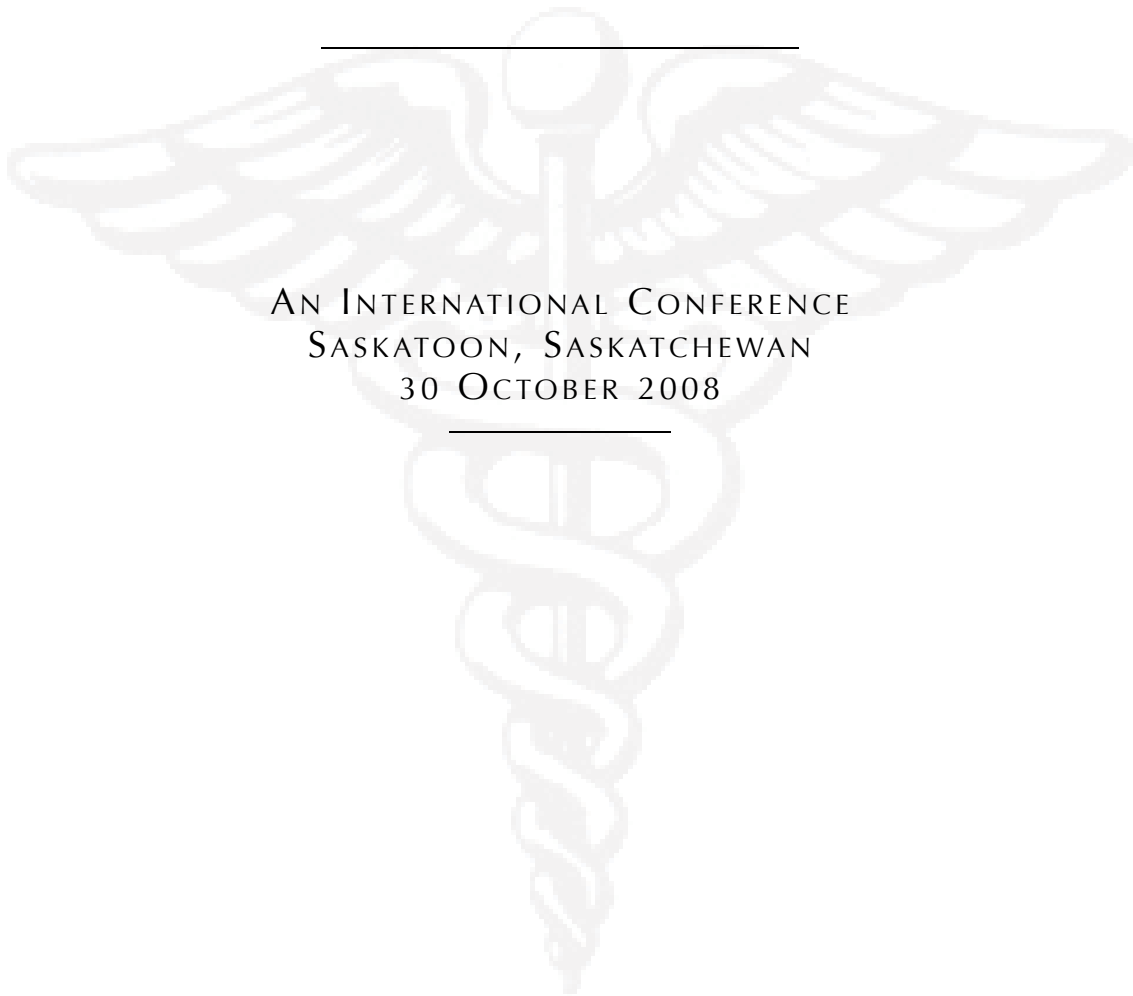


# The Role of Co-operatives in Health Care

## National and International Perspectives

---



AN INTERNATIONAL CONFERENCE  
SASKATOON, SASKATCHEWAN  
30 OCTOBER 2008

---

Report Prepared by Catherine Leviten-Reid  
Centre for the Study of Co-operatives  
University of Saskatchewan  
June 2009

