MUTUAL ENTERPRISES

The mutual enterprise sector is an eclectic mixture of organisations that includes building societies, credit unions, customer owned banks, health insurance funds, superannuation funds, mutual insurance funds and automobile associations. In 2016 there were an estimated 325 mutual enterprises actively trading in Australia. Of these 104 are engaged in financial services such as customer owned banks, credit societies or building societies. A further 43 were member-owned superannuation funds, and 24 were member-owned private health insurance (PHI) mutual enterprises. Another large group were 139 mutual enterprises operated by the Aboriginal and Torres Strait Islander communities as medical services providers. The remainder were engaged in agribusiness services, information and media, automobile associations, professional services to the medical professions, and utilities (water irrigation).

BUILDING SOCIETIES AND CREDIT UNIONS

Building societies began to emerge in Australia in the 1930s as a result of the impact of the Great Depression, and credit unions emerged in the late 1940s following the federal government's removal of restrictions on credit union registrations (Lyons 2001). Credit unions expanded strongly during the 1950s, 1960s and 1970s, with state governments introducing credit union legislation (Lewis 1996). However, the non-bank financial sector in Australia underwent significant changes commencing in the 1980s, with increasing prudential requirements, a deregulation of the banking sector, and growing competition from the banks. Over the past thirty years the number of credit unions and building societies declined, and in the years following the Global Financial Crisis (GFC) of 2007-2009, the level of market concentration within the banking sector increased. For example, in 2016 the four largest banks (e.g. ANZ, CBA, NAB and Westpac) held a combined market share of around 78% (Wu 2016a).

Another legacy of the GFC was a tightening of capital requirements under Basel III rules implemented by the Reserve Bank of Australia (RBA) from January 2013. This requires financial institutions that take customer deposits, to maintain higher levels of capital (e.g. cash, retained profits, equity) in order to guarantee greater stability in the financial system. Yet this also imposes higher costs on these financial institutions (Wu 2016a). The impact of these changes has been significant on the mutual financial services sector. For example, the annual growth rate in the sector over the five years to 2016 saw a decline of 12.2% for building societies (Wu 2015), and 15.8% for credit unions (Wu 2016b). Further consolidation within the sector is forecast and this has resulted in many mutual financial services firms converting into customer owned banks.

PRIVATE HEALTH INSURANCE FUNDS

As noted above, the private health insurance (PHI) sector has its origins in the friendly societies that emerged in Australia during the nineteenth century. Attempts to establish a national health care system in the 1930s and 1940s failed due to the Great Depression and Second World War. However, the *National Health Act (1953)* provided the first national legislative framework upon which the contemporary Australian healthcare system was built (Stoelwinder 2002). A primary factor influencing the creation of PHI funds has been the absence of a truly national healthcare system within Australia, which falls between the self-contained 'managed' system found in the United States, and the 'supplemental' system of Canada (Kay 2007).

Many of the PHI mutual funds have their origins in employee collective action to provide healthcare for sick or injured workers. An example, is Transport Health Ltd, a PHI mutual fund based in Victoria, which was established in 1888, by the Melbourne Tramway workers. Another is the Railway and Transport Health Fund Ltd from NSW, which was established in 1889 with collective action by the railway employees of that state. Other PHI mutual funds were established in the 1930s and 1940s. However, the sector grew strongly following the Second World War.

The introduction of Medicare in 1984 provided a basic universal healthcare system for all Australians. However, the cost of maintaining this system has continued to rise, leading to federal government policies to attract more people to take out PHI (Stoelwinder 2002; Seagal 2004). In 2016 the 24 mutual PHI funds comprise around 73% of all the health insurance businesses, but control only about 39% of the total market share. The biggest mutual PHI funds by market share are the Hospital Contribution Fund of Australia (HCF) (11.1%) and HBF Health Ltd (5.8%) (Wu 2016c).

Member Owned Superannuation Funds

Superannuation funds in Australia have a history that can be traced back as far as the early nineteenth century. The first was the Bank of Australasia's Officers' Retiring Fund, established in Sydney in 1842, which provided pensions for public service workers. These and similar schemes were based on those developed in Britain for the military and public service employees. By the early twentieth century, the Australian federal government introduced a national retirement benefits scheme with the passage of the *Invalid and Old Age Pensions Act (1908)*. It also sought to supplement this during the First World War, by offering employers tax concessions to make contributions to employee superannuation plans (Mees and Brigden 2017).

Attempts to introduce a national system of compulsory superannuation during the 1920s and 1930s failed due to political disputes between the Australian Labor Party (ALP) and the conservative parties of the time. Further political divisions made post-war reforms of the superannuation system problematic, despite increasing calls by trades unions for a superannuation system for workers. Some of the larger trades unions set up their own superannuation funds during the 1950s and 1960s, and additional funds were created in the 1970s. However, the Australian Council of Trades Unions (ACTU), was committed to the establishment of a national system of superannuation. With the election of the ALP government of Prime Minister Bob Hawke in 1983, the opportunity to create this national superannuation scheme was seized upon by the ACTU. This led, after much debate, to the passage of the *Occupational Superannuation Standards Act (1987)*, which created the first legal entity known as a superannuation fund (Mees and Brigden 2017).

While many of the current 43 member-owned superannuation funds pre-date the 1980s, the growth of the industry superannuation funds and the mutual funds took place in the 1990s and early 2000s. In 2017 there were 244 superannuation funds operating in Australia, with combined annual revenues of $284.1 billion. Growth in the sector over the period 2012 to 2017 was at an annual rate of 14.5%, although the outlook for the period out to 2022 is forecast for a more subdued rate of 3.6%. The largest superannuation fund is the member-owned Australian Super, which in 2016 had 4.6% of the national market (Wu 2017).

Automobile Associations

Australia has eight automobile associations (automobile clubs), which are motoring services mutual enterprises. These organisations are large and located in each state or territory. Their origins date back to the early twentieth century with the emergence of motor vehicles and the desire by owners of automobiles to join together in motoring clubs for mutual benefit. Initially these associations focus on motoring advice, lobbying for better road infrastructure and safety, and providing roadside assistance. Although these activities continue, the automobile

clubs have now included other services such as general insurance, travel and financial services. The combined annual revenue of these automobile associations in 2016 was around $1.2 billion (Allday 2016).

SENATE INQUIRY INTO CO-OPERATIVE, MUTUAL AND MEMBER-OWNED FIRMS

In 2015 the Australian Senate Economics Reference Committee conducted an inquiry into co-operative, mutual and member-owned firms. This focused on their role, importance and overall performance within the national economy. The inquiry examined the economic contribution of the CME sector, barriers to growth, innovation and freedom of competition, the impact of regulations, and how mutual ownership compared to the private sale of publicly held assets and services (The Senate 2016). The report contained 17 recommendations that are listed in Table 1.

TABLE 1: RECOMMENDATIONS FROM THE SENATE INQUIRY INTO THE CME SECTOR

1.	Commonwealth Government to ensure that a national collection of statistics and data is undertaken to provide an accurate picture of the scale and extent of the co-operative and mutual sector.
2.	Co-operative and mutuals sector to be better represented in government policy discussions, and actively promoted as a possible option for service delivery, particularly where community based initiatives are being considered.
3.	Commonwealth Government to work with states and territories to develop a program of supports to encourage the establishment of new co-operatives and mutual enterprises.
4.	That 'mutual enterprise' is explicitly defined in the Corporations Act 2001, and its associated regulations.
5.	The role of directors in mutual enterprises be defined in the Corporations Regulations to align with the proposed definition of a mutual enterprise in the Corporations Act.
6.	Commonwealth Government to work with states and territories to ensure the continual improvement to advice, guidance and information provided at all stages in the establishment, governance and regulation of co-operatives.
7.	Commonwealth Government to work with all relevant stakeholders to undertake a program of education and training to inform them about the role of co-operatives and mutuals.
8.	Commonwealth Government to examine ways in which it can improve the recognition and understanding of the co-operative and mutual sector in the national secondary school curriculum and that tertiary institutions consider the inclusion of co-operative and mutuals in accounting, business, commerce, economics and law degrees.
9.	That professional bodies, such as the Law Society and Institute of Chartered Accountants, require a demonstrated knowledge of the co-operatives and mutual structure before it will licence its members to practice accounting or law.
10.	Commonwealth Government amend the Indigenous Advancement Strategy to allow registered co-operatives the same access to allow levels of grant funding as other entities.
11.	Commonwealth Government review, and where necessary amend, the eligibility criteria for grants and funds across all of government grants and program guidelines to ensure that co-operatives and mutual enterprises are not excluded on the basis of their business structure.
12.	The co-operative and mutual sector be considered when the government is preparing a Regulatory Impact Statement that accompanies new regulatory policies.
13.	Commonwealth Government to liaise with its state and territory counterparts to ensure that the regulatory burden for small and medium sized co-operative and mutual enterprise aligns with the needs of these organisations and ensures they are not disadvantaged relative to companies of a similar size.
14.	Commonwealth Government to closely monitor the progress of the International Accounting Standards Board in developing solutions to bring co-operative shares under the definition of capital under AASB 132, and, where possible, facilitate equivalent amendments as expeditiously as possible.
15.	Commonwealth and State Governments to support the formalisation of some of innovative market-based approaches to raising capital for small and medium sized co-operative and mutual enterprises, in the form of advice and information, as they become available.
16.	APRA **to** set a target date for the outcome of discussions with the co-operative and mutuals sector on issues of capital raising and bring those discussions to a timely conclusion.
17.	Commonwealth Government examine proposals to amend the Corporations Act 2001 to provide co-operative and mutual enterprises with a mechanism to enable them access to a broader range of capital raising and investment opportunities.

Source (The Senate 2016).

The Senate inquiry and its subsequent reporting provide an important framework upon which the Australian CME sector can develop over the longer term. Better data collection and reporting on the size of the sector and its economic and social contribution is important. As outlined in this latest ACMEI report, the Australian CME sector is both large and able to make a strong economic and social contribution. Government policy makers should give more attention to the CME business model and recognise that it is different from that of the conventional investor owned firm (IOF), state owned enterprise (SOE) and not-for-profit social enterprise (NFPSE). This is due to the hybrid or dual-purpose of the CME business model, which has both an economic and social purpose, a strong member ownership and democratic governance (Levi 2006; Novkovic 2008; 2014).

There also needs to be better coordination between state, territory and federal governments to support the formation and growth of new CMEs. However, it should be recognised that the CME is a business model that is typically used to address market failures that cannot be readily addressed by alternatives. Fostering the creation of CMEs for the sake of increasing their numbers is not a sensible or sustainable strategy. At a minimum the establishment of a CME should be no more complicated than the establishment of any other type of business.

DEFINITIONS

A co-operative is an autonomous association of persons united voluntarily to meet their common economic, social and cultural needs and aspirations through a jointly-owned and democratically controlled enterprise. *(ICA, 2015)*

A mutual is a private company whose ownership base is made of its clients or policyholders. The defining feature of a mutual company is since its customers are also its owners, they are entitled to receive profits or income generated by the mutual company. It is owned by, and run for the benefit of its members. (UK Government 2011)

A member-owned business organisation is one that is owned and controlled by its members who are drawn from one (or more) of three types of stakeholder – consumers, producers and employees – and whose benefits go mainly to these members. (Birchall 2011 p. 3)

A co-operative or mutual enterprise (CME) is a member-owned organisation with five or more active members and one or more economic or social purposes. Governance is democratic and based on sharing, democracy and delegation for the benefit of all its members. (Mazzarol *et. al*. 2016)

The definition of what constitutes a 'mutual enterprise' is also important. While co-operatives are generally clearly defined, this is not the case for mutual enterprises. In addition, the inherent democracy of the 'one-member-one-vote' governance model found in co-operatives, does not always apply to mutual firms. This flows onto the role of directors in mutual enterprises, and to the professional advice that such directors receive in relation to the management and governance of CMEs.

Enhanced education and training, across all levels of education and within the professions, in the nature of the CME business model is also desirable. Currently the level of such education and the availability of quality course curriculum and teaching materials is inadequate. The CME is not a subject that has attracted much interest from academics and remains a fringe area within the mainstream research fields. Although the CME business model was given significant attention within mainstream economics during the late nineteenth and early twentieth centuries, this declined steadily from the 1950s (Kalmi 2007).

This trend has been attributed to the shift in focus within the field of Economics from a 'bottom-up' to a 'top-down' approach being pursued by economists:

> *"The decline seems to be related to the changing role of the economist, which now stresses top-down solutions instead of more local and institutionally sensitive ones, thus disfavouring cooperatives. This change is related to the shift in the economics paradigm from a more institutionally oriented analysis to neoclassical economics with its emphasis on optimal solutions and the downplaying of institutional characteristics. The increase in the economic role of the government provided economists with an opportunity to apply their neoclassical tool kit in their new capacity as 'social engineers'. At the same time, their interest in privately provided solutions to societal problems waned"* (Kalmi 2007 p. 641).

Addressing this trend will require a much greater focus within the academic community towards research into co-operative and mutual economics and how CMEs are designed, configured and managed. This will require a multidisciplinary approach drawing together a wide-range of academic fields (e.g. economics, business and management, law, social and public policy, history). However, it is unlikely to occur if the CME sector, and the governments that seek to regulate and support these enterprises, do not recognise the importance of investing in research and education programs with the university sector.

In summary, the Australian CME sector has evolved steadily over the past two centuries. Although its fortunes have waxed and waned it remains an active and vibrant sector within the national economy. The CME is not a perfect business model, and it may not be an appropriate organisational structure for all situations. However, it has demonstrated its effectiveness in addressing economic and social issues (Birchall 2004; Birchall and Simmons 2007; 2009). It also offers a potentially useful business model for economic development (Gringas *et al.* 2008; Kangayi *et al.* 2009; Vieta 2010; Tonnesen 2012).

HOW MANY CMES IN AUSTRALIA?

As noted in previous reports in this series (Mazzarol *et al*., 2014; 2015; 2016), the total number of CMEs in Australia is unknown. Prior to the commencement of the ACMEI project estimates ranged from 659 enterprises (Barraket & Morrison, 2010), to around 1,700 (ABS, 2012; Dennis & Baker, 2012). In 2016 a total of 1,983 CMEs was identified (Mazzarol *et al.*, 2016).

Research undertaken for this current report identified a total of 2,255 CMEs. However, 121 enterprises no longer appear to be active. This includes firms that have been liquidated, demutualised or merged. It also includes those firms that have cancelled their ABN and no longer appear to be in operation. If these inactive CMEs are removed from the list, we have a total of 2,134 active firms.

Table 2 lists these active CMEs and it can be seen that New South Wales (NSW) remains the state with the largest number of CMEs, with 779 firms or 36.7% of the total. Victoria (VIC) holds second place with 707 CMEs or 33.1% of the total. Queensland (QLD) is third with 364 firms or 17.1% of the total, followed in turn by South Australia (SA), with 121 firms or 5.7% of the total, and Western Australia, with 90 firms or 4.2% of the total. Tasmania (TAS), the Australian Capital Territory (ACT) and the Northern Territory (NT) all have relatively few CMEs, with between 16 and 31 firms.

As shown in Table 2 there is a wide distribution of CMEs across industry sectors. The most substantial concentrations are found in housing (13.6%), sport and recreation (12.4%), agribusiness (8.9%), community services (8.7%), education, training and child care (8.7%), and medical services (7.8%).

TABLE 2: AUSTRALIAN CO-OPERATIVE AND MUTUAL ENTERPRISES BY SECTOR, STATE AND TERRITORY[1]

State/Territory	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Total	%Total
Accommodation		9		1			6		16	0.7%
Agribusiness		36	2	79	24	3	36	9	189	8.9%
Arts & Culture	1	34		32	1	2	25	1	96	4.5%
Business Services	1	6		5	1		9		22	1.0%
Community Services		95		40	7	2	40	2	186	8.7%
Education, Training, Childcare	1	26		3	1		152	2	185	8.7%
Employment Services		4		14		1	5	1	25	1.2%
Environmental		9		9	1	1	12		32	1.5%
Banking & Financial Services	1	60	1	16	9	3	37	4	131	6.1%
Fishing		16		4	1		4	1	26	1.2%
Health Insurance		11		1	2	2	6	2	24	1.1%
Health Services	1	4		12	3	1	19	1	41	1.9%
Housing	2	56		42	31	7	146	7	291	13.6%
Information & Media		19	1	3			10		33	1.5%
Manufacturing	1	2			2		3	1	9	0.4%
Medical Services	4	55	22	30	12	1	24	19	167	7.8%
Motoring Services	1	1	1	1	2	2	1	1	10	0.5%
Professional Services		10		5			11	1	27	1.3%
Purchasing Services	1	3		1	4	1	2	7	19	0.9%
Religious Services		2					1		3	0.1%
Retailing	1	50		28	8	2	40	19	148	6.9%
Shared Services		21		7	1		4	1	34	1.6%
Sport & Recreation	1	187		10		1	65		264	12.4%
Telecommunications							2		2	0.1%
Transport Services	1	31		4	3		5	3	46	2.2%
Utilities (power, water, gas)		13		10	1		22	7	53	2.5%
Wholesaling		4		2	4	1	1		12	0.6%
Superannuation Funds		15		5	3	1	18	1	43	2.0%
Total	16	779	27	364	121	31	706	90	2,134	100%
% Total	0.7%	36.5%	1.3%	17.1%	5.7%	1.5%	33.1%	4.2%	100%	

[1] This data is based on the best available evidence but may not represent the total CME sector.

Of the 2,134 active CMEs identified for the 2017 ACMEI study 1,761 (82.5%) were co-operatives, 282 (13.2%) were mutual enterprises, 48 (2.2%) were Friendly Societies, and 43 (2%) were member owned superannuation funds. The mutual firms were heavily concentrated in the medical services (49.3%), financial services (36.9%), and health insurance (8.5%) sectors.

The Friendly Societies were concentrated in the health services (68.8%) and financial services (29.2%) sectors. The main sectors where the co-operatives were concentrated were housing (16.5%), sport and recreation (15%), community services (10.5%), education, training and child care (10.5%), agribusiness (10.6%) and retailing (8.4%) sectors.

At least 220 of the total number of CMEs were owned and operated by Aboriginal or Torres Strait Islander (ATSI) communities. The majority of these CMEs (70%) were focused on delivery of medical services. Other major concentrations were found in community services (15.5%), housing (5.5%) and Arts and Culture (4.1%). However, it should be noted that many of these ATSI CMEs have multiple services that address a relatively wide range of community needs designed to offer 'holistic' support for their communities.

