Health cooperatives in BC: The unmet potential

One solution to our health care crisis doesn't involve a radical reconfiguration of the health care system or a two-tiered approach, but is simply a return to a model that helped pave the way for our socialized medicare system in the first place: the health cooperative.

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With privately funded health care making significant inroads into British Columbia's health care landscape with the Cambie Surgery Centre and False Creek Surgical Centre promoting themselves as part of the answer to the woes of the public health care system in BC, the issue of how best to fix the problems being faced by BC's health care system has again come to the fore. The debate over the state of health care in BC has shifted to focus on the possibility of privately funded care as a solution for BC's health care problems. While lengthy wait times for knee and hip replacements, imaging, cataract surgery, and coronary angioplasty are an important concern for many British Columbians, more pressing for over 100 000 British Columbians is their current lack of a family physician.[1] The deficit of family physicians throughout the province has necessitated a number of changes to health care policy and delivery in BC. Expansion of the medical class at the University of British Columbia, distribution of the program to Victoria and Prince George, and development of nurse practitioner programs in BC have all been recent attempts to deal with the lack of primary care providers. In larger cities this massive deficiency is being stemmed by an increased dependence on services provided by walk-in clinics, while in smaller communities this has simply led to an increasing deficit in basic health care services. The resulting lack of basic screening programs for treatable illnesses and deficiency in counseling about health promotion and prevention at the population level has put an increasing demand on our tertiary health care system. It is obvious to most that the tertiary system is already greatly overstressed by demand for its services, necessitating long wait times, and is now being forced to deal with diseases presenting at later stages and necessitating more radical interventions.[2] It is clear that solutions are needed to solve the growing issues in health care delivery in BC, but what are they? Is the expansion of privately funded surgical and other care centres the answer that British Columbians want? Is there a way health care delivery at the primary care level in British Columbia can be changed that can have positive effects on all levels of the health care system? One innovative solution doesn't involve a radical reconfiguration of the health care system or a two-tiered approach, but is simply a return to a model that helped pave the way for our socialized medicare system in the first place: the health cooperative.[3]

In 1962 a group of pro-medicare physicians and citizens in Saskatoon concerned about the withdrawal of medical services by physicians following the provincial government's decision to implement publicly funded health insurance formed the Community Health Services (Saskatoon) Association.[4] The association helped form and currently operates the Saskatoon Community Clinic. This group of community-minded citizens organized their health services using a model of mutual assistance well established in farming communities: the cooperative.

What is a health cooperative?

A cooperative is an alternative organizational structure based on member control that can be applied to any type of health service delivery. Across Canada today there are over 101 health care cooperatives providing care to over 1 million people spanning eight

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provinces.[5] The International Health Cooperative Alliance claims over 100 million households worldwide are served by health cooperatives.[6] Saludcoop in Columbia, a health care cooperative, is the second-largest national employer and serves 25% of the population.[7] In Japan over 125 medical cooperatives serve nearly 3 million patients.[8] In Canada the majority of health cooperatives are currently involved in the provision of home care services, but in many countries in the world they operate on scales as large as whole hospitals.

A cooperative is defined as 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.[9] For health cooperatives this association can be made up of the providers of health care (workers' cooperative), patients or community members (client or user-owned cooperative), or a hybrid of the two (multistakeholder cooperative). The membership elects a board of directors who are nominated from within the membership. Their responsibility is to oversee the operation of the cooperative for an allotted term. The board of directors is then responsible for hiring a manager to negotiate contracts with health insurance companies, the government, and health care providers. The manager is in charge of the day-to-day operation of the health cooperative and is the functional link between the health care providers, the board of directors, and the membership.