---

# Contents

Preface and Acknowledgements	2
Health Co-operatives around the World: Some Basic Information <i>Jean-Pierre Girard</i>	3
Health Co-operatives in Japan and the Nagano Health Co-operative <i>Nobumasa Kitajima and Miwako Takato</i>	5
Health Co-operatives in Spain: An Overview <i>José Carlos Guisado del Toro</i>	9
Health Care Co-operatives in the USA and Canada <i>Jean-Pierre Girard</i>	11
Co-operative Clinics in Saskatchewan: Their Evolving Role in Primary Care <i>Anne Doucette</i>	14
Does Governance Matter? Innovation in Saskatchewan Community Clinics, 1962 – Present <i>Brett Fairbairn</i>	16
User Participation and Quality of Home Support Services <i>Catherine Leviten-Reid</i>	18
Looking Ahead: Public Policy and Co-operative Health Care <i>Greg Marchildon</i>	20
Conclusion	23

# Preface and Acknowledgements

CO-OPERATIVES PLAY AN IMPORTANT ROLE in health care delivery in Canada and overseas.

While Saskatchewan experiences these organizations as comprehensive primary care clinics governed by their members, co-operatives internationally own hospitals, sell insurance, and operate long-term care facilities.

What do these international co-operatives look like? How did they develop? In what kinds of public policy contexts do they operate, and what are the outcomes?

Domestically, how do our own co-ops compare? What opportunities exist and what kinds of public policies are required to realize the full potential of this model?

On 30 October 2008, the Centre for the Study of Co-operatives at the University of Saskatchewan and the Community Health Co-operative Federation hosted representatives of the International Co-operative Alliance's International Health Co-operative Organization for a one-day symposium on the role of co-operatives in health care delivery.

Presentations on international health co-operatives, which are summarized in this report, include the following: \*

- Health Co-operatives around the World
- Japanese Co-operatives in Japan and the Nagano Health Co-operative
- Health Co-operatives in Spain

Presentations on North American health co-operatives, also summarized in this report, include the following:

- Health Care Co-operatives in the United States and Canada
- Co-operative Clinics in Saskatchewan: Their Evolving Role in Primary Health Care
- Does Governance Matter? Innovation in Saskatchewan Community Clinics, 1962 – Present
- User Participation and Quality of Home Support Services
- Looking Ahead: Public Policy and Co-operative Health Care

This event was attended by health-care administrators, practitioners, policy makers, researchers, and students. Groups from Québec and Japan, participating in a separate study tour of Saskatchewan health care co-operatives, also attended the conference.

Funding for the conference was generously provided by The Co-operators, the Co-operatives Secretariat, the University of Saskatchewan, the Centre for the Study of Co-operatives, the Canadian Co-operative Association, the Social Sciences and Humanities Research Council, the Saskatoon Community Clinic Foundation, and the International Co-operative Health Organization.

\* Please note that the PowerPoint presentation by Mr. Per-Olof Jonsson on Medicoop in Sweden was not available.

## Health Co-operatives around the World: Some Basic Information

*Presenter: Jean-Pierre Girard, lecturer and researcher affiliated with the Institut de recherche et d'éducation pour les coopératives et les mutuelles de l'Université de Sherbrooke; Mr. Girard is also a member of the board of the International Health Co-operative Organization*

### Key Points

- ▶ There are many different actors in the health care system. Government, nonprofit organizations, commercial organizations, and co-operatives are all potential players and are present to varying degrees depending on the political jurisdiction.
- ▶ Health co-operatives exist in different forms, including worker-owned organizations, consumer-owned organizations, jointly (consumer/worker/community) owned organizations, and purchasing or shared service co-operatives.
- ▶ Health co-operatives provide a range of goods and services, including primary and acute care, health insurance, social care such as support with instrumental activities of daily living, pharmaceuticals, and shared services that support the work of clusters of health organizations.

### Summary of Presentation

MR. GIRARD'S PRESENTATION provided an overview of both the health system's functions and actors and explored the role of co-operatives in relation to each of these elements.

Mr. Girard explained that the health system is comprised of administrators, funders, and health care providers. Administration may be done by the state; funding may be provided through a public (tax-funded system), a social insurance system, or through private payments; and health services may be delivered by the state or by private actors, including nonprofit organizations, co-operatives, or commercial providers.

In the case of service provision, co-operatives may be locally focused and provide services to a small geographic area, or they may provide services across large and multiple regions. They may be organized as small clinics or as complex, integrated networks of service providers. Co-operatives may provide health services ranging from health promotion and prevention to rehabilitation and acute care.