THE CONTRIBUTION OF THE CME SECTOR TO THE AUSTRALIAN ECONOMY

The size of the CME sector and its contribution to the Australian economy can be assessed using both economic and social capital measures. Annual turnover is one economic measure and another is the total financial assets under management by these firms. However, as most CMEs are not legally required to publicly disclose their annual financial data securing reliable financial information on the sector is difficult.

Despite these limitations it was possible at time of writing to obtain annual financial turnover for 357 (16.7%) of the 2,134 CMEs identified as being active in Australia. Total financial assets information for these firms was also obtained. An examination of this information found that the combined annual turnover for these firms in FY215/2016 was $113 billion, with combined assets of $722.2 billion.

SUMMARY

There are at least 2,134 active CMEs in Australia.

This includes 1,761 co-operatives; 282 mutual enterprises, 43 member-owned super funds and 48 friendly societies.

Their combined gross annual turnover is more than $113 billion.

Their combined gross assets under management is greater than $722.2 billion.

Their combined active membership is more than 29.3 million memberships.

They employed more than 52,322 people.

Measuring social capital is even more problematic than economic capital. However, one potential measure is the size of the membership base for the CME sector. Once again it is difficult to get membership data from all CMEs as most don't publish this publicly. As a benchmark, in 2012 it was estimated that there were around 13.5 million Australians who were members of CMEs (Dennis and Baker, 2012). Our analysis captured membership data for 202 CMEs. The combined total of all memberships for this group was 29.3 million, which includes the members of automotive associations, superannuation funds, credit unions, customer owned banks, health insurance mutual funds, and co-operatives.

Data on employment was also available for 258 CMEs. These firms reported a combined full-time employment pool of 39,284 people and a combined part-time employment pool of 13,038, suggesting that the CME sector created employment for more than 52,322 people in 2016. Other social indicator data encompassed within the 2017 ACMEI study is that out of 360 CMEs where information on board directors was available, 345 (95.8%) reported having female directors with an average of 3 female directors on each board.

WHICH ARE THE LEADING CMES IN AUSTRALIA?

As part of the research contribution to the annual National Mutual Economy Report (BCCM, 2014; 2015; 2016) a league table of the Top 100 CMEs by annual turnover has been prepared. This provides a ranking of the largest firms by financial turnover and is consistent with the Top 100 largest co-operatives reporting that existed prior to the development of the ACMEI-NME study (e.g. CA, 2010; 2011; 2012). The key measures used in this assessment are annual turnover, assets and membership. All figures are taken from the FY2016 period due to the difficulty of securing reliable annual reports for the 2017 period.

THE TOP 100 CMES BY TURNOVER

One measure of assessing leadership in a business sector is the gross annual turnover of the firms that operate within it. This is how the Top 100 of CMEs has been traditionally calculated and for the 2017 report we have taken the gross turnover for FY2015/16 and drawn the largest firms by size of revenue. The reason for taking the data from FY2015/16 is that many firms did not have their FY2016/17 data available at the time this report was being complied. A further reason is that many CMEs in the sector report their figures for the calendar year rather than the financial year, and others don't issue annual financial reports until late in the year.

It should be noted that we deliberately excluded the member owned superannuation funds from the Top 100 CMEs due to their size from an annual turnover and assets perspective. These businesses have been listed separately in Appendix B.

Appendix A lists the Top 100 CME by gross annual turnover for FY2015/16. It comprises 28 co-operatives, 70 mutual enterprises and 2 friendly societies. The largest firm by turnover was the WA-based grains storage, handling and marketing business Co-operative Bulk Handling Ltd (CBH Group), which reported an annual turnover of $3.27 billion. This was the seventh year in a row that CBH had been ranked as Australia's largest CME by annual turnover. In second place, and for the past four years, was Australia's largest dairy business the Victorian based Murray Goulburn Co-operative Ltd (MGC) with an annual turnover of around $2.78 billion. In third place, again for the fourth year in a row, was the mutual health insurance firm, the Hospital Contribution Fund (HCF) from New South Wales (NSW). This business had an annual turnover of just over $2.46 billion.

The top 10 CMEs by annual turnover for 2016 were:

1. Co-operative Bulk Handling Ltd (CBH Group) [WA] – $3.27 billion.
2. Murray Goulburn Co-operative Ltd (MGC) [VIC] – $2.78 billion.
3. Hospital Contribution Fund (HCF) [NSW] – $2.46 billion.
4. Capricorn Society Ltd [WA] – $1.54 billion.
5. HBF Health Ltd [WA] – $1.51 billion.
6. Australian Unity [VIC] – $1.42 billion.
7. Members Equity Bank Ltd (ME Bank) [VIC] – $1.22 billion.
8. RACQ [QLD] – $1.03 billion.
9. RAC WA [WA] – $676.7 million.
10. RACV [VIC] – $584.8 million.

This pattern of Top 10 CMEs by turnover has remained the same over the past year, with co-operative and mutual enterprises from the agribusiness, health insurance, financial services and automobile club sectors featuring prominently in the list.

TOP 100 CME BY ASSETS

When ranked by total assets held (current and non-current assets), the mutual enterprises operating in the banking and finance sector topped the list. Appendix C lists the top 100 CMEs by assets, liabilities and equity. The Top 10 CMEs by assets were:

1. Members Equity Bank Ltd (ME Bank) [VIC] – $23.20 billion.
2. Credit Union Australia (CUA) [QLD] – $12.90 billion.
3. Newcastle Permanent [NSW] – $9.77 billion.
4. Heritage Bank Ltd [Qld] – $8.44 billion.
5. People's Choice Credit Union [SA] – $7.51 billion.

6. Greater Bank (Greater Building Society) [NSW] – $5.71 billion.
7. Teachers Mutual Bank Ltd [NSW] – $5.54 billion.
8. IMB Limited [NSW] – $5.22 billion.
9. Australian Unity [VIC] – $4.82 billion.
10. Beyond Bank (Community CPS Australia Ltd) [SA] – $4.76 billion.

TOP 100 CME BY MEMBERSHIP

As noted above there was reliable data on the membership of at least 202 CMEs. Appendix D provides a full list of the Top 100 largest CMEs by membership. However, the Top 10 (incorporating the member owned superannuation funds) were:

1. NRMA [NSW] – 2.4 million members.
2. Australian Super [VIC] – 2.1 million members.
3. RACV [VIC] – 2.1 million members.
4. University Co-operative Bookshop Ltd [NSW] – 2.1 million members.
5. Retail Employees' Superannuation Fund (REST) [NSW] – 1.9 million members.
6. RACQ [QLD] – 1.6 million members.
7. HBF Health [WA] – 1.03 members.
8. HOSTPLUS [VIC] – 985,419 members.
9. RAC WA [WA] – 840,000 members.
10. Health Employee's Superannuation Trust Australia (HESTA) [VIC] – 800,000 members.

FINANCIAL PERFORMANCE OF TOP 100 CMES

The combined annual turnover for the Top 100 Australian CMEs (excluding the member owned superannuation funds) for FY2015/16 was approximately $30 billion with combined assets of just over $153 billion. Table 3 provides a summary of the financial performance of the Top 100 CMEs over the past five financial years. This shows an increase over the previous five financial years of 6.6% for annual turnover and a further increase of 10.5% for assets. In terms of the general financial performance of these firms' median figures are shown for annual turnover, earnings before interest and tax (EBIT), net profit after tax (NPAT), assets, liabilities and equity. A median rather than a mean was used due to the high standard deviation across the largest and smallest firms in the Top 100 group.

TABLE 3: TOP 100 AUSTRALIAN CMES FINANCIAL PERFORMANCE FY2011/12-FY2015/16

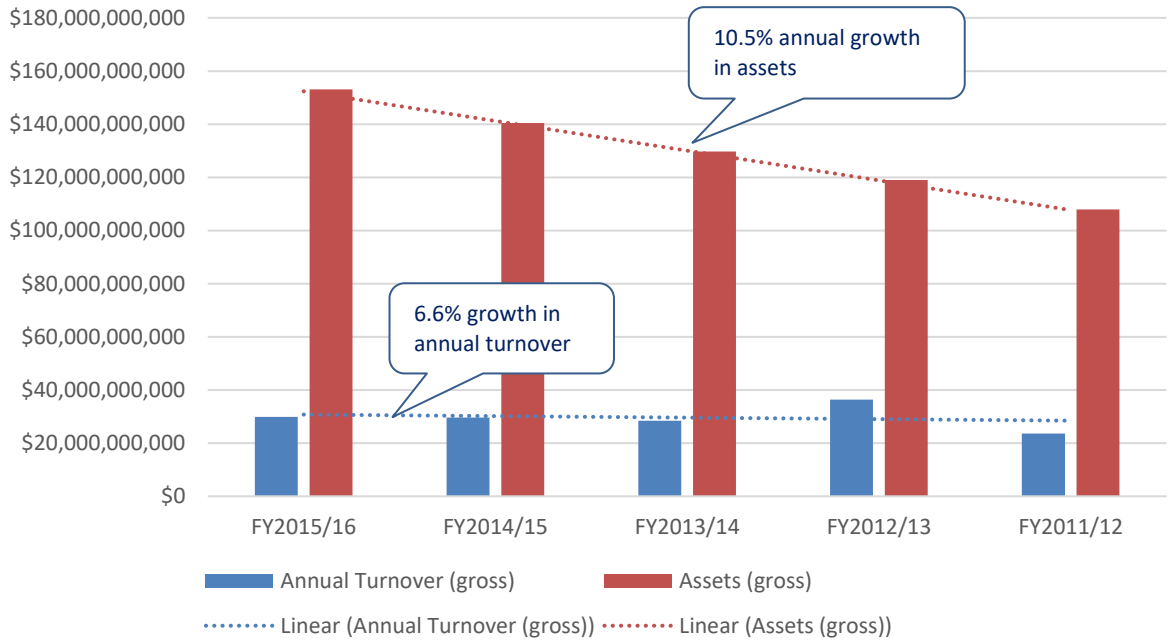
	FY2015/16	FY2014/15	FY2013/14	FY2012/13	FY2011/12	% Change
Annual Turnover (gross)	$29,891,839,463	$29,620,051,178	$28,475,809,226	$36,372,528,461	$23,657,015,064	6.6%
Assets (gross)	$153,117,735,856	$140,378,982,934	$129,715,995,117	$119,005,436,097	$107,913,188,309	10.5%
Annual Turnover (median)	$97,948,500	$122,578,741	$114,298,750	$104,624,084	$100,533,701	-0.6%
EBIT (median)	$5,267,500	$9,040,000	$10,631,755	$9,463,000	$13,747,000	-15.4%
NPAT (median)	$4,142,000	$6,902,029	$7,824,093	$7,498,000	$10,494,000	-15.1%
Assets (median)	$507,855,000	$712,491,000	$671,022,835	$611,896,895	$696,937,784	-6.8%
Liabilities (median)	$218,249,000	$422,734,000	$519,308,442	$526,369,000	$210,121,000	1.0%
Equity (median)	$94,906,500	$114,701,984	$106,155,000	$97,013,000	$122,570,000	-5.6%

[1] EBIT = Earnings before interest and tax. [2] NPAT = Net profit after tax.

It can be seen from Table 3 that growth in annual median income within the Top 100 CMEs declined slightly over the past five years by 0.6%. Median gross profit (EBIT) and median net profit (NPAT) also fell significantly by more than 15%. Significant declines were also found across median assets and equity.

Figures 1 and 2 illustrate the trend in median annual turnover and assets (Figure 1), and median earnings before interest and tax (EBIT) and median profit after tax (NPAT) (Figure 2).

FIGURE 1: TOP 100 CME ANNUAL (GROSS) TURNOVER AND ASSETS FIVE YEAR TREND



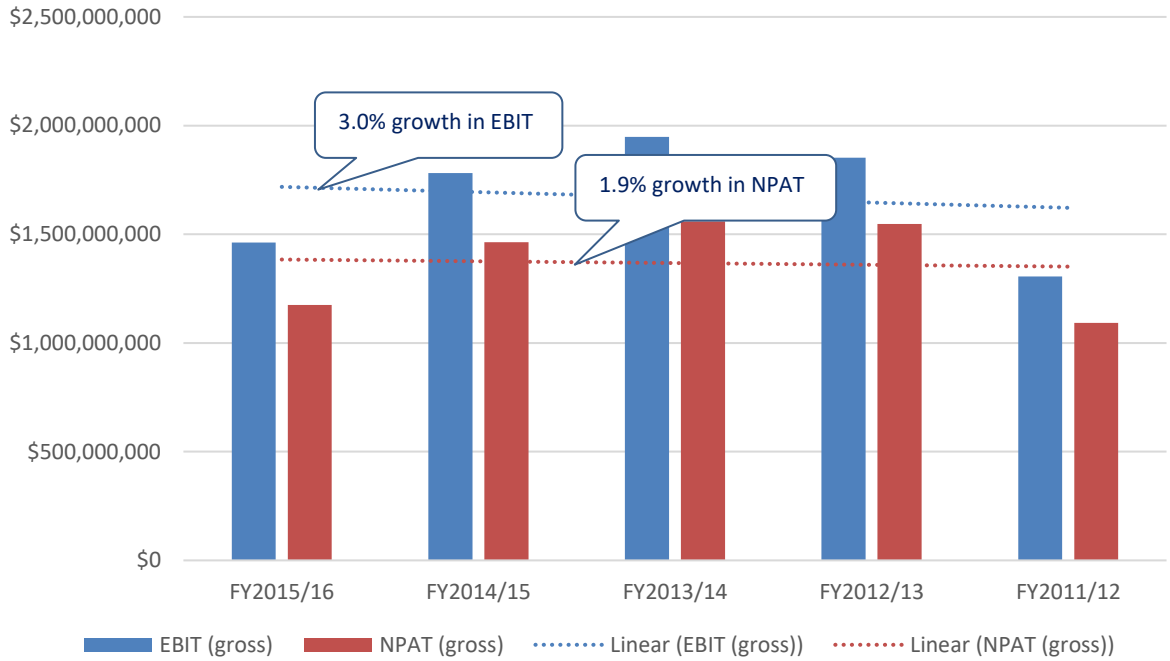
As shown in Figure 1, the trend in annual turnover and assets across the Top 100 CMEs over the five-year period from FY2011/12 to FY2015/16 shows an average growth rate in annual turnover of 6.6% for turnover and 10.5% for assets. Gross annual turnover grew from $23.7 billion in FY2011/12 to $29.9 billion in FY2015/16. Gross assets for the same period saw a rise from $107.9 billion to $153.1 billion.

However, an examination of median annual turnover and assets found there has been little or no significant growth in median annual turnover with an average decline in the growth rate of 0.6% over the past five years. The average growth rate in median assets was a negative 6.8% for the same period. Major declines were also found for profitability and equity. For example, both median EBIT and NPAT experienced negative average growth rates of 15.4% and 15.1% respectively, and median equity of negative 5.6% growth. However, median liabilities grew at an average rate of 1% over the five years from FY2011/12 to FY2015/16.

As illustrated in Figure 2 the gross earnings before interest and tax (EBIT) and net profit after tax (NPAT) for the Top 100 CMEs rose and fell over the previous five years from FY2011/12 to FY2015/16, with declines in profitability from FY2013/14. However, the overall trend saw gross EBIT rise by an average of 4.3% and NPAT by an average of 3.1%. Nevertheless, the general trend in recent years has seen profitability fall.

An analysis of these profitability figures by industry sector within all firms in the database not just the Top 100, suggests that decline in profitability was generally uniform across most sectors. For example, the mutual health insurance funds experienced a median annual growth in turnover of 21.1% over the five-year period from FY2011/12 to FY2015/16. However, their median EBIT and NPAT both declined by an average of 9.6%, while median assets fell by an average of 0.1% over the same period.

FIGURE 2: TOP 100 CME (GROSS) EBIT AND NPAT FIVE YEAR TREND



In financial services sector the median annual turnover for the credit societies, customer owned banks and building societies declined by an average of 16% over the five-years from FY2011/12 to FY2015/16, with EBIT and NPAT both declining by 22% over the same period. By contrast the automobile clubs within the motoring services sector fared better, with their median annual turnover growing by an average of 6%, their EBIT by 39.5% and their NPAT by 25.6%. The co-operatives in the agribusiness had a more mixed experience, with median annual turnover growing by 9.2%, while their median EBIT and NPAT declined by just over 20%.

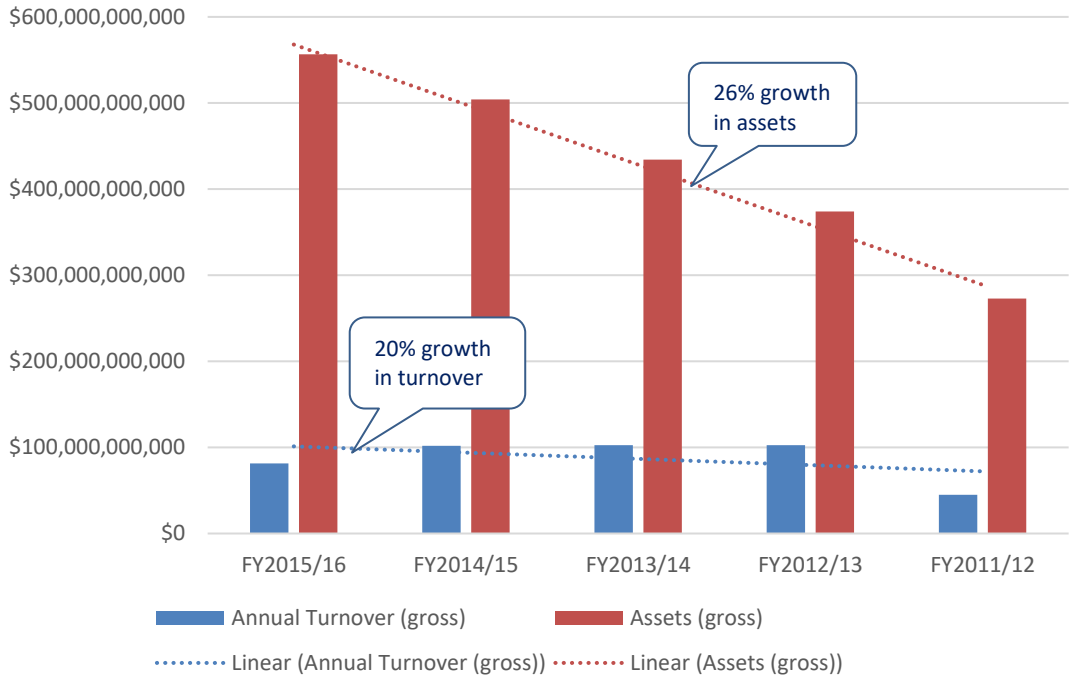
Amongst the major Top 100 co-operatives Murray Goulburn reported significant increases in EBIT over the three years from FY2013/14 to FY2015/16, yet other large agribusiness co-operatives experienced significant declines. For example, CBH Group Ltd saw its EBIT decline from $160.5 million to $51.5 million over the three-year period to FY2015/16, and the Namoi Cotton Co-operative Ltd saw its EBIT fall from $7.68 million to a loss of $10.7 million in the same period.