To become a member each user or worker must purchase a share in the cooperative and thereby become a part owner of the cooperative. It is this structure that differentiates a cooperative from other forms of health care delivery because a cooperative exists to provide services to its members and is not driven by a profit motive. To ensure access by all citizens regardless of socioeconomic status most health cooperatives ensure that membership is affordable, and in some cases allow membership fees to be waived (oral communication with Ingrid Larson, membership director, Saskatoon Community Clinic, 24 November 2005). Share prices are determined by the members of the cooperative and can range anywhere from $5 to several thousand dollars, depending on the goals and funding of the cooperative. Services provided by health cooperatives funded directly by the government are available to all citizens so users who are not members of the cooperative can still access services.

The board of directors can range in size from five to twelve or more members, with the goal usually being at least nine. In the multi-stakeholder model these positions can be subdivided into categories such as patient members and health care professional members, with a fixed proportion of the board allocated to each. Members can purchase any number of shares to support the co-op but are only entitled to one vote regardless of their number of shares. Health cooperatives place a strong emphasis on patient input and encourage members to express their concerns about their health, community, and the cooperative itself through a variety of member involvement programs. Members are involved in defining the co-op's mission, mandates, goals, and the types of services offered through board representation, steering committees, development of needs assessments, satisfaction surveys, fundraising, volunteer involvement, and other avenues.[10]

Due to their focus on community health and meeting the needs of their membership rather than generating a profit, primary care health cooperatives also have a slightly different philosophy than traditional clinics. In 1990, Angus and Magna identified the following five general principles common to primary care cooperative clinics: 1) community-based organization and control; 2) a spectrum of primary health, social, and related services in one location; 3) multidisciplinary teams to deliver medical services; 4) an emphasis on prevention, health promotion, education services, and ambulatory services; 5) remuneration of health care professionals by salary or capitation rather than fee-for-service.[11]

Health cooperatives in BC

Despite a history of health cooperatives tracing all the way back to the formation of the Health Services Society in British Columbia in 1946, the health cooperative movement in the province has grown significantly only in the last few years.[5] The recent expansion in the cooperative health sector in BC can be traced back directly to the time surrounding the restructuring of the health authorities by the Liberal provincial government in 2002 and the resulting loss of health services in many communities. This restructuring also happened to coincide with a province-wide outreach and education program sponsored by the British Columbia Cooperative Association (BCCA) about the potential of health cooperatives for BC. The restructuring of the health authorities resulted in the closure of many smaller hospitals and the expropriation of locally purchased medical equipment to major regional hospitals, which galvanized many smaller (especially rural) communities, to consider the cooperative model of health care delivery as a way of replacing lost services for their communities (oral communication, Jan Taylor, director, Co-op Development, BCCA, 17 November 2005). This focus has evolved along with the cooperatives with many now focusing instead on defining the specific priority health and social care services their communities need and that co-ops can provide and attempting to meet these priorities.

There are currently eight health cooperatives in the province recog-

nized by the BCCA: the Alberni Valley Housing and Healthcare Co-op in Port Alberni, Care Connection Health Services Co-op in Mission, Community First Health Co-op in Nelson, Edgar J. Kaiser Jr. Valley Health Co-op in Sparwood, Enderby Memorial Co-op in Enderby, Golden and District Community Health Services Co-op in Golden, Kootenay Lake Eastshore Eldercare Co-op in Crawford Bay, and the Rainbow Community Health Co-op in Surrey. Of these eight cooperatives only Care Connection and Valley Health are currently providing health services; the rest are either still in the process of forming or are not currently providing services.