Co-operatives also play a variety of other roles in the health system. They may provide social care (such as home support services) or they may manufacture pharmaceuticals or sell insurance.

They may support their member health organizations — for example, a shared service co-operative that provides laundry services, administrative support, staff recruitment, and training to its members. They may also allow members to jointly purchase goods, such as pharmaceuticals, at a competitive price.

The following examples illustrate this range of roles:

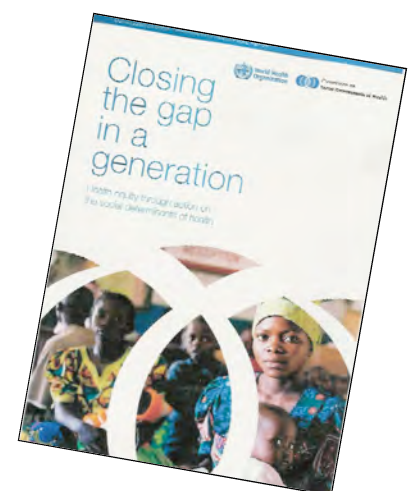
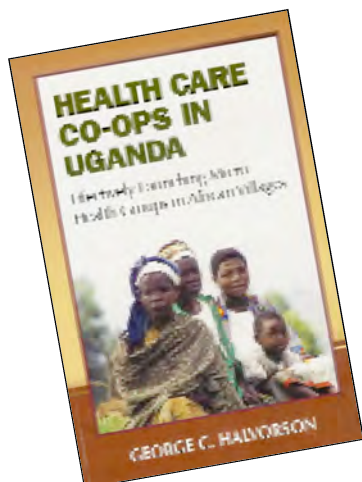
- The Farmers Health Cooperative of Wisconsin allows farmers and agribusinesses a mechanism through which to purchase affordable health insurance: [www.farmershealthcooperative.com](http://www.farmershealthcooperative.com)
- The Partners in Pharmacy Cooperative is a purchasing co-operative comprised of independent pharmacy owners in the United States: [www.pipco.com](http://www.pipco.com)
- The Coopérative de solidarité de services à domicile Orléans is a home support co-operative that offers services such as housecleaning and meal preparation to its consumer members: [www.cssdq.com](http://www.cssdq.com)

Co-operatives may also appear in all of their usual forms: they may be consumer-driven, worker-owned, purchaser-owned, or they may have a multistakeholder model of governance in which consumers, workers, and community representatives are on the board.

Mr. Girard also described the important role that co-operatives play in delivering health services, quoting a United Nations study which found that co-operatives were active in forty-three different countries in 1995, and that 53 million people were using their services. Most co-operatives (about 80 percent) are located in “northern” regions, including European and North American countries, as well as Israel and Japan.

Mr. Girard concluded his presentation by providing the following print resources:

- *Gouvernance et intérêt général dans les services sociaux et de santé*, published by CIRIEC (2008)
- *Health Care Co-operatives in Uganda: Effectively Launching Micro Health Groups in African Villages*, by George C. Halvorson
- *Co-operative Enterprise in the Health and Social Care Sectors: A Global Survey*, published by the United Nations (1997)
- *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*, published by the World Health Organization (2008)



## Health Co-operatives in Japan and the Nagano Health Co-operative

*Presenters: Nobumasa Kitajima, Health Cooperative Association of Japanese Consumer's Cooperative Union and the Asia-Pacific Health Cooperative Organization; and Miwako Takato, the Nagano Health Co-operative*

### Key Points

- ▶ Health co-operatives are prominent in Japan and involve facilities ranging from hospitals to dental clinics and adult day-care centres.
- ▶ The focus of health co-operatives is on preventative care and community health.
- ▶ Han groups, small groups of approximately ten individuals at the neighbourhood level, are the foundation of the co-operative health system in the country.
- ▶ These health co-operatives partner with international organizations and other members of the Asia Pacific Health Co-operative Organization to work on issues of international development, global health, and co-operation

### Summary of Presentations

#### **Health Co-operatives in Japan**

IN CONTRAST TO THE RELATIVELY SMALL NUMBER of health co-operatives in Canada and the United States, health co-operatives are prominent in Japan. Mr. Kitajima explained that there are 117 of these co-operatives in the country, which involve 81 hospitals, 351 medical clinics, 55 dental clinics, 227 nursing stations that provide home care, 375 home-care support centres, and 297 facilities that provide day-care services to adults. These co-operatives have total sales of 280 billion Yen and employ more than 28,000 individuals full time. Further, they may expand into further service areas such as athletic facilities and housing.