FINANCIAL PERFORMANCE OF THE MEMBER OWNED SUPER FUNDS

An examination of the financial performance of the Member Owned Superannuation Funds over the same five-year time period found a strong positive trend in both gross and median annual turnover and assets. Figure 3 illustrates these trends. Total annual turnover within the member owned super funds rose from around $44.8 billion in FY2011/12 to $81.4 billion in FY2015/16. Total assets rose from $272.8 billion to $556.6 billion over the same five-year period.

Median turnover and assets were also examined due to the variance that exists across the 43 member-owned super funds in terms of size. A positive growth trend was still found, with median annual turnover rising by 10.3% and median assets by 21.2% over the previous five years. The profitability of the superannuation funds was also positive. Over the five-year period from FY2011/12 to FY2015/16, median EBIT increased by 4.3% and median NPAT by 6.4%.

FIGURE 3: MEMBER OWNED SUPER FUNDS (GROSS) TURNOVER AND ASSETS FIVE YEAR PERIOD



OBSERVATION

Based on the available data the picture emerging from this year's financial analysis of the CME sector is that while the overall pattern across the sector is one of growth, some variation was found between industry sectors. This was particularly noticeable in relation to industry profitability. As discussed above, the superannuation industry, as represented by the member-owned superannuation funds, demonstrated good growth in annual turnover and assets, with quite healthy profits. A similarly positive pattern was found within the motoring services sector, with the automotive clubs generally demonstrating quite good growth in turnover and very good levels of growth in profitability.

However, within the health insurance industry the pattern was more subdued, with relative strong growth in turnover, but equally large declines in profitability. As outlined in the case study on HIF later in this report, the private health insurance industry has experienced rapid growth in the past five years, but much of this has been at the expense of profits, and the outlook for growth and profitability remains somewhat problematic.

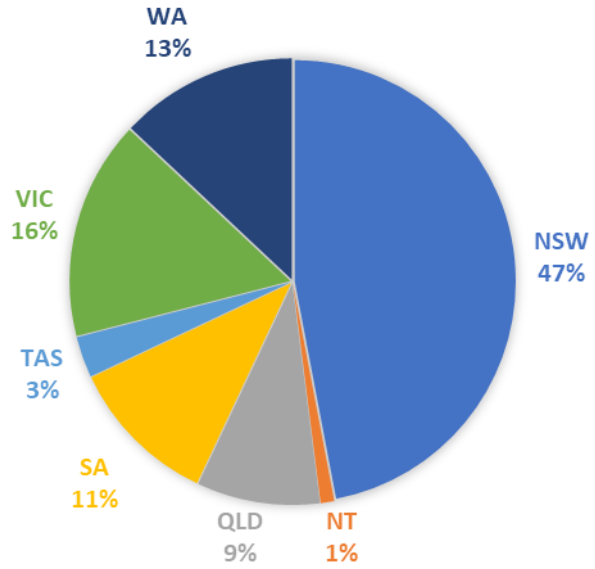
The financial performance of the credit societies, customer owned banks and building societies was also found to be one of increasing assets, but declining rates of profitability and little real growth in total annual turnover. Finally, the agribusiness sector showed an overall pattern of strong growth in both annual turnover and assets, but a significant decline in profitability.

This is the first year in which we have had sufficient financial data to examine both longitudinal trends and inter-sectoral performances. The data still remains available for only a small proportion of all CMEs, with 17% of the 2,134 active firms suppling financial data for FY2015/16, and an average of 9% across the entire five-year period from FY2011/12 to FY2015/16. As time passes it is hoped that the supply of financial data from across the CME sector will increase as firms participate in this annual review.

Geographic Distribution of the Top 100 CME

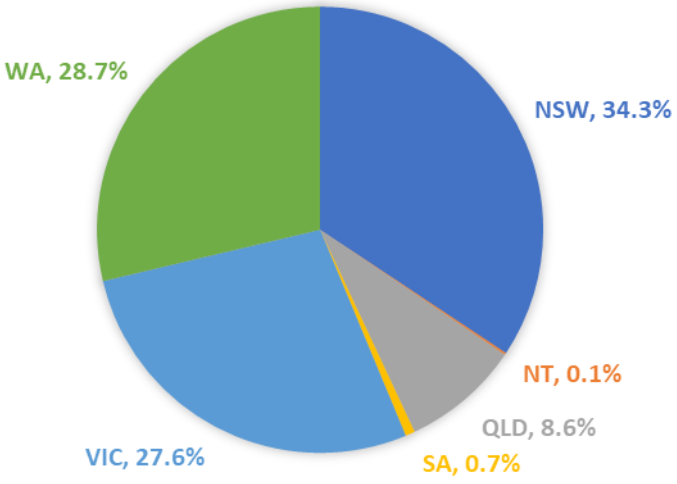
The largest proportion (47%) of CMEs in the Top 100 was headquartered in NSW. This is not surprising as NSW has the greatest number of CME of all kinds. The other states and territories accounted for the remainder as follows: Victoria 16%, South Australia 11%, Western Australia 13%, Queensland 9% and Tasmania 3%. This year the Northern Territory had one CME in the Top 100 lists. This was the Central Australian Aboriginal Congress Aboriginal Corporation. Figure 4 illustrates the distribution of the Top 100 by State and Territory.

Figure 4: Top 100 CME Distribution by State and Territory



Despite having only 13% of the Top 100 CMEs, WA accounted for 28.7% of the combined turnover, whereas NSW with 47% of the businesses accounted for 34.3% of total turnover. Figure 5 illustrates the breakdown of collective turnover for the FY2015/16 by State and Territory. This is a reflection of the presence in WA of several large CMEs, including the CBH Group, HBF Health Ltd, Capricorn Society Ltd and the RACWA.

Figure 5: Top 100 CME Turnover by State and Territory



Distribution of the Top 100 CMEs by Industry

Figure 6 shows the distribution of the Top 100 CMEs by industry. These firms represent a wide range of industry sectors although the largest concentration (41%) were found within the financial services sector. This includes the customer owned banks, credit unions, friendly societies and building societies. The second largest concentration (17%) was in the area of private health insurance (PHI), where there were a large number of PHI mutual funds. The third largest concentration was in the agribusiness sector. Here were a mixture of producer co-operatives encompassing storage, handling and processing of grains, milk, meat, fruit, berries, nuts, sugar and cotton.

Figure 6: Top 100 CME Turnover by Industry Sector

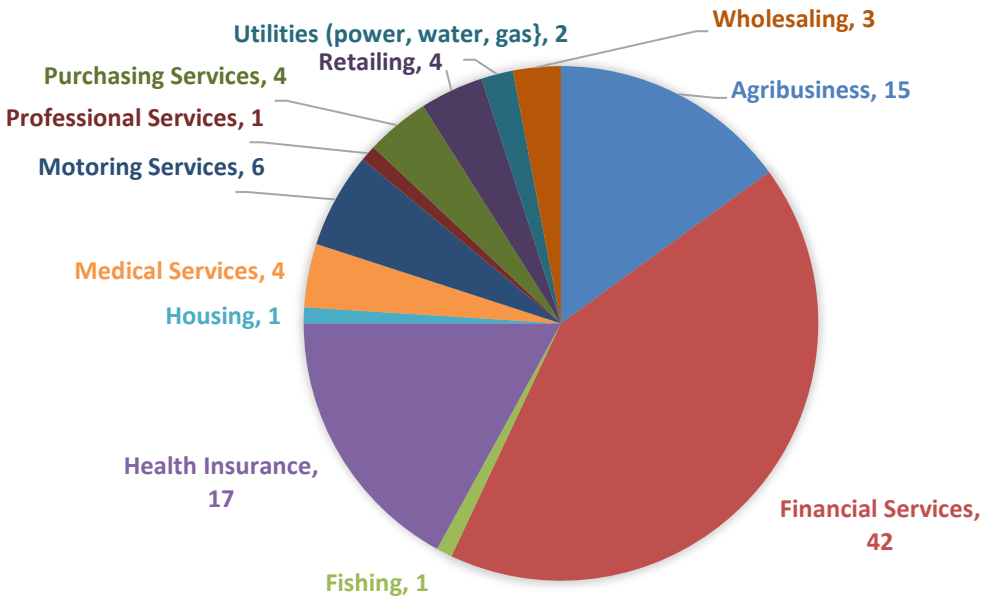


Table 4 provides a breakdown of the various industry sectors and how the Top 100 CMEs are grouped by a range of financial indicators. As can be seen three sectors contained only a single firm so it is difficult to draw any substantive conclusions from them. The firms in these sectors not only represent the largest CMEs in Australia, but also some of the largest firms in their industry sector.

For example, Australia's largest co-operative CBH Group Ltd has 27.4% of the national grain storage industry placing it well in front of the three other major competitors GrainCorp Ltd, with 16% market share, or Glencore Grain Pty Ltd and Cargill Australia Ltd, which both have just over 7% of the national market (Tonkin 2016a). It also has 19% of the national grain wholesaling market, which places it almost equal with Glencore Grain Pty Ltd (19.2%), and in front of GrainCorp Ltd (11%) and Cargill Australia Ltd (6.6%) (Tonkin 2016b).

In a similar way the second largest co-operative, Murray Goulburn Co-operative Ltd, has around 42.5% of the national milk powder market (Tonkin 2016c), 26.9% of the butter and dairy market (Tonkin 2016d), 31.3% of the milk and cream processing market (Tonkin 2016e), and 11.8% of the cheese manufacturing market (Tonkin 2016f). Further, the Geraldton Fishermen's Co-operative Ltd comprises around 25% of the $1.5 billion national fishing industry (De Corrado 2016).

Within the health insurance industry, the largest mutual PHI funds, the Hospitals Contribution Fund of Australia Ltd (HCF), HBF Health Ltd, Australian Unity Ltd and Teachers Federation Health Ltd together hold around 22.2% of the national market (Wu 2016). In the liquor wholesaling industry, the Independent Liquor Group (Suppliers) Co-operative and Independent Liquor Group Distribution Co-operative hold around 6% of the Australian market (Thomson 2017).

TABLE 4: TOP 100 AUSTRALIAN CO-OPERATIVE AND MUTUAL ENTERPRISES FY2015/16 BY SECTOR

Sector	N	Combined Turnover	Median Turnover	Median EBIT	Median NPAT	Combined Assets
Agribusiness	15	$8.2bn	$134.1m	$1.5m	$0.99m	$5.2bn
Banking and Financial Services	41	$5.2bn	$62.6m	$8.3m	$7.3m	$123.6bn
Fishing	1	$372.2m		$0.46m	$1.2m	$140.9m
Health Insurance	17	$8.1bn	$162.6m	$7.8m	$7.7m	$10.7bn
Housing	1	$44.5m		$3.3m	$3.3m	$787.6m
Medical Services	4	$158.0m	$38.5m	$1.7m	$1.7m	$131.8m
Motoring Services	6	$3.2bn	$571.2m	$33.5m	$26.7m	$8.1bn
Professional Services	1	$281.5m		$28.4m	$26.2m	$2bn
Purchasing Services	4	$1.8bn	$100.8m	$1.5m	$1.1m	$424.8m
Retailing	4	$306.7m	$72.1m	$0.88m	$0.68m	$144.1m
Utilities (power, water & gas)	2	$149.5m	$74.7m	($9.7m)	($2.1m)	$1.1bn
Wholesaling	3	$649.3m	$209m	$7.6m	$1.3m	$114.1m
TOTAL	100	$30.3bn	$102m	$5.3m	$4.1m	$153.5bn

Notes to Table:

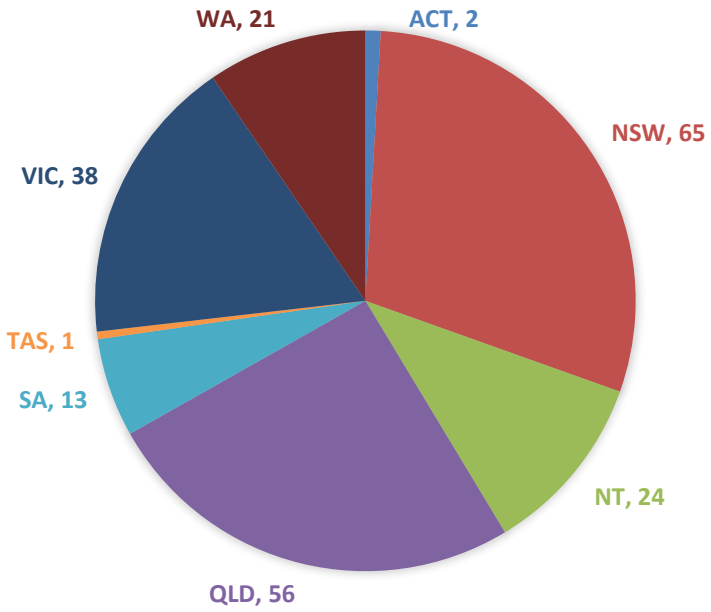
1. EBIT= earnings before interest and tax. NPAT = net profit after tax. All values are reported in Australian $ million
2. Only the Top 100 Australian CME by turnover for the FY 2015/16 was considered for inclusion in this list. Refer to the Appendix A notes.

As can be seen from this overview of the Top 100 firms, the CME sector in Australia is distributed across a wide-range of industry sectors, and many of these firms are major players in those sectors. The member-owned superannuation funds are also a significant part of the national superannuation industry. For example, Australian Super has 4.6% of the national market share, making it the largest fund in 2016 (Wu 2017). The combined annual turnover for the 43 member-owned superannuation funds represented around 29% of the total industry revenue for FY2015/16 (Wu 2017).

ABORIGINAL AND TORRES STRAIT ISLANDER CMES

A significant part of the Australian CME sector is those enterprises that are owned and operated by the Aboriginal and Torres Strait Islander (ATSI) community. There were at least 220 ATSI CMEs actively trading in FY2015/16. As shown in Figure 6, they were distributed across all states and territories, with the largest number found in NSW and Queensland.

FIGURE 6: ABORIGINAL AND TORRES STRAIT ISLANDER CMES BY STATE AND TERRITORY



As noted earlier, the majority of these CMEs were focused on the delivery of medical services (70%) or community services (15.5%), housing (5.5%) or Arts and Culture (4.1%). However, in practice these enterprises offer a wide range of services (e.g. child care, education, financial assistance) and are a key part of their local communities.

Many (approx. 30%) of these ATSI CMEs are registered as charities with the National Charities and Not-for-profits Commission (NCAC). The Senate inquiry in CMEs found that while ATSI co-operative and mutual enterprises were making a significant contribution to their communities, they were often not well recognised in their achievements, and that there has been a lack of support for communities wishing to establish them (The Senate 2016. As noted in their report:

> *"Evidence suggests the co-operative model is ideal in delivering services in remote areas, such as Indigenous communities, where issues can be complex and service provision through the private sector is often not suitable or available…Despite their apparent suitability to deliver services through community ownership in communities, the committee heard that many co-operatives are being pressured to convert to corporations in order to access government funding"* (The Senate 2016 p. 38).

This led The Senate to recommend amendments to the Indigenous Advancement Strategy to allow co-operatives better access to grant funding and put them on the same level as other forms of business model.

In the following sections of this report we overview several case studies of CMEs with a specific focus on the health services and health insurance sectors.

NATIONAL HEALTH CO-OPERATIVE: CHALLENGING THE STATUS QUO

The National Health Co-op (NHC) is a non-distributing (not-for-profit), member owned health services co-operative headquartered in the Australian Capital Territory (ACT).

At time of writing NHC had around 36,000 individuals who used the co-operative's services as patients. It also employed more than 90 staff in medical and administrative roles across eight sites located within Canberra. In 2016 NHC generated revenues of just over $8.3 million and had total assets of around $2.2 million (NHC 2016). Adult members who join the co-operative pay an initial $30 joining fee and a monthly fee of $10 or annually at a discount rate of $100. This entitles them to unlimited access to bulk-billed primary healthcare services.[1] Members' children aged under 18 years, are free (Peake 2016b). However, free membership is also provided to members in need on a case-by-case basis.

The range of services provided by NHC includes general practitioner (GP) medical treatment, psychology, diabetes education, physiotherapy, dietetics, clinical pharmacy, obstetrics and gynaecology, aged care, practice nursing, and neuropsychological assessments. The primary aim of NHC is to deliver affordable and accessible healthcare to its members, and to significantly reduce preventable diseases.

RESPONDING TO A MARKET FAILURE

Like most co-operative and mutual enterprises (CMEs) the creation of NHC was motivated by a community response to a market failure. This took the form of a lack of General Practitioners (GPs) in the West Belconnen region of Canberra. This northern suburban area is home to over 20,000 people, but the continuous closure of medical practices had left many households without ready access to GP services. This decline in GP services, in particular bulk-billing clinics, across the ACT had been taking place for many years. For example, in 2003 the ACT had the lowest bulk-billing rates (37%) in Australia, where the national average was around 87 percent (Peake 2016a).

In September 2004, local residents and community organisations held a public meeting to discuss this GP shortage. An outcome of this meeting was the formation of a community representative committee, with a small executive group tasked to identify potential solutions. The co-operative business model was identified as a potentially effective solution to the problem. The justification for selecting a co-operative business model was explained by the NHC management as follows:

> *"The co-operative business model was selected after a great deal of consideration by the establishment committee because it is a model that is legitimately owned by the community, and is there solely for the benefit of the community. Further, it is a really nice model that allows the business to operate as a 'business', but ensures that the ownership of the business remains vested in the community, and the community benefits from the services that are delivered"* (Blake Wilson, Deputy CEO NHC).

The establishment committee had considered other business model options. For example, an initial choice was a not-for-profit Association registered under the *Associations Incorporation Act (ACT) 1991*. However, this was not considered to be sufficiently robust, nor did it compel the organisation's board and management to act in the interests of the community. The Association model was also limited by the number of members that it could have before it would be required to reorganise into a corporation limited by guarantee.

[1] Bulk-billing by GP clinics involves the doctor charging all their fees directly to Medicare rather than charging the patient directly and then having the patient make the claim to Medicare for reimbursement.