Two of Vancouver's urban community clinics, Reach Community Health Centre and Mid-Main Community Health Centre, are structured similarly to health cooperatives, with a heavy focus on patient decision-making and involvement, but they have chosen not to incorporate as cooperatives. With a board of directors, a focus on interdisciplinary care, emphasis on health prevention and promotion, salaried physicians, and opportunities for patients to become members, these clinics are similar in structure to the primary care health cooperatives in other provinces but do not formally identify as cooperatives.[12]

The cooperative potential

Health cooperatives have a proven record both in Canada and internationally for delivery of cost-effective, responsive, patient-centred, multidisciplinary care.[11,13] Health cooperatives also have enormous potential for health care delivery in this province in several distinct areas. One of the most basic benefits offered by cooperative health care delivery is an economic one. In their article on cooperative health care delivery, Angus and Magna showed that per patient costs were 17% lower than fee-for-service, hospitalization rates were up to 30% lower, and 21% less money was spent on prescription drugs.[11] With our provincial health care budget and Pharmacare spending increasing steadily every year, consideration of a model of primary care delivery with such obvious fiscal benefits over traditional health care delivery is clearly needed.[2]

Another benefit of the cooperative model is derived from the multidisciplinary nature of cooperative health care delivery. Having physicians work in conjunction with a range of other health professionals makes it much simpler to stream patients to the most appropriate health care professional for their needs, thereby allowing doctors to spend their time treating the patients most in need of their specialized care. This allows doctors to meet two fundamental patient concerns: first, spending the appropriate amount of time with patients to fully address their concerns and thereby prevent unnecessary repeat visits, and second, providing time to focus on health prevention and promotion. By allowing physicians and other health professionals to dedicate more time to address health concerns before they become acute and to focus on health prevention and promotion, health cooperatives will help relieve the burden on our tertiary system. By diverting patients with issues that can be cared for by nurses, nurse practitioners, physiotherapists, dietitians, or other allied health professionals, physicians will be able to accept more new patients and alleviate some of the burden caused by the acute shortage of doctors in the province. Member surveys identify the multidisciplinary nature of cooperative health care as one of the main reasons for choosing cooperatively run clinics.

The geographic constraints of a widely dispersed population with tremendous variation in local health care needs are unique to health care provision in British Columbia. The basic health needs of British Columbians living in the downtown eastside of Vancouver and those living in Deese Lake are vastly different. The current top-down approach to health care delivery in the province struggles to meet the unique needs of these populations. The variation in health needs and outcomes is all the more apparent when looking at the health disparities between BC's Aboriginal and non-Aboriginal populations.[9] The member-control model of health cooperatives provides a unique solution to this problem by empowering patients and communities to be involved in the decision-making process on how health care is delivered in their communities. This bottom-up approach to decision making ensures the unique and diverse needs of local communities are being met appropriately. Health cooperatives have also been shown to have a unique strength in arising where there has been inadequate provision by public health services and where other institutions have been either unable or unwilling to meet the community's identified needs. Culturally sensitive delivery of health services that focus on the capacities and strengths of Aboriginals has been identified as one of the central requirements of Aboriginal people for their health services.[9] The health cooperative model, with its emphasis on patient involvement and community empowerment, offers a unique solution to this desire in both Aboriginal and non-Aboriginal communities. The patient-member structure of health cooperatives helps build both healthy populations and healthy communities through member decision making, activism, and empowerment.

Current challenges

Despite a modest presence in the province currently, the health cooperative movement in BC has the potential for substantial growth. Health cooperatives face two major challenges. The first is lack of physician involvement. There are currently no physicians involved in any of the eight

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health cooperatives recognized by the BCCA. For the cooperative model of health care to expand beyond the realm of home care it clearly needs the active involvement and interest of physicians. Besides the obvious problem this presents in terms of a deficiency of providers central to health care, the lack of physician involvement also plays an essential part in the other major challenge being faced by health cooperatives: funding.

Unlike in Saskatchewan, where health cooperatives are now recognized as an essential form of health care delivery and are funded directly by the provincial government, BC currently provides no funding to health cooperatives and has not passed any legislation to support the development of health cooperatives. This has left health co-ops in the province with only one option: to compete for community health services contracts or private funding. The lack of physician involvement has meant that health cooperatives do not have the resource of knowledgeable and experienced physicians to submit quality proposals for community service contracts. In fact, they have been criticized by the government for poor-quality proposals. Most of the current health cooperatives in the province are being forced to turn to provision of private health care services like home support. This is a direct result of the lack of available government funding as well as the requirement by insurers like ICBC and WorkSafeBC that health co-ops have 2 years of service provision before those services will be recognized. This has posed a dilemma for many in the health cooperative movement who have always seen cooperatives not as an avenue to private health care but as a community-based model for public health care delivery.