These Japanese co-operatives emphasize prevention and health promotion and work under the assumption that most of their members are in good health. The co-operative system also works on issues of “health building” at the community level, including advocating for social policies and working with the World Health Organization to create age-friendly cities in Japan.

These organizations have adopted a three-pronged approach to providing excellent care: providing high quality treatment; minimizing unnecessary consultation and treatment; and helping their members to be well informed and directive in the care they receive.

Individuals participate in the co-operative system through local Han groups, which consist of about ten people who live in the same neighbourhood. There are 26,217 Han groups within Japan's health co-operatives. Through regular meetings, these groups discuss health services and programming and provide their co-operatives with input and feedback. They are also involved in health promotion by supporting each other to do health checks and engage in physical activity.

Health co-operatives in Japan are also involved in international work. They donated US\$10,000 to the Jawa earthquake victims in 2006; they donated 2 million Yen to Doctors of the World in response to the Myanmar cyclone in 2008. They provide assistance to other members of the Asia Pacific Health Cooperative Organization, participating in study tours and exchanges with co-operative hospitals or dental clinics in Nepal, Sri Lanka, South Korea, and Mongolia.

### The Nagano Health Co-op

The Nagano Health Co-operative was established in 1966 with six hundred members. It now has more than forty-nine thousand members and the following facilities: a central hospital, two medical clinics, one nursing home with a hundred beds, one nursing station focused on home care, a group home, an adult day-care centre, and two home-care support centres.

Their activities are representative of how health co-operatives are organized and operate. For example, they are involved in health promotion (through self-health checks) and community health initiatives; some of the activities of the Nagano Health Co-operative are illustrated in the pictures included in this document.



Parent-child pediatric group

Adult day care



Summer festival at rehabilitation ward



Health checks



Towel stretching exercise





Medical student study tour of Sri Lanka, 2006

Health campaign promotion



Dental co-operative in Mongolia



Day care



Han group exercises

## Health Co-operatives in Spain: An Overview

*Presenter: Dr. José Carlos Guisado del Toro, CEO of the Espriu Foundation and chair of the International Health Co-operative Organization*

### Key Points

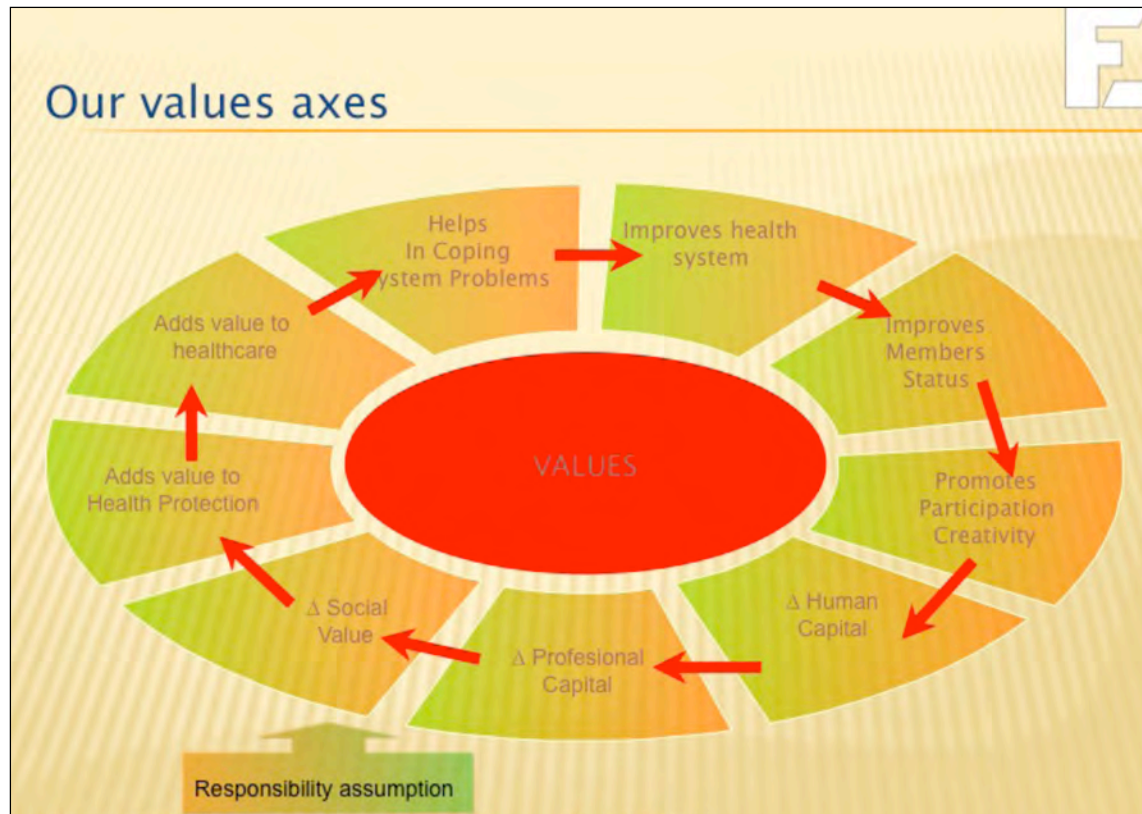
- ▶ Health co-operatives in Spain operate as a system: a consumer co-operative owns a hospital; a worker co-operative of doctors operates health facilities and owns a health insurance company; a third worker co-operative of doctors owns an insurance company. Together, these organizations co-manage their health system; they call it an “integral health co-operative system.”
- ▶ The Espriu Foundation supports the work of the integral health co-operative system through activities such as research, training, and outreach.