The West Belconnen Health Co-operative Ltd was established in December 2006, and registered under the *Co-operatives Act (ACT) 2002*. Its first GP clinic was opened in January 2010 in the Canberra suburb of Charnwood. This suburb had been particularly affected by the loss of GP services placing increasing pressure on retail pharmacists to deliver frontline healthcare. Community concerns were being expressed within local community groups such as Neighbourhood Watch and the Parents and Citizens (P&C) group at the local Primary School. Initial capital grants of around $400,000 were secured from the ACT and federal governments to compliment the community generated support. These resources enabled the recruitment of a doctor from the United Kingdom, and the establishment of the first GP clinic (Peak 2016a).

Membership increased strongly, and by 2016 NHC had eight GP clinics located across the ACT and had moved into New South Wales (NSW) with the building of a clinic in Yass. In 2014 the name changed to National Health Co-operative, to reflect the wider goals of the co-operative. The board of the NHC now plans to expand nationally, and since the adoption by the ACT Government of the *Co-operatives National Law (ACT) Act 2017*, considers that there are few legislative impediments to this ambition.

PURPOSE AND MEMBER VALUE PROPOSITION

In designing the underlying business model of the NHC, a core purpose or 'philosophy' was adopted that seeks to differentiate the co-operative from the mainstream 'corporate medicine' model, which is focused primarily on profit. As a non-distributing co-operative, NHC uses all its revenue to deliver services to its members, and seeks to achieve both economic and social outcomes. The co-operative is a registered charity under the Australian Charities and Not-for-profits Commission (ACNC), and this makes a difference, as explained by NHC CEO Adrian Watts:

> *"Where does the money go? We need to invest every single dollar back into healthcare. If we were a distributing co-operative, and effectively giving back the patient's money, it wouldn't really make much sense to us. So that is why we decided very early on to be a non-distributing co-operative and therefore not-for-profit."*

According to the NHC senior management, the motivations that their members have in joining the co-operative are varied. For example, many are driven primarily by financial motivations, to access affordable healthcare. The bulk-billing of GP services and competitive pricing of other services offered by NHC is therefore attractive to these people. However, there are also many more people who have embraced the co-operative spirit. These people like the idea that the NHC is member owned, is a not-for-profit charity, and exists only for the benefit of its members.

As explained by NHC's senior managers, their membership engagement strategy is focused on communicating that the co-operative is different because it is a member-owned, not for profit enterprise. Further, it is committed to offering affordable healthcare to all Australians not just existing members. NHC also aims to significantly reduce the instances of preventable diseases, and the personal and societal impact of preventable conditions. The co-operative actively promotes this vision to the wider community:

> *"Being told about the vision and objectives of this organisation, which are far bigger than any single individual's specific use case, is a really big factor in explaining why we exist"* (Blake Wilson, Deputy CEO NHC).

The NHC feels that their message of purpose and the value proposition that they put to their members is resonating with the community in particular young people. This is viewed as a 'massive backlash' against the incumbent business corporations, in particular big business:

> *"Well, you see this manifested by the protests against big banks, or the major supermarket chains, which just can't resonate with the community at large anymore. That is because people are disconnected. They've seen these giant corporations, operating for the benefit of shareholders, but not their customers, and there is a general distrust. But the co-operative is not like that. We are not run for the profit of a few, we are run for the benefit of many, our members"* (Adrian Watts, CEO NHC).

ENHANCED HEALTHCARE AND KEEPING PEOPLE OUT OF HOSPITAL

NHC considers that its key point of strategic differentiation is its focus on 'Enhanced Healthcare'. This is the ability to manage a patient's health, including pre-existing conditions, so as to keep them out of hospital and thereby avoid higher costs to both the patient and the national healthcare system. As explained by Blake Wilson, Deputy CEO NHC:

> *"One of the biggest contributions we can possibly have is keeping people out of hospital. So, the fact that you get people going to hospital because they have unmanaged chronic diseases, or they haven't been pre-treated or haven't had access to alternative affordable healthcare options, are all problems that we can solve now. A major way we can have impact is by looking at the data we have, looking at it in total via a cohort analysis, and then predicting diseases that a patient might get based on their profile. Then we can pre-treat and we are already doing this by enrolling people in programs and providing outreach services to individuals who are likely to develop a disease and then help to reduce their risk of getting ill"*.

This view was echoed by Brian Frith, Chair NHC who explained the wider contribution that the approach being taken by the co-operative could have on the national healthcare system:

> *"We've measured the impact that our model has on territory and federal government savings, and they are so much that effectively we can claim that our patients' don't end up in hospital because of the management programs we have in place, and therefore that is a very positive saving to the community and to the Australian public."*

NHC'S CHALLENGE TO THE STATUS QUO OF HEALTHCARE SERVICES

A key factor motivating the board and senior management of NHC is the spiralling cost of healthcare in Australia. In 2016 the healthcare services sector was estimated to generate annual revenues of around $120 billion, with a forecast growth rate of about 3 percent over the period to 2022 (Mullaly 2016). This high growth rate has been the same over the previous five years, driven by an ageing population, and the increased growth in private health insurance.

Against this growing demand for healthcare services, federal and state government health budgets have been placed under increasing strain. Much of the burden has fallen on the rising cost of hospital services, and other primary care such as GP medical services. Medicare costs are forecast to rise by an annualised rate of around 4.6 percent over the next five years, leading to the federal government placing a freeze on Medicare rebates for GP services until 2018 (Mullaly 2017).

This freeze on Medicare rebates will significantly impact the GP medical services sector. In 2017 there were around 6,338 GP services businesses across Australia, the majority of these being small, independent proprietorships. A handful of large investor owned firms such as Sonic Healthcare Ltd, Primary Health Care Ltd, and Healthscope Ltd, control around 7 percent of the market, which was estimated to be worth around $12 billion in 2017 (Mullaly 2017).

Major health insurance providers have also commenced entering this market. For example, in 2014 BUPA Medical Pty Ltd (now BUPA Hi Holdings Pty Ltd), a subsidiary of UK-based global health insurance giant BUPA, opened its first GP clinic in Sydney. This complements the existing acquisition of dental clinics, optometrists and

other healthcare services businesses by BUPA within Australia and New Zealand during the past decade (IBISWorld 2015).

Faced with rising demand and the government's freeze on Medicare rebates, the GP services sector has seen its profits squeezed. To compensate GPs have adopted one of two business models. The first is the traditional small, independent medical practice with lower patient volumes, but able to compensate by not bulk-billing, and charging higher fees than the standard Medicare schedule. The second, is that of the large-scale GP clinics, with higher patient throughput, but without the choice of doctor for many patients. These clinics bulk-bill, and maintain their profit margins through economies of scale and a tight control over time spent per patient by each doctor (Mullaly 2017).

The NHC believes that its co-operative business model may be able to address many of the problems facing the national healthcare services sector. They view the rising cost of GP services as potentially something that can be addressed by increasing the supply of GP practitioners. However, they note that the most important factor that has pushed up the cost of healthcare is the dominance of investor owned business models within the sector, which are focused on the maximisation of shareholder returns.

According to NHC management, the investor owned firm's business model represents a "misalignment of incentives" with shareholders seeking increasing returns via higher profits, and the consumer wanting more affordable healthcare services:

> *"So, this goes back to some classic Adam Smith economics, where a lot of organisations, such as private health insurance companies primary goal is to maximise shareholder returns. Now that is completely appropriate for their style of company, but it is a misalignment with what the end consumer needs. When you've got a situation in which private companies are seeking to maximise shareholder investment, you can only do it a certain way. You can either charge more to increase revenue, spend less, or do both. This results in a situation in which the company is working against the interests of the individuals that it is supposedly serving. By comparison, a co-operative or mutual business model, such as NHC or HCF, they exist to provide benefits to their members. Raising revenue is a by-product of the services that they provide and a mechanism within which to provide the services that are demanded. So, there is no misalignment"* (Adrian Watts, CEO NHC).

The focus of NHC is to keep the cost of their services as low as possible and reinvest any surplus funds back into the delivery of more services. To this end the co-operative aims to increase its growth in order to help grow the overall healthcare sector, and also maintain the affordability of primary healthcare to the Australian public. It views this mission as a critical one that will focus its strategic activity over the longer term.

PLANNING FOR A NATIONAL EXPANSION

With the success of NHC within the ACT and regional NSW the co-operative's board is now looking to the future and planning for a national expansion. However, in the short term (i.e. 2017-2019) attention will be given to consolidation of the existing network of GP clinics within the ACT and surrounding regions in NSW. Having captured around 10 percent market share within the ACT and regional area, NHC aims to grow this to around 20 percent in the period to 2020, thereby providing the co-operative with a very strong base within Canberra from which to grow.

Over the medium to long term (i.e. 2020-2027), the NHC plans to establish around 200 clinics across every state and territory in Australia. A potential challenge facing NHC will be to replicate its business model in large states such as Queensland and Western Australia where there is a need for frontline healthcare services in regional and remote areas. However, the co-operative's management are willing to embrace this challenge as it is something that needs to be done.

An advantage the NHC feels it has is that it does not have any incumbent infrastructure to worry about. This allows them to avoid the previous high 'up-front' infrastructure costs, and use more flexible models and technologies for service delivery. One of its potential growth paths will be to work with the existing small GP practices:

> *"So, could we see integration with small GP practitioners? Yes, we are going to bring a whole lot of efficiencies. Let's say we have a three-doctor practice 1,000 kilometres away from the nearest major city, then we may be able to have them become part of the co-op itself. They probably would not significantly change the way they deliver healthcare on a one-to-one basis, but they would gain access to a whole lot of additional allied healthcare services and support mechanisms, and thereby giving them more time to spend back with their patients* (Blake Wilson, Deputy CEO NHC)*."*

The range of medical and healthcare services that NHC offers is already wide and the approach taken by the co-operative in the management of these services enables them to be offered to its members at a cost that is lower than might be otherwise obtained on the open market.

> *"In addition to the many health specialists we already employ, we are working with independent private businesses, who we essentially manage on behalf of our members, and we do this in a manner that allows them to access this medical service at a rate much cheaper than they might do on the open private market. At the same time, we help that clinician manage their business, so they can go home at night and spend time with their family instead of worrying about their business systems. Our approach to how we deliver better healthcare to members is solution agnostic, we don't mind how we do it, it is the outcome that we are concerned about"* (Adrian Watts, CEO NHC).

Overtime NHC may even consider moving into the management of hospitals. This is not something they are currently planning to do, but they acknowledge that this is the area of greatest cost to the Australian healthcare sector. In the more foreseeable future, NHC has identified areas such as day surgery where it might be able to provide value to its members. In addition, NHC considers that it can potentially take a lot of cost pressures off hospitals by providing in home care:

> *"We can take a lot of the load off hospitals by providing in-home care. This really leverages our workforce and our community roots, to change the way that people view a hospital and the way those services are delivered. And the biggest contribution we can make is keeping people out of them"* (Adrian Watts, CEO NHC).

STRATEGIC CHALLENGES AND FUNDING FOR GROWTH

The key strategic challenges that NHC sees in the future are changes to government policy. For example, the Medicare rebate freeze has impacted the co-operative due to its focus on bulk-billing. Another challenge is accessing capital. As a non-distributing co-operative NHC does not have the option of attracting investment and has grown its business to date on retained earnings and debt. However, the co-operative has been monitoring alternative capital raising options for future growth. This may see NHC consider a range of financing options such as co-operative capital units (CCUs):

> *"CCUs are certainly one option we could consider moving forward. However, we've got to make sure that we don't take on investment in a form that will corrupt our focus and look at merely generating returns. Yet, taking on a loan from a commercial lender forces us to focus on financial returns so that we can honour the debt obligation…Our business model will mature over time as the needs of the organisation mature…but we've got to look at ways that we can raise capital so that we can expand at a rate that meets the demand. Because if we choose to grow slowly we can have an impact, but we won't have an impact at the scale and the speed that is needed to alleviate the need that is one of the core issues in*

> *society, and access to affordable healthcare is something that really needs to have been solved yesterday"* (Adrian Watts, CEO).

For the board and senior management of NHC, the strategic challenge they face is the ability to grow rapidly, but at the same time, to not lose focus on its core purpose and underlying business model. If growth leads to the co-operative losing sight of its original purpose and focusing too much on financial returns, it will risk losing the support of its members and the broader community.

NHC recognises that its ambition to grow nationally will place pressure on its ability to retain the close relationships that it has developed in the ACT with its existing membership base. To address this problem the co-operative has established a method of tracking the changing demographics of the areas where it is operating. A key tool in this process is the creation of Local Community Committees. This involves setting up a committee of people from within a defined geographic area who provide feedback to the NHC on the needs of that target population. In this way, the co-operative is able to make decisions about where it invests surplus funds into new services targeted at the specific needs of a given community.

GOVERNANCE OF THE CO-OPERATIVE

The NHC is mindful of the importance of having a strong and effective board to help guide the future strategy and anticipated growth. According to the Chairman Brian Frith, this is something that has been a key focus of the co-operative since its establishment:

> *"This is something that I have been driving for the past three or four years. Yes, we have had some changes but now we are getting to the point where I am completely satisfied with the range of skills and the exceptional level of governance that is being carried out by the board."*

. The focus of NHC is on their members and the delivery of affordable healthcare. Any planned growth is to achieve that purpose and not to deliver financial benefits to shareholders. In fact, the co-operative and mutual business model is viewed by NHC as a potential solution to many of the problems facing areas like health, and addressing the weaknesses that have been highlighted in the investor owned business model.

> *"A lot of businesses have one motive, and that is a return on investment for their investors. Our business model fully excludes that. I believe that the co-operatives and mutuals are in a much better place than any investor owned business organisation to put every single dollar back into what it is that they are trying to achieve"* (Adrian Watts, CEO).

The board of directors of NHC note that most people are motivated by self-interest, but co-operatives require that individuals put aside their self-interests to cooperative in the interests of the wider community to solve commonly shared problems. For example, the establishment of the NHC took a lot of voluntary effort by dedicated individuals, and then the willingness of the community to buy into the co-operative. This is not an easy process to achieve. It requires a combination of the right people, with the same common purpose, and the necessary skills, to work collaboratively to make this type of co-operative enterprise a success. It is therefore rare for a co-operative such as the NHC to emerge, and even more rare for it to have achieved such success. As such the focus of the board is on ensuring that the co-operative is able to continue to grow successfully and fulfill its purpose of delivering affordable healthcare to Australians.

MUTUAL PRIVATE HEALTH INSURANCE FUNDS – FACING CHANGE

The cost of providing affordable health care to people is currently one of the world's most pressing problems, and it is one that is essentially a political rather than an economic or technical process (Rajan, Barroy and Stenberg 2016). According to the World Health Organisation (WHO):

> *"Both the affordability and efficiency of the solution to address a health problem need to be carefully considered. In other words, this criterion encompasses the issue of whether the health intervention is affordable in absolute terms as well as the relative cost to the health sector, to the community and to individuals for tackling the health problem. The cost of the intervention must be economically feasible and economically sustainable. An example is the proposal to establish national health insurance. While for the health sector this may seem an obvious solution for solving the problem of catastrophic health expenditure, the feasibility and sustainability of a comprehensive insurance scheme will to a large extent depend on political commitment and the country's macroeconomic perspective."* (Terwindt, Rajan and Soucat 2016 pp. 23-4)

The Australian private health insurance (PHI) industry plays a significant role in supplementing or 'topping up' the gaps that have been left between what the government funds under the compulsory public Medicare health scheme (Boxall 2011). It is a sector that is unique in global terms, as it is not self-contained as in the United States where PHI firms control all 'core' health care services for their members. Nor is it purely supplemental as found in Canada, where PHI firms deal primarily with 'non-core' health services that are not covered under that country's universal health care system. It is a hybrid model, which has long been a focal point for tensions between federal, state and territory governments, as well as the professional bodies such as the Australian Medical Association (AMA) (Kay 2007).

Australia's private health insurance (PHI) industry is both highly competitive and highly regulated. In 2016 there were 33 PHI funds operating in Australia with a combined annual turnover of $22.5 billion, and combined profits of $1.6 billion. Annual growth in the period from 2011 to 2016 was around 6.5% (Wu 2016). Over 13 million people have PHI policies, and in 2014/15 around 67% of elective surgeries, with PHI funds injecting around $1.65 billion into the public hospital system (PHA 2016).

There are 25 mutual PHI funds operating in Australia comprising around 76% of all health insurance firms. Most of these enterprises are small and regionally based. They face a number of significant challenges over coming years. How will the mutual PHI funds respond to these challenges, and what might mutuality do to enhance their competitiveness and ability to earn the loyalty of their members?

SIGNIFICANT CHALLENGES FACING THE PRIVATE HEALTH INSURANCE INDUSTRY

There are major challenges facing the PHI sector. The first of these is the need to maintain a balance between policyholders who are healthy and make few claims, and those that are unwell and make significant claims. All Australian PHI funds are bound by the 'Community Rating' system, which requires insurers to treat all people equally regardless of their health status, age, gender, race or sexual orientation. It is enshrined under the *Private Health Insurance Act 2007* (Cth), and creates a challenge for PHI funds because it means that they have to consistently attract sufficient younger and healthier people to take out insurance, to offset those policyholders who are older or who have illnesses that require them to make more claims and/or more costly claims. However, getting younger and healthier people to take out and maintain PHI policies is becoming increasingly difficult (Boxall 2011), and raises more questions about the ongoing effectiveness of the legislative mechanisms (including the Rebate and Lifetime Health Cover loading (LHC) used to achieve PHI participation by younger people.

A second challenge is the duplication of services that are covered between the public and private systems. This duplication is much higher in Australia than for many other countries (Boxall 2011). PHI policies supplement the services already available through the Medicare public system. Because PHI is an expensive discretionary expenditure, and because the Medicare scheme provides for most core services such non-elective surgery in hospitals, many people choose not to take up PHI.

Another challenge facing the PHI funds is that the overall cost of medical care keeps rising at rates that are faster than the eight, state weighted consumer price index (CPI), and this puts significant upward pressure on premiums for the policies, and negatively impacts consumer sentiment toward affordability. This has forced the PHI funds to keep raising their premiums over recent years, and was accompanied by a significant increase (24%) in consumer complaints to the Private Health Insurance Ombudsman (PHIO 2017). Consumer advocacy group Choice (2017) reported that for many consumers, particularly younger people, PHI cover was not good value for money.