The example provided by the Saskatchewan cooperative health associations is quite illustrative of the needs in this province if health cooperatives are to succeed. The Saskatoon Agreement between physicians and the provincial government, which ended the doctors' strike and allowed the implementation of socialized health care, required that all health care services provided by doctors be billed as fee-for-service. The agreement forced doctors who worked at health cooperatives to pool the money they billed as fee-for-service to help pay the salaries and help maintain the other costs of the co-operative association.[4] This ineffective method of financing cooperatives caused almost constant financial problems for the cooperative associations that had to lobby, along with others from the cooperative movement, for recognition of the model and a more appropriate funding arrangement. After an arduous struggle the provincial government finally recognized the strengths of the cooperative model and now funds the cooperative associations directly for the services provided by the community clinics they operate, with the Saskatoon Community Clinic receiving approximately $8.25 million per year.[14]

The need for the support of physicians in the province if health cooperatives are to succeed is clear. Until the BCMA and physicians recognize that the cooperative model of community-centred care best facilitates their identified goals of patient autonomy, leadership in multidisciplinary care, health prevention and promotion, and fiscally responsible health care, it will remain on the fringes of our health care system. With active involvement of physicians and support from the BCMA in lobbying the government for recognition and supportive legislation, British Columbia's health cooperative movement may be able to transform our national health care system and revitalize it from primary care to tertiary care. The "third way," as the cooperative sector is called in Quebec, may turn out to be the solution to the problems in our national health care system after all.

References

1. BCMA Council on Health Economics and Policy. Ensuring Excellence: Reviewing BC's Primary Care System. A Discussion Paper by BC's Physicians. BCMA E02:02, 2002.
2. British Columbia Ministry of Health Services. Toward Better Health Care for British Columbians: Putting Patients First; Access, Equity, Quality. November 2004.
3. British Columbia Cooperative Association. Health Programs. www.bcca.coop/programs/health.htm (accessed 18 November 2005).
4. Gruending D. The First Ten Years. Community Clinic. Saskatoon, 1974:3-4.
5. Craddock T, Vayid N. Health Care Cooperatives in Canada. Cooperatves Secretariat, Government of Canada. August 2004.
6. International Health Cooperative Organization. www.coop.org/ihco/ (accessed 18 November 2005).
7. International Cooperative Alliance. Statistics. www.coop.org/coop/statistics.html (accessed 20 November 2005).
8. Committee for the Promotion and Advancement of Cooperatives. The Contribution of Cooperatives to the Implementation of the World Summit for Social Development Declaration and Programme of Action. Conference Room Paper. New York, 17-28 May 1999.
9. Rohan S. Opportunities for Co-operative Health Provision in Rural, Remote and Northern Aboriginal Communities. Government Affairs and Public Policy. Canadian Cooperative Association. 2003.
10. Social Medicine Portal. Health Cooperatives. www.socialmedicine.org/smatoz.html (accessed 19 March 2006).
11. Angus M, Manga P. Co-op/Consumer Sponsored Health Care Delivery Effectiveness. Ottawa: Canadian Co-operative Association. June 1990.
12. Mid-Main Community Health Centre. www.midmaincommunityhealth.net/ (accessed 25 November 2005).
13. UN. Cooperative Enterprise in the Health and Social Care Sectors: A Global Survey. UN Publications Sales No. E.96.IV.11. 1997.
14. Saskatoon Community Clinic. History. www.saskatooncommunityclinic.ca/ (accessed 15 November 15, 2005).