This has triggered a flurry of anti-PHI sentiment within the media. For example, columnist Naaman Zhou, writing in *The Guardian*, suggested that PHI was not worthwhile for most young people aged under 30 years. He pointed to the Choice report, which suggested that even with the government imposing a Medicare premium of 2% per annum for every year a person over the age of 30 goes without PHI cover, the benefits did not outweigh the costs (Zhou 2017). According to Zhou:

> *"Statistically, health insurance is a bad deal for any young person, who will on average spend more than they get back and rely on the public system more often than not. In many ways, that is the how the system is meant to work."*

In addition to these pressures, the PHI sector is now facing a period of intense competition between funds, coupled with slowing growth and shrinking profit margins. According to senior managers within the PHI sector who were interviewed for this study, the rate of growth of PHI funds has traditionally been around 3% to 3.5%. However, that rate of growth has declined to where it is now close to zero.[2]

In October 2017, the federal government responded to this trend by announcing that it would introduce changes to how PHI funds operate. The Federal Health Minister Greg Hunt, announced that by April 2019, PHI funds could offer policies with discounted premiums for people aged under 30 years, as well as other discounts for hospital cover for those aged between 18 and 40 years. There would also be increases in the level of permitted excesses for PHI, and changes to how hospital treatment insurance policies were packaged with a less complex categorization into basic, bronze, silver and gold, and general treatment (commonly known as 'extras') into bronze, silver and gold (Murphy 2017).

THE EVOLUTION OF THE PRIVATE HEALTH INSURANCE INDUSTRY

Historically, the Australian PHI sector can be traced back to the 1830s with the establishment of the Friendly Societies in Sydney. Their role in providing financing for health care insurance continued to be important during the remainder of the nineteenth century and into the first half of the twentieth century. However, a national health care system did not exist until the passage of the *National Health Act 1953* (Cth), which provided the first national legislative framework upon which the current system was created (Stoelwinder 2002).

The desire for a publicly funded universal health care system had long been championed by the Australian Labor Party (ALP). It was a policy pursued by Prime Minister Ben Chifley in the late 1940s with the introduction of the *National Health Service Acts 1948* and *1949* (Cth), which were never implemented for constitutional reasons

[2] These interviewees have requested that their comments not be attributed.

(NMA 2017). The Labor government of Prime Minister Gough Whitlam subsequently introduced Medibank in 1975, only to have it abolished by a successor Liberal National coalition government led by Prime Minister Malcolm Fraser. The current compulsory Medicare scheme was introduced by the Labor government of Prime Minister Bob Hawke in 1984, thereby providing a basic universal health care system (Segal 2004).

However, the introduction of Medicare did not replace the need for PHI. The ever-increasing cost of medical services and inpatient health care has meant that governments of both major political parties have sought to retain a PHI sector. For example, from 1997 to 2000 the federal government introduced tax incentives to encourage the take up of PHI. This comprised a 30% premium subsidy and selective age-based premium increases. The net result of these policies was a 50% increase in PHI enrolments, in particular amongst the younger age groups (Ellis and Savage 2008).

Although Australia spends a relatively small proportion (approx. 9%) of its GDP on healthcare, it still manages to achieve a higher per capita spending outcome. Government regulations impacting PHI include age based subsidization through the community-rating rules, risk equalization, lifetime health cover and tax rebates for PHI. These have assisted in increasing the uptake of PHI within the community and to make Australian healthcare more accessible than is typically the case in other OECD countries (Odeyemi and Nixon 2013).

Despite these positive outcomes, the cost of maintaining the healthcare system in Australia continues to rise. In 2015 the federal Treasury's "Intergenerational Report" identified Medicare as one of the fastest growing areas of federal government expenditure over future decades (Richardson 2015). As noted above, faced with this pressure, and the need to support the public hospital systems controlled by the states and territories, the federal government has signaled its intention to overhaul the Medicare system. This has impacts on the PHI sector because whatever is not covered by Medicare is potentially an area for private insurance.

Another important change in regulation for the PHI sector was the abolition of the Private Health Insurance Administration Council (PHIAC), and its incorporation within the Australian Prudential Regulation Authority (APRA). This change commenced in July 2015, and following a 'honeymoon' period, came into force in July 2016. The main impact of this change in regulatory agency was the treatment of PHI funds by APRA, in the same manner as occurs for banks, credit unions, general insurance firms and superannuation funds.

A SECTOR OF COMPETITIVE RIVALRY AND MUTUAL OWNERSHIP

The Australian PHI sector is highly competitive and dominated by a small number of large investor owned firms (IOFs). For example, in 2016 just over half (54.6%) of the market was controlled by only two firms, Medibank Private Ltd with 27.5% market share, and BUPA Australia Holdings Pty Ltd with 27.1% market share. Over the decade from 2006 to 2016, the number of PHI funds in Australia shrank from 38 to 33, and industry analysts suggest that this number will decline to around 31 by 2021 (Wu 2016c).

As noted above, the mutual PHI funds comprise around 76% of the PHI sector in terms of active businesses. Table 1 lists these firms and it is worth noting that four of the seven largest PHI funds in Australia are not-for-profit, mutual PHI funds. These include the Hospital Contribution Fund (HCF), HBF Health Ltd, Australian Unity and the Teacher's Health Fund. The Mutual PHI funds together comprise around 38% of the national market.

A challenge facing mutual PHI funds is how to communicate their value proposition to members, particularly the younger age groups who are healthy and who have been sold on the idea that the dominant measure of value is price. As one senior manager from a mutual PHI fund observed:

> *"I'm going to point straight to price. The price conversation is going on ad nauseum in our industry, but what I think we should be talking about is not price, but value. This is a real challenge for us, because the*

message that often plays out in the public domain in relation to health insurance is that it is unnecessarily complicated, they can't understand it and even when they try to understand it they become more confused. They have this view that there are thousands of products and consumers are totally inadequate when it comes to comparing them. Few products seem the same and while everyone talks about price, hardly anyone talks about the value".

TABLE 1: MUTUAL HEALTH INSURANCE FIRMS AUSTRALIA

Company	State/Territory	Annual Revenue FY2016
Hospital Contribution Fund (HCF)	NSW	$2,465,036,000
HBF Health Ltd	WA	$1,512,147,000
Australian Unity	VIC	$1,420,728,000
Teachers Health Fund	NSW	$543,814,107
GMHBA Ltd	VIC	$524,475,000
CBHS Health Fund Ltd	NSW	$360,713,000
Westfund Health Ltd	NSW	$178,602,403
Latrobe Health Services Ltd	VIC	$165,806,096
Heath Insurance Fund of Australia (HIF)	WA	$162,574,199
Queensland Teachers Union Health Fund (TUH)	QLD	$149,045,892
Health Partners Ltd	SA	$136,808,000
Peoplecare Health Insurance	NSW	$131,683,497
St Luke's Medical & Hospital Benefits Association Ltd	TAS	$103,020,000
Railway and Transport Health Fund	NSW	$101,074,000
Navy Health Ltd	VIC	$69,542,000
Mildura District Hospital Fund Ltd	VIC	$53,941,757
Phoenix Health Fund	NSW	$31,543,421
Health Care Insurance Ltd (HCI)	TAS	$17,977,754
Reserve Bank Health Society	NSW	$13,821,132
ACA Health Benefits Fund	NSW	NA
CDH Benefits Fund	NSW	NA
GMF Health (now part of HBF)	WA	NA
Lysaght Peoplecare Ltd	NSW	NA
Police Health	SA	NA
Transport Health Ltd	VIC	NA

[1] Revenue figures for FY2016

Government policy, designed to create more competition within the PHI sector, has seen the entry into Australia of UK-based BUPA, which was originally founded in 1947 as the British United Provident Association (BUPA). It now has subsidiaries in over 190 countries and entered the Australian market in 2008 through the acquisition of the Medical Benefits Fund of Australia (MBF). Since then BUPA has grown rapidly and had acquired a chain of optometrists' stores, dental clinics, general medical practices and a network of purpose built medical assessment centres across Australia funded by a contract secured from a contract it won from the Australian Department of Immigration and Border Protection in 2014 (IBISWorld 2015).

In addition to the entry of BUPA, other significant changes to the PHI competitive environment in recent years have been the privatization and public listing of the former not-for-profit state-owned enterprise Medibank Private in 2014, and the earlier demutualization and public listing of the former mutual PHI fund, Newcastle Industrial Benefits Hospital Fund in 2007 as NIB Ltd.

Discussions with senior managers and directors within the mutual PHI funds sector suggest that while there has been reasonably strong growth in the PHI funds over the past five years, this rate has now slowed considerably. Despite the emergence of publicly listed funds such as Medibank Private and NIB, or the overseas entrants such as BUPA, the general market environment for PHI within Australia is largely static. As of mid-2017 the rate of net

growth within the sector is almost zero, with some funds going backwards. This is being driven by policyholders abandoning their PHI and moving back to the public system. They attribute this to the rising cost of PHI:

> *"You will have seen some of the commentary in the press recently, the concept of regular 6% price increases, year on year, for the next twenty years, is considered by almost everybody as being an unpalatable, obscene prospect."*

This is also taking place within a softening economy with many people finding it harder to get work or sufficient hours of work, making PHI a luxury that they cannot justify. For large investor owned firms (IOF) PHI funds (e.g. Medibank Private, NIB) this slowing of growth in the market has shifted attention to acquisitions. However, the large firms cannot merge with each other in case they risk intervention by the Australian Competition and Consumer Commission (ACCI).

With many of the mutual PHI funds being quite small firms, the outlook is for greater consolidation within the industry over future years (Wu 2016). Further, they anticipate that government policy might also shift towards a consolidation within the sector:

> *"So, PHIAC's functions have now been assumed by APRA, and APRA like doing things the same across the board, a sort of 'one model fits all'. So, if the government had an agenda to tidy up the industry, to have not 37 health funds but say 10 or 12, that they could put pressure on the smaller health funds by introducing prescriptive rules that increases the amount of capital they're required to hold, or putting pressure on boards to reduce management expense ratios"*.

According to a representative of one mutual PHI interviewed for this report, over the next ten years the outlook within the PHI sector is for more consolidation. This may take the form of mergers and acquisitions, with the prospect of some of the smaller funds disappearing or becoming subsidiaries of larger ones. Size is important within the PHI sector as economies of scale contribute to the profitability of these funds (Wu 2016).

An examination of the financial performance of the mutual PHI funds over the five years from FY2011/12 to FY2015/16 undertaken for this year's report found that while median annual turnover had grown by 21%, median profitability (e.g. EBIT and NPAT) had declined by 9.6% and median assets had remained largely static.

For the mutual PHI funds, the imperative to grow is likely to be of less importance than for their larger publicly listed IOF counterparts. One of the strategic imperatives of a publicly listed company is the need to continuously grow shareholder value. This will require either increasing market share, growing profitability and/or diversification into related sectors. The growth and diversification strategy being followed by BUPA since its entry into the Australian market is an example of this.

GOVERNANCE MODELS IN THE MUTUAL HEALTH INSURANCE SECTOR

Whether the mutual PHI funds are vulnerable to this threat of takeover is likely to depend upon their governance model and how loyal their membership is to the fund. For example, when NIB publicly listed in 2007 it set upon a strategy for growth through acquisition. According to directors and senior managers from mutual PHI funds interviewed for this report, its success in doing so was limited by the desire amongst the mutual PHI sector to remain independent.

This was the case when NIB sought to acquire funds such as GMHBA Ltd, HCF and AHM. As one respondent explained with reference to the GMHBA case:

> *"NIB went around seeking to acquire smaller health funds, and eventually they targeted and pursued GMHBA in Geelong, Victoria. That was considered to be a significant amount to take on, around 85,000 policies at the time. So first they went in friendly, they sponsored the local football team, and made their*

> *presence known around the town, which is a pretty close community. But, these indirect approaches didn't work, so then they went in harder, by challenging the board, but in the end, NIB's approaches failed. The board and management of GMBHA were both absolutely determined that they were not going to be swallowed up by a listed entity. So, there's a lot of parochialism, but also a strong sense of community within the mutual funds, with the sense that we're here to look after each other".*

Eventually NIB acquired Tower Medical Insurance in New Zealand in 2012, and formed an alliance with QANTAS in 2015 to create the Assure brand. However, the challenge for NIB was the governance model of the mutual health fund. As one director of a mutual PHI fund explained, seeking to acquire a mutual health fund was not the same as seeking take over a small IOF where you could buy up the smaller shareholders:

> *"You don't have anything to sell if you are a member of GMHBA, or any other mutual. You are a policyholder, but the ownership structure of funds like GMHBA or HBF, is that there are only a relatively small number of company members (not to be confused with policyholder members), and in the case of a respondent mutual PHI, about 12 company members who potentially have the power to assign control over the company. This is not like a shareholder who might take the six grand and say 'here's my shares'".*

This governance model varies from fund to fund, with some offering more policyholder member democracy in the decision-making processes over demutualization.

The governance models of the PHI mutual funds are quite different to the more open structures found in the co-operatives. Rather than a 'one-member-one-vote' democracy, the control of some of the PHI mutual firms is placed in the hands of a relatively small number of policyholder members who in the case of a respondent company limited by guarantee, occupy the position of company member (i.e. in addition to being a policyholder), with an ability to vote (e.g. at an annual general meeting). This, according to representatives of a mutual PHI who were interviewed, is a potential factor in the ability of small PHI mutual funds to remain independent of takeover, and to facilitate their longevity, as noted by one respondent:

> *"I examined government models of health insurance mutuals, and I'd say that a lot of governance models could be very tactical in nature. They're set up so that you cannot break into the fortress. In other words, you would have to persuade a lesser number of people, in order to sell the company, so I don't think their particularly open".*

For mutual PHI funds the process of demutualization and public listing requires the board to convince both itself and the membership will be better off as an IOF business model than as a CME in which the primary focus is on the members' benefits rather than the value of the share capital for investors. This was summed up by one of the mutual PHI representatives as follows:

> *"Because listing introduces shareholders, who demand profit, and they demand dividends. Yet not only that, they demand double digit growth every year, and if you touch the dividend your share price can suffer dramatically. There's no mandate for our business to demand that we become a listed public company. Unless we had some growth ambition that required some significant acquisition, or we wanted to diversify into a different business that complements or supplements health insurance".*

A STRATEGIC FOCUS ON THE MEMBER AND OFFERING A VALUE PROPOSITION

For mutual PHI funds a key challenge will be to refocus their members attention away from a conversation driven almost entirely by price, onto one that is based on the mutual funds being able to make a coherent and sustainable value proposition to their policyholder members. As one CEO from a mutual PHI fund respondent explained, the key issue is to build a membership base around a strategy of 'earning' rather than 'buying' the loyalty of their membership. This distinction addresses the importance of not competing on price, but seeking to build a value proposition that members will recognise and respond to with their loyalty:

> *"It is about the things that we can earn from you as a member. We can earn your respect, your trust and ultimately your loyalty".*

However, the health insurance industry is a highly competitive mass market, and that any fund wishing to compete successfully in the market must move at a rapid pace. Further, the ability to offer value is something that all businesses are pursuing. The example of NIB's alliance with QANTAS to offer the "Assure" health insurance product that will earn frequent flyer points was given. This is not something that many of the smaller mutual PHI funds can do. However, there is a much stronger view that they can make a strong case around the value of membership in a mutual PHI fund.

To achieve this will require a sustained conversation with members at all stages of their lives and across a wide range of lifestyles. It will require the mutual PHI funds to secure the trust and respect of members and this may be difficult in a market where premiums keep rising as costs are passed through the system, from health providers (e.g. hospitals, doctors and others), to funds to fund members, media commentary is mostly negative or hostile, and many consumers purchase their insurance via online aggregators who tend to place an emphasis on price.

Mutual PHI funds seeking to compete in this market will need to develop sophisticated marketing communications strategies. These will need to appeal to members across all age groups and offer value to their needs. A key message strategy will be to position private health insurance as a means by which the policyholders secure not only peace of mind, but also control over their own health when they need it, which is not possible with the public health system.

LOOKING TO THE FUTURE

As noted above, the Australian PHI sector is facing challenges and change. Over recent years the arrival of BUPA into the market, and the public listing of Medibank Private and NIB has created significant major IOF PHI funds. These businesses have been aggressively seeking growth through acquisition and/or diversification. As the rate of natural growth in PHI has slowed, the competition between the mutual PHI funds has also increased. All the major health insurance mutual funds have expanded into the national market, and are engaged in a competitive pursuit of each other's market share.

There is a view amongst some mutual PHI funds senior managements, that if government policy does not change, the publicly listed IOF PHI firms will pursue a strategy that will put out an annual average price increase of around 6% for the next twenty years. At the same time the mix between the contribution that members make and the contribution from the government from tax payers' money (e.g. rebates), will also change. The net result of this will see the gap between the rising cost of health cover, and the amount that the consumer will be able to claim back from the Medicare scheme will also widen. They note that the PHI sector is currently in decline or not growing, and by contrast public healthcare is growing. This will not be sustainable for state and federal government budgets over the longer term. As a result, they consider that a shift is needed in government policy:

> *"If the government believes that there is a ratio of public-private within the Australian population that is greater than what it currently is; in other words, you need to see more happening in private, to take some of the heavy lifting financial costs. Then it really needs to be rethinking those outdated 'carrot and stick' models that it is currently using. They need to incentivize people, in particular young people, to patronize private health insurance".*

The most recent public statements by the federal health minister over reforms to the PHI sector may offer some hope of building more incentives into attracting young people to take up health insurance. If they do the mutual PHI funds will need to build upon this opportunity with a strong message of their mutuality and member focus

as a key point of differentiation from their larger IOF counterparts. If they can successfully win this argument their ability to remain sustainably within the market will be secured.

RUMBALARA ABORIGINAL CO-OPERATIVE: THE HEART OF THE COMMUNITY

The Rumbalara Aboriginal Co-operative Ltd is a community-owned and controlled non-distributing (not-for-profit) enterprise located in Shepparton, Victoria. At time of writing Rumbalara had approximately 600 registered members, which represented about 30% of the Aboriginal and Torres Strait Islander population living in the Greater Shepparton region.

With an annual turnover of around $20 million, Rumbalara employs approximately 200 people and provides an integrated service delivery model for its members. This makes Rumbalara one of the largest service providers to the Aboriginal and Torres Strait Islander community in Victoria, and one of the largest indigenous owned co-operatives in Australia. The co-operative is also a registered charity under the Australian Charities and Not-for-profits Commission (ACNC).

'GALNYAN YAKURRUMDJA'

The name given to the integrated service model delivered by Rumbalara is 'Galnyan Yakurrumdja' or 'I respect' in the Yorta Yorta language. This is a holistic or all-encompassing model focused on providing the co-operative's members with the services they need to live healthy, meaningful lives. At the core of this process is a recognition that Indigenous Australians have many challenges that do not face the majority of their counterparts in the non-Indigenous community. For example, Aboriginal and Torres Strait Islander people have a shorter life-expectancy than non-Indigenous Australians, with a life expectancy gap of 10.6 years for men and 9.5 years for women (DPMC 2017).

The approach Rumbalara takes to service delivery is focused on cultural and social understanding and respect. For example, its medical services are delivered by 'Woongi Danga' practitioners, which in Yorta Yorta language means to, 'Do it our way'. This includes not only addressing the needs of a person's medical or health needs, but also their financial, mental, family and social needs.

The range of services provided by Rumbalara includes family support and counselling, housing, financial advice and counselling, women's education and training, and legal and justice services (e.g. family violence, youth support, night patrols). Family services encompass a wide-range of programs designed to enhance the overall security and well-being of families and children. Rumbalara also provides educational support programs for children that include child health and parenting support, kindergarten, after school homework club and autism support group.

In addition to its services for children, youth and families, Rumbalara also offers programs for its older and disabled members. This includes both home care support, and a 30-bed Rumbalara Elders Facility. These home care services include cleaning, gardening, maintenance, meals and nutrition, mobility aids and equipment, shopping, home nursing and companionship for general wellbeing. As explained by Rumbalara's CEO Lee Joachim:

> *"So, we are a legal entity under the Co-operatives Act, but some of the range of operations covers health, community, justice and aged care services. These are all contracted by government to provide a specific range of services to Aboriginal and Torres Strait Islander people living in specified geographical boundaries".*

COMMUNITY ACTION – THE 'CUMMERAGUNJA WALK-OFF'

The core community that Rumbalara serves is the Yorta Yorta Nation, whose traditional lands encompass both sides of the Murray River from Cohuna to Albury-Wodonga covering an area of approximately 20,000 square kilometres across New South Wales (NSW) and Victoria (YYNAC 2017). The name 'Rumbalara' or 'Rainbow' is the traditional home of the Yorta Yorta Nation with a history dating back thousands of years (Deadly Vibe 2013).

By the middle of the last century the area was part of the Cummeragunja Mission Station located in New South Wales (NSW). The mission was established in 1888. Its initial aim was to build a farm of around 730 hectares of land for the local Yorta Yorta people to use for self-sufficiency. However, the station was placed in the management of George Bellenger, who treated the community harshly, resulting in illness, removal of food rations and threats of expulsion. Although Bellenger resigned in 1891, the situation with replacement managers did not improve until 1894, when George Harris was appointed. He sub-divided the land into small lots and granted these to families and individuals (Koori History 2016).

This improved the conditions for the community who were able to grow their own food, and manage their own affairs. The community began trading wool, wheat and dairy produce, and reinvested the funds back into the community. However, in 1909 the *Aborigines Protection Act (NSW)* was passed and the community was placed under the control of the *Aborigines Protection Board* of NSW. This steadily eroded the limited independence that they had achieved. All profits generated from the Cummeragunja Mission Station were retained by the board, and the level of housing, sanitation and family cohesion began to decline, including the forced removal of children from their families (Koori History 2016).

During 1920s and 1930s conditions within Cummeragunja, like many Aboriginal missions across NSW, worsened. The impact of the Great Depression led to massive unemployment amongst Indigenous people, and there was pressure from within the white community to force Aboriginal people out of the towns. This resulted in an exodus of Aboriginal families from the townships into the mission stations, swelling the already overcrowded community facilities and worsening the living conditions (Attwood and Markus 2004).

In 1939, following several deaths within the mission community caused in part by malnutrition, the Yorta Yorta organised a strike or 'walk-off'. They acquired boats and crossed the Murray River into Victoria where they set up a camp near the town of Barmah. Approximately 100 men, women and children left Cummeragunja Mission Station and crossed into Victoria. With the Second World War looming, and lacking other means of support, many of those who walked off were forced to return or relocate elsewhere. However, their protest action captured the attention of the wider community, and their cause was supported by the Australian Aborigines' League and some of the Trade Unions. The event has been identified as one of the first organised Aboriginal civil rights protests in Australian history (Attwood and Markus 2004).

By the 1950s there were around 300 Yorta Yorta people living on the river flats, an area that is prone to flooding. In 1958 the Aboriginal Welfare Board and the Victorian Housing Commission built 10 prefabricated concrete houses in the area, although they lacked hot water and sewerage. By the late 1960s housing improved with the connection of sewerage and hot water supply, and the renovation of the houses to include toilets, bathrooms and laundry facilities. However, the settlement was never designed to be permanent, and by 1969 Rumbalara was abandoned. During the 1970s the Yorta Yorta community lobbied both state and federal governments to secure control over the site, which was eventually granted to the co-operative for a nominal sum (Rumbalara 2017).

As explained by Lee Joachim, the foundation of the Rumbalara Aboriginal Co-operative was a genuine case of community collective action:

> *"The co-operative got started in the 1970s when there were really major issues in getting access to health services, and really huge issues in relation to the justice system at that time as well, and housing really became an issue also. So, a group of women came together to deal with this and they decided on where they wanted to move forward with this as a community, and bring the community forward on that as well. It worked out really well because there was no money involved."*

INDIGENOUS CO-OPERATIVES

There are around 220 Indigenous co-operatives actively trading in Australia. They can be found across all states and territories and focus primarily on medical services (70%), community services (16%), housing (6%), or arts and culture (4%). The remainder are focused on education, training and childcare, financial services, information and media, or professional services (e.g. legal).

According to Lee Joachim the co-operative business model is a good fit for Aboriginal and Torres Strait Islander communities because of its collectivist governance and mutual ownership. This, he suggests, is consistent with the 'environmental socialism' that is inherent in Indigenous community culture. This has also been a foundation for the Galnyan Yakurrumdja holistic service delivery model, which recognises that everything is connected.

However, he notes that a major problem for Indigenous co-operatives is that they are typically totally dependent on government funding for their operation. For example, Rumbalara is 100% dependent on this funding, and this can be a problem because government authorities don't always understand the business model of the co-operative as it seeks to pursue its Galnyan Yakurrumdja service model:

> *"Trying to relay what the co-operative's business model is can be very hard to explain to the government. The focus of the co-operative should be on economic self-development, but as government funding has been provided, it has moved us back to a welfare-type model…the welfare mentality has become really ingrained and now we need to break the welfare mentality. We need to focus on how do you give a person a hand up rather than just to give a person a hand out."*

He suggested that what needed to occur in the future, was for Rumbalara to disappear and be replaced with a model where the Aboriginal people had good outcomes in relation to health, justice, housing and education. This would require a focus on getting individuals within the community to become more economically independent.

According to Joachim, part of the shift that needs occur within the business model of Rumbalara, and other similar Indigenous co-operatives, is a shift from a welfare model to a fee-for-service model. As he explained:

> *"It includes extending our services into areas where we have demonstrated expertise and include a fee for service option. This will generate independent income, it is also about building the capacity to teach people our model of care and what that actually means for both the individual and the broader community as well."*

PURPOSE

This need to focus on the individual's total needs, and understand these needs within the context of their wider community, lies at the heart of the purpose for which the Rumbalara Aboriginal Co-operative exists. It is also the focus of its member value proposition. As Joachim explains:

> *"So, it needs to take a look at the whole person and the issues related to that whole person. For example, you might come here for a medical appointment, but we will say to you, 'let's sit down and really have a chat', so that we can investigate what is really affecting your life as a whole. You might be a 65-year-old woman who's come here just for a medical check-up, but you might also be looking after your*

> *grandchildren, and there might be domestic violence and alcohol abuses in the immediate family. But you might also be suffering from economic stress because you now have to feed more people, or your utility bills are going up, so it is how are we going to deal with the whole range of issues that are facing that individual who has just come here for one appointment, and how do we create a case management process around that person, to help build capacity for the individual and the family?"*

This challenge involved not only dealing with the individual member who uses the co-operative's services, but their family, and the need to change a mindset that has developed as a welfare recipient.

To achieve this outcome, the co-operative needed to remove some of the barriers or 'walls' that were built up across the different service delivery areas and configure its resources towards the holistic model of Galnyan Yakurrumdja. However, the government funding programs tend to focus effort on just one area at a time as outlined in the funding contract. Despite these restrictions, Rumbalara has learnt to use individual initiative to find ways to work within these contracts and deliver the outcomes that are desired.

EXPANSION PLANS AND CHALLENGES FROM GOVERNMENT REFORMS

The model of holistic healthcare developed by Rumbalara is proving its value, and the co-operative has been working with the government funding agencies to help expand its delivery of services to a wider community. Joachim explained that plans were already in place to expand from their current location to a second site which will be monitored over a 5-year period to assess how the model works and develops.

This second site currently under consideration is Palm Island, Queensland. Here the partner will be the Palm Island Community Company (PICC) located in Townsville. The PICC is a not-for-profit organisation focused on the delivery of services to the Aboriginal community of Palm Island, and aimed at strengthening the social, cultural and economic capacity of that community (PICC 2017).

Achieving this expansion plan will require Rumbalara and the PICC to enter into a contract and secure funding from both state and federal governments. Dealing with different governments and a number of different government agencies and programs poses a significant challenge to the co-operative's management. As explained by Joachim:

> *"There are a range of reforms that are happening. We have noted at least 11 reforms. So, in the state of Victoria we are dealing with 'The Roadmap to Reform', which is very much a focus on self-determination for Indigenous organisations and Indigenous communities. There are reforms in relation to the out of home care, driven by reforms to Section 18 of the Children's and Young People's Act (Vic). Then at a state level you have many other reforms taking place in relation to education and health. Then at a Commonwealth level you have aged care reforms, health reforms. There are also other reforms taking place across federal and state levels in relation to justice and healthcare. So, we have been monitoring these changes and setting up our systems so that we have viability."*

MEMBER VALUE PROPOSITION AND MARKETING THE CO-OPERATIVE ADVANTAGE

A major impact on Rumbalara has been the removal of block funding, which has shifted the money from the service provider to the end-user. This has now made the environment in which Rumbalara operates more of a consumer market. The co-operative has had to go out to its members to explain that they are now the funding source for the services that it delivers. As a result, Rumbalara is now focused on promoting its services to the community.

To secure the engagement and patronage of its members, Rumbalara has had to rethink how it communicates its member value proposition (MVP), and also how it undertakes the marketing of its co-operative advantage

(MOCA). This has involved purchasing double-page spreads in the local newspaper, as well as via newsletters and the co-operative's Facebook page.

> *"We are taking a huge communications strategy across the organisation at the moment. We'll be also taking that out to community. Our first meeting took place about two weeks ago and a lot of the 'unforgotten' have turned up"* (Lee Joachim, CEO Rumbalara)

This communications strategy will focus on getting out to the community and promoting the value of the co-operative and its services. The communications plan will involve use of social media, as well as more traditional media channels such as radio and newsletters. Many of the community who have been 'forgotten' have indicated that they don't use social media and instead listen to the radio, so this has led to the co-operative taking up space in specific radio stations and shows that their community is known to listen to.

A key focus for Rumbalara's marketing strategy is to ensure that every member of their community is aware of events that they are holding. This requires a range of different media channels to be used:

> *"So, there are different strategies we're trying to take, because for this organisation to exist we need every Aboriginal and Torres Strait Islander that lives in this town and surrounding areas to utilize our services. If we do not then we are gone"* (Lee Joachim, CEO Rumbalara)

An important message they are seeking to communicate is that the members should not be complacent and think that the government will not shut down the co-operative if it is not supported.

> *"People say 'Oh government won't allow Rumbalara to close down', because if that happens we can't get services, but I'm trying to explain that if people don't use our services, then actually they will, and if we don't meet the KPIs or contractual arrangements that is what will happen"* (Lee Joachim, CEO Rumbalara).

According to Joachim, the community has not fully understood the impact of the removal of block funding, and need to engage more actively with their co-operative if they wish to see it continue into the future.

The engagement of the community and their active participation in using the services the co-operative has to offer, is something that Rumbalara's management has identified as needing to be constantly promoted. In the view of Joachim, Rumbalara has not been as successful as it needs to be in selling the message of what the value of membership to the co-operative really means. Of particular importance is to clarify what is an 'active' member and what is an 'inactive' member?

One area of focus for the co-operative going forward is to seek more voluntary engagement from the members. Currently there are a small number of members who are active in making complaints to the government about the co-operative, which risks harming Rumbalara's reputation. Joachim suggested that this seemed to be an attempt to shut the co-operative down. This would risk the consequent loss of its services. Yet what seemed to be motivating this behaviour were largely personal issues. This, highlighted the need for Rumbalara to focus on shifting the community's view from that of an individual one to that of a 'bigger picture' relating to the community purpose of the co-operative:

> *"They're not looking at the bigger picture, so, we need to try and influence what our membership is, and that our membership has a responsibility back to the service. So that we continue to learn and we can benefit from their input. We also need to run consultations or community events so that they can come and talk about what we need for them in the future. I think that education should be a constant thing and I don't think that we do that well"* (Lee Joachim, CEO Rumbalara).

According to Joachim, the major changes that have occurred in government support, such as the removal of block funding, haven't yet been fully understood by the community. As such, they find it difficult to understand why it is that the co-operative is focusing on strategies to introduce fee for service. In essence shifting to a 'hand-up' from a 'hand-out' model is something that many members find hard to accept.

GOVERNANCE ISSUES

Another major challenge facing Rumbalara is the difficulty of securing directors for its board. At time of writing, Rumbalara was in voluntary administration caused by a difficulty it has experienced in attracting and retaining board members. The underlying causes of this problem were attributed to an 'upheaval in the community'. However, the co-operative has had many board-level tensions in the past relating to disagreements over the strategic direction of the organisation. According to Joachim, one of the causes of this problem is the need for a better educated board:

> *"I think what we have to realise as a community is that we need educated people sitting on boards. We need people with a legal background, accounting background, who can really take us forward. We need to understand as an Indigenous people working on the board, our legal obligations and responsibilities not only to our community to the co-operative itself, and what governs us as an organisation. That's been a failure I think."*

Joachim noted that this lack of professional directors at the board level has been a problem for many Indigenous co-operatives. There had been cases of financial mismanagement at boards across both Indigenous and non-Indigenous co-operatives, but the directors had to understand the financial reporting, and the legal duties and responsibilities that they have in the overall management of the enterprise. However, a further problem facing Rumbalara when seeking to enhance its board through the appointment of directors with specialist skills, was the negative reaction from the community:

> *"What we're looking at is how do we get skilled operators onto the board? When I've taken this to the community they've said, 'Oh you just want white people on the board'. To this I have said no, what is wrong with you getting your daughter or your son, or your grandchildren, through the process of high school, onto university to be lawyers and accountants and economists, or doctors and nurses. What is wrong with you doing that? Because what you are saying is that Indigenous people will never be educated and that is wrong"* (Lee Joachim, CEO Rumbalara).

Rumbalara is working to develop the capacity of its community to provide future directors and has been working with the Australian Institute of Company Directors (AICD) to this end by putting its directors and some future directors on a week-long company directors training course. This is designed to help directors understand their responsibilities and liabilities. Yet this education for the directors of the co-operative is part of a wider program designed to educate all members of staff who work in the organisation. It can include the doctors and nurses who have to understand their own liabilities and responsibilities. In addition to developing the capacity of the community to provide directors from within the memberships, the co-operative is also looking at the possibility of appointing independent directors.

FUTURE DIRECTIONS – EDUCATION AND ENTERPRISE

The immediate focus for Rumbalara is to consolidate their model of holistic healthcare and to undertake research to provide the data to demonstrate the value and impact that this model has. Over the medium to longer term, the co-operative plans to pursue innovative programs designed to help alleviate the social and economic disadvantage within their community. This is going to be targeted primarily through education.

One example of this is an education program targeted at young mothers with babies that helps them develop good parenting skills, and also foster community support and stronger family outcomes. In addition, the co-operative is considering enterprise programs that might foster home-based business start-ups and offer micro-loans to help fund such ventures. It aims to encourage enterprise behaviour through teaching business and financial management skills to youth, and to work with local TAFE colleges to put Indigenous people through programs such as the Certificate III and IV in Small Business Management.

Over time Rumbalara is planning to establish a school that can run for its members from K to 10, with a curriculum that is focused on teaching science, technology, engineering and mathematics (STEM), but through a lens of Indigenous culture. It would be more appropriate for the Indigenous community than the current curriculum that is less culturally relevant to Aboriginal people.

This is part of a wider vision to help groom up the next generation of Indigenous leaders who can be empowered through education and a different way of looking at the world. The co-operative has already set aside funds for developing the program. This will work with Indigenous children from Year 8 through to Year 12, to enhance their longer-term employment prospects. They have been working with the State Education Department on the development of this program.

According to Joachim, the co-operative had 'become isolated' and inward looking. If it is to achieve these strategic goals, it must start to widen its networks and strategic partnerships. In particular this will involve working more closely with government agencies:

> *"What has happened with this organisation over the last 10 years is that it has become isolated. It has isolated itself within the broader community as well, where there have not been successful partnerships. This includes the hospital or the health services, or even with some government departments. So, what we're trying to do is break that barrier down, and say 'hey, we bring in $20 million in funding to this region on a yearly basis, we employ 110 Aboriginal people…so we are trying to build a framework to show that we are important and that we are needed. This will help to build the local capacity for networking here"* (Lee Joachim, CEO Rumbalara).

The long-term vision espoused by Lee Joachim is an ambitious one, but he is passionate about the need for Rumbalara Aboriginal Co-operative to fulfil its purpose of helping strengthen the economic and social foundations of the Indigenous community. Historically the co-operative business model has been a mechanism for providing communities with the ability to achieve economic self-sufficiency while simultaneously strengthening social capital and alleviating poverty (Birchall and Simmons 2007).

> *"I think that as Rumbalara becomes more successful we can subsidize our market based operations to make them more affordable, or more comprehensive – that is to provide more services in the one price – to provide value for the community. Active memberships are also a must for Rumbalara's future, and with that, offering more benefits for active membership. We also must recognise the need to adapt and change. To be the oldest living race of people, we have been proactive in responding to change, and in doing so, have reduced the negative impacts and leveraged the opportunities for a millennium"* (Lee Joachim, CEO Rumbalara).

The co-operative business model has been used by many Indigenous communities across Australia for the delivery of services and this has attracted support from governments at both state and federal level. However, the true potential of a co-operative is for them to be self-sufficient from government. They need to be focused on enhancing their member's economic and social well-being through the efficient and effective provision of services, as well as the dissemination of information and education to help build community capacity.

CONCLUSION

This year's review of the Australian CME sector continues to highlight the size and diversity of the sector. With a total active sector comprising around 2,134 enterprises, with over 29.3 million active memberships, more than 52,322 employees and a combined annual turnover in excess of $113 billion, the CME sector is relatively large. However, to put this into perspective the total number of CMEs represents only 0.1% of the 2.1 million registered businesses in Australia, but its combined annual turnover is more than 7.4% of the national GDP of $1,560 billion (OECD 2017).

The CME business model is unique in the focus it has on member value, and the pursuit of both social and economic goals as part of its purpose. In areas such as agribusiness, community services, health services and the economic and social advancement of Indigenous communities, the CME business model offers a potentially valuable mechanism for addressing market failures that have not been addressed by government state-owned enterprises (SOEs), investor owned firms (IOFs), or not-for-profit social enterprises (NFPSE). This has been the historic role of the CME business model and why it continues to attract the attention of communities and of governments around the world (Michie and Rowley 2014).

Despite the relative importance of the CME sector within Australia it remains poorly understood and recognised. As highlighted by The Senate report, there is a paucity of definition and a lack of good underlying data on the sector. Further, there is also a lack of interest from universities in co-operative and mutual enterprises as a field of research and study. Professional associations, the government and the media, also lack a real understanding and appreciation of the CME as a business and as a sector. To change this situation will take time.

Much has been achieved since the 2012 UN International Year of the Co-operative. The existence of the BCCM as a national leadership body has been a major development and has helped to place the sector more prominently into the wider public debate. The introduction of the CNL has also given new opportunities for the co-operatives sector to grow and expand geographically, and to foster the formation of new co-operatives. Finally, the Senate inquiry has also provided the CME sector with a foundation of recommendations for future development over the longer term.

However, the CME sector needs to do more to speak with a single voice and to promote or market its co-operative advantage (MOCA) (Webb 1996). As a highly diverse sector it is challenging to bring the otherwise disparate elements together into a common purpose. If the CME sector is to increase the level of recognition and support from government and the wider community, its directors and senior managers need to embrace their mutuality, understand the unique differences of their business model, and follow the dictum of the distinguished economist Alfred Marshall in his inaugural address to the Co-operatives Congress in England in 1889:

> *"What distinguishes co-operation from all other movements is that it is at once a strong and calm and wise business, and a strong and fervent and proselytising faith."*

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APPENDIX A: TOP 100 CME BY ANNUAL TURNOVER FOR FY2015-16

Rank	Name	State	Turnover (AUD $)	EBIT (AUD $)	NPAT (AUD $)	Total Assets (AUD $)
1	Co-operative Bulk Handling Ltd	WA	3,270,597,000	51,497,000	49,786,000	2,110,123,000
2	Murray Goulburn Co-operative Co Ltd	VIC	2,777,672,000	57,542,000	39,848,000	2,177,833,000
3	Hospital Contribution Fund (HCF)	NSW	2,465,036,000	179,057,000	177,022,000	1,999,424,000
4	Capricorn Society Ltd	WA	1,542,947,000	22,670,000	15,908,000	320,094,000
5	HBF Health	WA	1,512,147,000	35,392,000	35,392,000	1,694,558,000
6	Australian Unity	VIC	1,420,728,000	55,172,000	35,562,000	4,817,751,000
7	Members Equity Bank Ltd (ME Bank)	VIC	1,221,621,000	107,472,000	76,832,000	23,203,395,000
8	RACQ	QLD	1,031,287,000	32,209,000	23,073,000	2,495,661,000
9	RAC WA	WA	676,721,000	34,866,000	30,324,000	1,602,197,000
10	RACV	VIC	584,800,000	53,400,000	46,700,000	2,096,000,000
11	NRMA	NSW	557,584,000	35,162,000	34,111,000	1,332,894,000
12	Teachers Health Fund	NSW	543,814,107	22,799,538	22,799,538	408,867,622
13	Norco Co-operative Ltd	NSW	541,138,000	2,003,000	1,380,000	178,030,000
14	GMHBA Limited	VIC	524,475,000	15,244,000	16,221,000	338,807,000
15	Credit Union Australia (CUA)	QLD	520,064,000	72,480,000	51,664,000	12,898,410,000
16	People's Choice Credit Union (Australian Central CU)	SA	407,251,000	49,400,000	35,948,000	7,514,308,000
17	Newcastle Permanent	NSW	396,003,000	56,774,000	39,430,000	9,773,168,000
18	Heritage Bank Ltd	QLD	393,174,000	51,111,000	36,141,000	8,440,727,000
19	Geraldton Fishermen's Co-operative Ltd	WA	372,217,055	458,864	1,197,450	140,874,029
20	Independent Liquor Group Distribution Co-operative	NSW	371,646,955	11,802,424	46,058	58,493,321
21	CBHS Health Fund Limited	NSW	360,713,000	7,754,522	7,754,522	258,970,000
22	RAA SA	SA	329,407,000	5,571,000	5,531,000	456,492,000
23	Avant Mutual Group	NSW	281,471,000	28,360,000	26,183,000	2,027,034,000
24	WA Meat Marketing Co-operative Ltd	WA	280,521,000	435,000	2,156,000	87,498,000
25	Namoi Cotton Co-operative Ltd	NSW	279,713,000	(10,698,000)	(7,558,000)	199,852,000
26	Teachers Mutual Bank Ltd	NSW	274,682,000	43,201,000	30,271,000	5,543,012,000
27	Greater Bank (formerly Greater Building Society Ltd)	NSW	270,728,000	42,211,000	29,512,000	5,715,315,000
28	CUSCAL	NSW	266,300,000	16,800,000	13,300,000	2,173,400,000
29	Almond Co Ltd	SA	238,556,000	5,241,000	4,806,000	179,229,000
30	IMB Limited	NSW	237,814,000	42,222,000	29,556,000	5,224,118,000
31	Northern Co-operative Meat Co. Ltd	NSW	229,951,000	1,570,000	771,000	150,990,000
32	Beyond Bank	SA	229,633,000	33,040,000	24,591,000	4,760,663,000
33	EML (formerly Employers Mutual Ltd)	NSW	229,350,000	(720,000)	(1,023,000)	316,271,000
34	Independent Liquor Group Suppliers Cooperative Ltd	NSW	208,987,386	3,292,421	2,610,661	55,618,409
35	Westfund Health Ltd	NSW	178,602,403	14,697,535	14,697,535	181,987,127
36	Bank Australia (formerly bank mecu)	VIC	167,428,000	31,188,000	22,592,000	4,038,759,000
37	Latrobe Health Services Ltd	VIC	165,806,096	10,631,966	10,631,966	205,264,970

Rank	Name	State	Turnover (AUD $)	EBIT (AUD $)	NPAT (AUD $)	Total Assets (AUD $)
38	Queensland Country Credit	QLD	163,235,000	8,317,000	8,693,000	1,358,074,000
39	Health Insurance Fund of Australia	WA	162,574,199	(5,567,182)	(5,567,390)	118,791,257
40	P&N Bank	WA	149,657,098	12,567,000	8,550,000	3,761,092,000
41	Queensland Teachers Union Health Fund	QLD	149,045,892	(2,229,390)	(2,229,390)	125,137,763
42	Health Partners Ltd	SA	136,808,000	5,294,000	5,757,000	137,418,000
43	Plumbers' Suppliers Co-operative Ltd (NSW)	NSW	142,583,718	858,694	(262,726)	65,245,838
44	Dairy Farmers Milk Co-operative Ltd	NSW	134,050,000	423,000	427,000	18,805,000
45	University Co-operative Bookshop Ltd	NSW	133,029,243	(1,397,052)	(1,397,052)	61,204,447
46	Qudos Bank (formerly QANTAS Credit Union)	NSW	132,460,673	20,276,000	14,223,000	3,347,074,000
47	Peoplecare Health Insurance	NSW	131,683,497	6,642,985	6,642,985	97,867,166
48	Medical Indemnity Protection Society Ltd (MIPS)	VIC	111,005,000	22,340,000	20,322,000	507,855,000
49	St Luke's Medical & Hospital Benefits Association Ltd	TAS	103,020,000	5,073,000	5,073,000	108,684,000
50	Railway and Transport Health Fund	NSW	101,074,000	1,162,000	1,162,000	77,429,000
51	Australian Scholarship Group Friendly Society	VIC	94,823,000	4,785,000	452,000	1,579,753,000
52	Victoria Teachers Mutual Bank	VIC	90,490,383	21,564,000	16,103,000	2,161,646,000
53	Police Bank	NSW	89,568,165	12,502,323	8,829,938	1,555,132,280
54	MDA National	WA	88,497,000	4,889,000	3,407,000	392,586,000
55	Defence Bank	VIC	86,289,000	14,429,000	10,002,000	1,780,500,000
56	NSW Sugar Milling Co-operative	NSW	85,540,000	NA	NA	NA
57	Murrumbidgee Irrigation Limited	NSW	80,529,000	30,517,000	30,979,000	575,086,000
58	StateCover Mutual Ltd	NSW	79,142,000	NA	NA	450,655,000
59	Hastings Co-operative	NSW	75,671,360	1,246,359	1,318,983	21,241,427
60	QTMB	QLD	73,987,000	7,442,000	5,394,000	1,434,370,000
61	Police Credit (BankVic)	VIC	71,895,000	14,574,000	10,245,000	1,502,852,000
62	Bananacoast Community Credit Union	NSW	71,666,416	12,602,000	8,845,000	1,523,127,000
63	International Macadamias Ltd (Macadamia Processing Co. Ltd)	NSW	71,504,720	4,312,660	3,713,742	31,453,717
64	Navy Health Ltd	VIC	69,542,000	9,536,000	9,536,000	95,375,000
65	Murray Irrigation Limited	NSW	68,943,000	(49,821,000)	(35,262,000)	482,458,000
66	Rapid Group Cooperative Ltd (Rapid Clean)	NSW	68,700,000	NA	NA	NA
67	Community Co-op Store (Nuriootpa) Ltd	SA	68,507,658	945,621	650,191	48,121,603
68	Regional Australia Bank	NSW	63,418,000	10,588,000	7,326,000	1,179,112,000
69	CCW Co-op	SA	62,556,786	389,672	290,826	4,257,824
70	OZ Group Co-op	NSW	61,935,605	3,639,890	525,000	15,621,705
71	Royal Automobile Club of Tasmania	TAS	61,118,000	4,084,000	4,190,000	96,243,000
72	Master Butchers Co-operative Ltd (SA)	SA	59,049,522	2,143,730	2,200,076	39,450,790
73	Yenda Producers Co-operative Ltd	NSW	59,031,271	1,451,118	1,206,904	37,670,517
74	Mildura District Hospital Fund Ltd	VIC	53,941,757	1,115,731	1,115,731	87,685,221
75	Institute for Urban Indigenous Health ltd	QLD	48,950,118	1,985,828	1,985,828	21,920,138

Rank	Name	State	Turnover (AUD $)	EBIT (AUD $)	NPAT (AUD $)	Total Assets (AUD $)
76	Australian Military Bank (Australian Defence Credit Union)	NSW	48,611,001	6,519,000	4,746,000	1,131,797,000
77	Capricorn Mutual Limited	WA	46,538,000	5,626,000	5,464,000	59,134,000
78	Lenswood Cold Stores Co-operative Ltd	SA	46,210,719	(2,069,716)	(1,509,197)	25,743,808
79	Gateway Credit Union	NSW	45,960,000	3,807,000	2,656,000	1,036,868,000
80	Maritime, Mining & Power Credit Union	NSW	45,132,802	4,413,913	3,245,560	872,545,724
81	Hume Bank	NSW	45,106,000	5,324,000	3,707,000	1,004,578,000
82	Credit Union SA Ltd	SA	45,045,000	5,025,000	3,851,000	927,793,000
83	Police Credit Union Limited	SA	44,810,000	5,788,000	4,094,000	858,831,000
84	CEHL	VIC	44,467,498	3,271,795	3,271,795	787,621,013
85	Community First Credit Union	NSW	44,007,000	3,118,000	2,401,000	909,106,000
86	Central Australian Aboriginal Congress Aboriginal Corporation	NT	41,281,995	1,371,705	1,371,705	25,775,801
87	UniMutual	NSW	39,351,563	1,993,531	1,748,440	59,007,928
88	Wesbuilders Co-operative Ltd	WA	37,830,717	86,535	65,731	
89	Queensland Police Credit Union Ltd	QLD	37,377,461	3,508,654	2,462,517	805,701,915
90	Sydney Credit Union	NSW	37,295,000	3,039,000	2,345,000	844,095,000
91	Kimberley Aboriginal Medical Services Ltd (was Kimberley Aboriginal Medical Service Co-operative)	WA	35,749,745	(461,644)	(461,644)	37,078,777
92	SGE Credit Union	NSW	35,571,000	3,292,000	2,302,000	879,148,000
93	Batlow Fruit Co-operative Ltd	NSW	35,440,928	(755,479)	(530,411)	16,850,117
94	B&E Personal Banking	TAS	33,160,000	4,590,000	3,217,000	727,867,000
95	G&C Mutual Bank / Quay Mutual Bank (Quay Credit Union Ltd)	NSW	32,875,000	4,041,000	2,837,000	723,996,000
96	Summerland Credit Union Limited	NSW	32,021,000	4,733,000	3,333,000	630,904,000
97	Aboriginal and Torres Strait Islander Community Health Service Brisbane Limited	QLD	31,982,777	6,184,723	6,184,723	47,050,385
98	Phoenix Health Fund	NSW	31,543,421	374,349	374,349	25,310,700
99	Mount Barker Co-operative Ltd	WA	29,436,951	813,395	711,641	13,572,225
100	Railways Credit Union (Move)	QLD	28,924,802	2,811,724	1,975,939	590,276,292

Notes to Table:

1. EBIT= earnings before interest and tax. NPAT = net profit after tax. n/a=not available. All values are reported in Australian $.
2. Turnover for some CMEs has included the total income received by the enterprise as a co-operative or mutual rather than the amount of income accounted for by the enterprise as a business entity.
3. Financial information has been sourced in most cases from company annual reports, and where that has not been available from IBISWorld industry reports. All care has been taken to ensure the accuracy of this data, however, it is possible that some information may be incorrect.
4. Some businesses that appeared in earlier Top 100 reports have been removed as they were unwilling to provide financial information.
5. Member owned superannuation funds are reported in Appendix B.

APPENDIX B: MEMBER OWNED SUPERANNUATION FUNDS 2016

Rank	Name	State	Turnover (AUD $)	ABBT (AUD $)	ABAT (AUD $)	Total Assets (AUD $)
1	Australian Super	VIC	17,540,115,000	16,640,333,000	15,722,789,000	103,693,062,000
2	UniSuper	VIC	8,153,000,000	5,950,000,000	5,496,000,000	55,839,000,000
3	First State Super Fund	NSW	6,804,639,000	3,544,973,000	3,089,954,000	56,558,130,000
5	Retail Employee's Superannuation Trust (REST)	NSW	6,089,119,000	5,045,226,000	4,697,845,000	41,520,906,000
4	Sunsuper	QLD	6,001,059,000	3,152,983,000	2,822,487,000	37,210,905,000
6	Construction & Building Superannuation (CBUS)	VIC	5,542,374,000	4,980,054,000	4,636,133,000	35,861,819,000
7	Health Employee's Superannuation Trust Australia (HESTA)	VIC	5,260,953,000	4,930,136,000	4,580,245,000	35,760,443,000
8	HOSTPLUS	VIC	3,516,772,744	3,200,375,744	2,976,862,149	20,165,604,006
9	VicSuper	VIC	2,214,050,000	2,060,025,000	1,935,702,000	16,587,455,000
10	CareSuper	NSW	1,687,363,000	1,570,865,000	1,473,122,000	14,254,744,000
11	MTAA Superannuation Fund	NSW	1,537,561,000	1,403,916,000	1,297,114,000	9,447,878,000
12	Local Government Super	NSW	1,262,852,000	916,244,000	851,188,000	9,458,409,000
13	Tasplan Ltd	TAS	1,251,601,082	1,206,971,116	1,182,742,784	3,535,436,989
14	Mine Wealth + Wellbeing	NSW	1,042,447,000	217,677,000	168,267,000	10,024,649,000
15	Catholic Superannuation Fund	VIC	1,032,965,110	952,692,984	909,434,436	7,456,400,631
16	CSF Pty Limited (MyLifeMyMoney Superannuation Fund)	VIC	1,032,965,110	952,692,984	909,434,436	7,456,400,631
17	Equipsuper	VIC	1,012,651,000	489,232,000	446,518,000	7,631,106,000
18	NGS Super Pty Ltd	VIC	959,539,000	432,542,000	392,234,000	7,234,877,000
19	Statewide Super	SA	950,693,000	451,044,000	392,525,000	6,656,979,000
20	Vision Super Pty Ltd	VIC	819,102,000	289,983,000	243,353,000	7,791,064,000
21	Australian Catholic Superannuation and Retirement Fund	NSW	768,583,828	261,486,258	219,163,581	7,230,309,124
22	Energy Super	QLD	684,060,000	290,367,000	266,651,000	6,183,571,000
23	Building Unions Superannuation Scheme (Qld)	QLD	681,760,843	629,901,706	597,411,646	3,802,865,601
24	TWU Super	NSW	652,578,000	212,095,000	176,537,000	4,445,144,000
25	Kinetic Financial Services Pty Ltd	NSW	649,528,743	526,724,541	483,148,915	3,272,462,353
26	Media Super	VIC	494,462,000	455,375,000	442,287,000	4,567,618,000
27	Maritime Super	NSW	487,071,000	105,464,000	77,741,000	4,862,372,000
28	Prime Super	NSW	458,595,000	417,714,000	385,248,000	3,115,850,000
29	Legalsuper	VIC	424,757,074	398,934,003	368,871,080	2,901,575,454
30	Intrust Super Fund	QLD	330,999,094	290,399,634	269,785,076	2,013,653,935
31	First Super	VIC	319,830,632	276,259,062	257,191,574	2,429,661,695
32	AMIST Super	NSW	267,160,623	235,865,720	212,133,871	1,890,431,156
33	Austsafe Super	QLD	262,316,158	238,820,075	217,971,495	2,017,417,721
34	REI Super	VIC	217,701,000	204,118,000	185,745,000	1,369,342,000
35	QIEC Super Pty Ltd	SA	188,537,000	167,142,000	156,376,000	1,267,246,000
36	Christian Super	NSW	183,464,552	163,286,100	155,936,443	1,159,133,854
37	LUCRF Super	VIC	167,901,000	115,041,000	106,489,000	5,563,510,000

Rank	Name	State	Turnover (AUD $)	ABBT (AUD $)	ABAT (AUD $)	Total Assets (AUD $)
38	Combined Super	VIC	121,770,354	55,087,151	45,997,907	827,941,164
39	Meat Industry Employees' Superannuation Fund	VIC	99,168,357	23,779,366	17,102,846	740,145,543
40	NESS Super Pty Ltd	NSW	83,009,010	37,979,902	32,281,971	626,344,745
41	Electricity Industry Superannuation Fund	SA	71,600,000	(32,600,000)	(35,700,000)	1,099,000,000
42	Concept One Super	WA	62,894,790	55,282,050	50,789,477	465,521,388
43	Victorian Independent Schools Superannuation Fund (VISSF)	VIC	44,781,000	(6,351,000)	(10,973,000)	643,861,000

Notes to Table:

1. ABBT= allocation of benefits tax. ABAT = allocation of benefits after tax. n/a=not available. All values are reported in Australian $.

APPENDIX C: TOP 100 AUSTRALIAN CME BY ASSETS FY2015-16

Rank	Name	State	Assets (AUD $)	Liabilities (AUD $)	Equity (AUD $)
1	Members Equity Bank Ltd (ME Bank)	VIC	23,203,395,000	22,237,443,000	965,952,000
2	Credit Union Australia (CUA)	QLD	12,898,410,000	11,984,385,000	914,025,000
3	Newcastle Permanent	NSW	9,773,168,000	8,895,767,000	877,401,000
4	Heritage Bank Ltd	QLD	8,440,727,000	7,998,622,000	442,105,000
5	People's Choice Credit Union (Australian Central CU)	SA	7,514,308,000	6,981,017,000	533,291,000
6	Greater Bank (formerly Greater Building Society Ltd)	NSW	5,715,315,000	5,262,529,000	452,786,000
7	Teachers Mutual Bank Ltd	NSW	5,543,012,000	5,104,921,000	438,091,000
8	IMB Limited	NSW	5,224,118,000	4,915,539,000	308,579,000
9	Australian Unity	VIC	4,817,751,000	4,238,228,000	579,523,000
10	Beyond Bank	SA	4,760,663,000	4,354,174,000	406,489,000
11	Bank Australia (formerly bank mecu)	VIC	4,038,759,000	3,602,808,000	435,951,000
12	P&N Bank	WA	3,761,092,000	2,701,103,000	260,540,000
13	Qudos Bank (formerly QANTAS Credit Union)	NSW	3,347,074,000	3,108,725,000	238,349,000
14	RACQ	QLD	2,495,661,000	1,354,844,000	1,140,817,000
15	Murray Goulburn Co-operative Co Ltd	VIC	2,177,833,000	1,002,139,000	1,175,694,000
16	CUSCAL	NSW	2,173,400,000	1,923,600,000	249,800,000
17	Victoria Teachers Mutual Bank	VIC	2,161,646,000	1,980,278,000	181,368,000
18	Co-operative Bulk Handling Ltd	WA	2,110,123,000	462,008,000	1,648,115,000
19	RACV	VIC	2,096,000,000	576,800,000	1,519,200,000
20	Avant Mutual Group	NSW	2,027,034,000	994,144,000	1,032,890,000
21	Hospital Contribution Fund (HCF)	NSW	1,999,424,000	650,780,000	1,348,644,000
22	Defence Bank	VIC	1,780,500,000	1,630,286,000	150,214,000
23	HBF Health	WA	1,694,558,000	466,213,000	1,228,345,000
24	RAC WA	WA	1,602,197,000	792,249,000	809,948,000
25	Australian Scholarship Group Friendly Society	VIC	1,579,753,000	1,481,696,000	98,057,000
26	Police Bank	NSW	1,555,132,280	1,379,860,150	175,272,130
27	Bananacoast Community Credit Union	NSW	1,523,127,000	1,403,804,000	119,323,000
28	Police Credit (BankVic)	VIC	1,502,852,000	1,348,916,000	153,936,000
29	QTMB	QLD	1,434,370,000	1,287,428,000	146,492,000
30	Queensland Country Credit	QLD	1,358,074,000	1,178,912,000	179,162,000
31	NRMA	NSW	1,332,894,000	448,860,000	884,034,000
32	Regional Australia Bank	NSW	1,179,112,000	1,080,075,000	99,037,000
33	Australian Military Bank (Australian Defence Credit Union)	NSW	1,131,797,000	1,048,458,000	83,339,000
34	Gateway Credit Union	NSW	1,036,868,000	938,861,000	98,007,000
35	Hume Bank	NSW	1,004,578,000	937,268,000	67,310,000
36	Credit Union SA Ltd	SA	927,793,000	835,987,000	91,806,000
37	Community First Credit Union	NSW	909,106,000	830,448,000	78,658,000
38	SGE Credit Union	NSW	879,148,000	798,233,000	80,915,000

Rank	Name	State	Assets (AUD $)	Liabilities (AUD $)	Equity (AUD $)
39	Maritime, Mining & Power Credit Union	NSW	872,545,724	797,255,070	75,290,654
40	Police Credit Union Limited	SA	858,831,000	790,352,000	68,479,000
41	Sydney Credit Union	NSW	844,095,000	767,696,000	76,399,000
42	Queensland Police Credit Union Ltd	QLD	805,701,915	731,204,107	74,497,808
43	CEHL	VIC	787,621,013	96,622,648	690,998,365
44	B&E Personal Banking	TAS	727,867,000	664,254,000	63,613,000
45	G&C Mutual Bank / Quay Mutual Bank (Quay Credit Union Ltd)	NSW	723,996,000	645,197,000	78,799,000
46	Summerland Credit Union Limited	NSW	630,904,000	577,190,000	53,714,000
47	Community Alliance Credit Union	NSW	626,340,000	585,047,000	41,293,000
48	Maitland Mutual Building Society Ltd	NSW	598,334,000	558,682,000	39,652,000
49	Railways Credit Union (Move)	QLD	590,276,292	529,205,816	61,070,476
50	Murrumbidgee Irrigation Limited	NSW	575,086,000	109,403,000	465,683,000
51	Holiday Coast Credit Union	NSW	552,091,000	511,873,000	40,218,000
52	Medical Indemnity Protection Society Ltd (MIPS)	VIC	507,855,000	212,778,000	295,077,000
53	Murray Irrigation Limited	NSW	482,458,000	70,752,000	411,706,000
54	RAA SA	SA	456,492,000	229,192,000	227,300,000
55	StateCover Mutual Ltd	NSW	450,655,000	312,345,000	138,310,000
56	Southern Cross Credit Union Ltd	NSW	421,922,000	375,341,000	46,581,000
57	WAW Credit Union Co-operative	VIC	421,898,687	394,857,907	27,040,780
58	Teachers Health Fund	NSW	408,867,622	128,456,684	280,410,938
59	MDA National	WA	392,586,000	218,249,000	174,337,000
60	Coastline Credit Union Ltd	NSW	390,934,000	358,833,000	32,101,000
61	Centuria Life Limited	VIC	353,528,000	3,650,000	349,878,000
62	ECU Limited	QLD	340,667,000	319,862,000	20,805,000
63	GMHBA Limited	VIC	338,807,000	138,720,000	200,087,000
64	Queenslanders Credit Union Limited	QLD	333,368,563	290,247,494	43,121,069
65	Select Credit Union Ltd	NSW	323,161,298	283,226,544	39,934,754
66	Capricorn Society Ltd	WA	320,094,000	169,412,000	150,682,000
67	EML (formerly Employers Mutual Ltd)	NSW	316,271,000	205,139,000	111,132,000
68	Goulburn Murray Credit Union Co-Operative Ltd	VIC	311,902,868	272,686,371	39,216,497
69	Horizon Credit Union Ltd	NSW	307,824,045	286,583,904	21,240,141
70	Intech Credit Union Ltd	NSW	305,514,697	283,820,729	21,693,968
71	Australian Settlements Ltd	NSW	299,126,322	290,712,674	8,413,648
72	EECU Limited	VIC	298,595,000	282,647,000	15,948,000
73	The Capricornian Ltd	QLD	291,808,017	270,368,481	21,439,536
74	ENCOMPASS Credit Union Ltd	NSW	289,629,000	250,493,000	39,136,000
75	Hunter United Employees Credit Union Ltd	NSW	278,158,337	254,885,361	23,272,976
76	CBHS Health Fund Limited	NSW	258,970,000	84,339,000	174,631,000
77	Northern Inland Credit Union Ltd	NSW	251,150,706	217,252,704	33,898,002
78	Macarthur Credit Union Ltd	NSW	242,356,114	218,461,359	23,894,755

Rank	Name	State	Assets (AUD $)	Liabilities (AUD $)	Equity (AUD $)
79	Warwick Credit Union Ltd	QLD	240,777,427	223,993,622	16,783,805
80	Key Invest Ltd	SA	223,506,192	191,340,659	32,165,533
81	My Credit Union Ltd	NSW	208,049,674	176,961,131	31,088,543
82	Latrobe Health Services Ltd	VIC	205,264,970	45,628,836	159,636,134
83	Namoi Cotton Co-operative Ltd	NSW	199,852,000	76,307,000	123,545,000
84	Coleambally Irrigation Co-operative Ltd	NSW	186,462,000	22,856,000	163,606,000
85	Orange Credit Union Ltd	NSW	184,423,804	159,807,393	24,616,411
86	Westfund Health Ltd	NSW	181,987,127	52,587,607	129,399,520
87	AlmondCo Ltd	SA	179,229,000	157,276,000	21,953,000
88	Norco Co-operative Ltd	NSW	178,030,000	104,655,000	64,214,000
89	First Option Credit Union Ltd	NSW	176,752,853	163,660,078	13,092,775
90	Laboratories Credit Union Ltd	NSW	172,623,642	160,328,932	12,294,710
91	Bankstown City Credit Union Ltd	NSW	166,714,593	145,175,900	21,538,693
92	Dnister Ukrainian Credit Co-operative Ltd	VIC	153,317,000	134,028,000	19,289,000
93	Northern Co-operative Meat Co. Ltd	NSW	150,990,000	61,755,000	89,235,000
94	Australian Friendly Society	VIC	149,986,000	140,034,000	9,952,000
95	South West Slopes Credit Union Ltd	NSW	149,171,000	129,165,000	20,006,000
96	Central West Credit Union Ltd	NSW	145,911,000	127,532,000	18,379,000
97	Geraldton Fishermen's Co-operative Ltd	WA	140,874,029	114,969,927	25,904,102
98	Ford Co-Operative Credit Society Ltd	VIC	134,940,000	125,843,000	9,097,000
99	Queensland Teachers Union Health Fund	QLD	125,137,763	41,926,191	83,211,572
100	Health Insurance Fund of Australia (HIF)	WA	118,791,257	50,462,446	68,328,811

Notes to Table:

1. This list contains businesses ranked by total assets not turnover and includes several firms that did not appear in the Top 100 lists by turnover (Appendix A), while some of the firms listed there do not appear in this list.
2. Financial information has been sourced in most cases from company annual reports, and where that has not been available from IBISWorld industry reports. All care has been taken to ensure the accuracy of this data, however, it is possible that some information may be incorrect.

APPENDIX D: TOP 100 AUSTRALIAN CME BY MEMBERSHIP FY2015-16

Rank	Name	State	Members
1	NRMA	NSW	2,400,000
2	Australian Super	VIC	2,100,000
3	RACV	VIC	2,100,000
4	University Co-operative Bookshop Ltd	NSW	2,063,358
5	Retail Employee's Superannuation Trust (REST)	NSW	1,900,000
6	RACQ	QLD	1,600,000
7	HBF Health	WA	1,025,236
8	HOSTPLUS	VIC	985,419
9	RAC WA	WA	840,000
10	Health Employee's Superannuation Trust Australia (HESTA)	VIC	800,000
11	First State Super Fund	NSW	760,000
12	Construction & Building Superannuation (CBUS)	VIC	732,922
13	RAA SA	SA	664,861
14	Hospital Contribution Fund (HCF)	NSW	650,000
15	Sunsuper	QLD	600,000
16	Credit Union Australia (CUA)	QLD	442,000
17	UniSuper	VIC	420,000
18	People's Choice Credit Union (Australian Central CU)	SA	353,000
19	Newcastle Permanent	NSW	325,000
20	Heritage Bank Ltd	QLD	316,000
21	Australian Unity	VIC	300,000
22	Big Sky Credit Union Ltd	NSW	280,000
23	Kinetic Financial Services Pty Ltd	NSW	275,000
24	CareSuper	NSW	250,000
25	MTAA Superannuation Fund	NSW	248,000
26	Greater Bank (formerly Greater Building Society Ltd)	NSW	240,000
27	VicSuper	VIC	240,000
28	Westfund Health Ltd	NSW	240,000
29	Beyond Bank	SA	198,373
30	GMHBA Limited	VIC	180,770
31	IMB Limited	NSW	180,000
32	Royal Automobile Club of Tasmania	TAS	178,000
33	Teachers Mutual Bank Ltd	NSW	177,000
34	LUCRF Super	VIC	163,000
35	Australian Scholarship Group Friendly Society	VIC	155,000
36	Teachers Health Fund	NSW	140,214
37	Statewide Super	SA	140,000
38	Bank Australia (formerly bank mecu)	VIC	130,000
39	Health Insurance Fund of Australia	WA	128,000

Rank	Name	State	Members
40	Intrust Super Fund	QLD	120,000
41	Prime Super	NSW	120,000
42	TWU Super	NSW	120,000
43	Tasplan Ltd	TAS	109,496
44	Victoria Teachers Mutual Bank	VIC	108,801
45	Austsafe Super	QLD	108,000
46	Vision Super Pty Ltd	VIC	101,000
47	Police Credit (BankVic)	VIC	100,263
48	Hastings Co-operative	NSW	100,000
49	NGS Super Pty Ltd	VIC	100,000
50	Qudos Bank (formerly QANTAS Credit Union)	NSW	100,000
51	Australian Catholic Superannuation and Retirement Fund	NSW	93,000
52	CBHS Health Fund Limited	NSW	92,647
53	Defence Bank	VIC	90,000
54	Local Government Super	NSW	90,000
55	Media Super	VIC	90,000
56	Centuria Life Limited	VIC	85,186
57	Latrobe Health Services Ltd	VIC	85,104
58	Building Unions Superannuation Scheme (Qld)	QLD	85,000
59	Catholic Superannuation Fund	VIC	77,000
60	CSF Pty Limited (MyLifeMyMoney Superannuation Fund)	VIC	77,000
61	Avant Mutual Group	NSW	72,000
62	Police Bank	NSW	71,011
63	Mine Wealth + Wellbeing	NSW	70,076
64	Regional Australia Bank	NSW	70,000
65	Queensland Teachers Union Health Fund	QLD	70,000
66	AMIST Super	NSW	67,169
67	QTMB	QLD	66,480
68	First Super	VIC	64,000
69	Queensland Country Credit	QLD	60,000
70	Hume Bank	NSW	58,000
71	Community First Credit Union	NSW	55,488
72	Bananacoast Community Credit Union	NSW	54,991
73	Police Health	SA	51,000
74	Australian Military Bank (Australian Defence Credit Union)	NSW	50,000
75	Credit Union SA Ltd	SA	50,000
76	MDA National	WA	50,000
77	Energy Super	QLD	48,000
78	Equipsuper	VIC	48,000
79	Medical Indemnity Protection Society Ltd (MIPS)	VIC	47,924

Rank	Name	State	Members
80	Legalsuper	VIC	43,550
81	Health Partners Ltd	SA	40,000
82	Police Credit Union Limited	SA	40,000
83	G&C Mutual Bank / Quay Mutual Bank (Quay Credit Union Ltd)	NSW	36,000
84	Maritime, Mining & Power Credit Union	NSW	35,000
85	Peoplecare Health Insurance	NSW	33,236
86	Holiday Coast Credit Union	NSW	31,238
87	Concept One Super	WA	30,787
88	Mildura District Hospital Fund Ltd	VIC	30,005
89	B&E Personal Banking	TAS	30,000
90	Christian Super	NSW	30,000
91	Gateway Credit Union	NSW	30,000
92	Maritime Super	NSW	30,000
93	REI Super	VIC	30,000
94	SGE Credit Union	NSW	30,000
95	WAW Credit Union Co-operative	VIC	30,000
96	StateCover Mutual Ltd	NSW	30,000
97	Community Alliance Credit Union	NSW	29,000
98	APS Benefits Group	VIC	29,000
99	Queensland Police Credit Union Ltd	QLD	26,000
100	QIEC Super Pty Ltd	SA	25,978

Notes to Table:

1. Not all CMEs make their membership numbers publicly available. This list has been compiled using data sourced from their websites, annual reports and secondary sources such as IBISWorld. In some cases, these figures may represent an estimate of numbers by the source.

About the authors:

Tim Mazzarol is a Winthrop Professor in Entrepreneurship, Innovation, Marketing and Strategy at the University of Western Australia and an affiliate Professor with the Burgundy School of Business, Groupe ESC Dijon, Bourgogne, France. He is also the Director of the Centre for Entrepreneurial Management and Innovation (CEMI), an independent initiative designed to enhance awareness of entrepreneurship, innovation and small business management. Tim is also a Qualified Practising Market Researcher (QPMR) as recognised by the Australian Market and Social Research Society (AMSRS), and President of the Small Enterprise Association of Australia and New Zealand (SEAANZ). He has around 20 years of experience of working with small entrepreneurial firms as well as large corporations and government agencies. He is the author of several books on entrepreneurship, small business management and innovation. He holds a PhD in Management and an MBA with distinction from Curtin University of Technology, and a Bachelor of Arts with Honours from Murdoch University, Western Australia.

Johannes Kresling is a research associate with the University of Western Australia. He has a Bachelor's degree from the University of Paderborn in popular music and media. He also completed a Master's Degree from UWA in Management, Electronic Business and Electronic Marketing in 2010. In 2011 he joined the UWA Team engaged in the "Slow the Meter" ARC Linkage project and has been an invaluable member with responsibilities for managing the website and coordinating the data collection process. In 2009 he was employed as a Research Assistant within the UWA Business School on another project. Prior to embarking on this academic career path, Johannes was a music consultant for BMG ZOMBA Production Music and an intern for Roadrunner Records GmbH in Germany where he worked in the marketing department. He also held a short-term position in 2008 with Sony Music Entertainment within their eMedia department where he was responsible for the management of an online store and the content management for artists' homepages.