### Summary of Presentation

DR. GUIADO DESCRIBED TWO CO-OPERATIVE HEALTH STRUCTURES in Spain. The first is called an “integral health co-operative system.” A consumer co-operative, in the province of Barcelona, owns a hospital and has 170,000 members. A worker co-operative of 5,000 doctors, also in the province of Barcelona, operates health facilities and owns a health insurance company. A third co-operative of 20,000 doctors owns an insurance company and operates country-wide; this co-op also owns the widest network of nonpublic hospitals and clinics throughout Spain. Together, these organizations, spearheaded by Dr. Joseph Espriu, co-manage their health system.

These organizations espouse the following principles: one member, one vote; political independence; the absence of intermediaries; financial self-sufficiency; open doors; and the annual reinvestment of surplus in support of the health system. Their values, presented in the slide on the following page, form a feedback loop that links member participation to the development of human, professional, and social capital, all of which add value to health care and improve the health system.

The second structure is the Espriu Foundation, created in 1989 by the three co-operatives described above. The work of the foundation supports the model of integral health co-operation. For example, the foundation conducts research on co-operation and health care; it promotes the “integral health co-operation” model by organizing seminars and conferences and by publishing resources (such as *Compartir*, which can be found at [www.fundacionespriu.coop](http://www.fundacionespriu.coop) in English, French, and Spanish); and it maintains a library.



Dr. Guisado described the international framework in which the Spanish health co-operatives are located. This framework includes organizations such as the International Health Co-operative Organization, a sectoral organization of the International Co-operative Alliance, as well as the International Labour Organization and the World Health Organization (WHO). Health co-operatives in Spain also have national-level relationships, such as with an association of foundations (the Asociación Española de Fundaciones), a federation of consumer co-operatives (the Federación Cooperatives de Consumo de Cataluña), and affiliates of the International Center of Research and Information on the Public, Social and Cooperative Economy.

Dr. Guisado closed his presentation with some important remarks about the future of health care delivery and the role of co-operatives in particular. He mentioned the Tallin Charter, discussed at a WHO meeting on health systems in 2008, which did not emphasize models of health delivery, but rather health outcomes of individuals and countries. He also stated that the education and training of health providers are fundamental and major challenges faced by every jurisdiction around the world. Still, he argued that health systems and models of delivery are important. Specifically, co-operatives and social economy organizations are important vehicles in that they represent a convergence of public and private market-based delivery.

## Health Care Co-operatives in the USA and Canada

*Presenter: Jean-Pierre Girard, lecturer and researcher affiliated with the Institut de recherche et d'éducation pour les coopératives et les mutuelles de l'Université de Sherbrooke; Mr. Girard is also a member of the board of the International Health Co-operative Organization*

### Key Points

- ▶ Co-operatives in the United States and Canada have emerged to meet the unique health care needs in each country.
- ▶ Co-operatives providing health services in the United States include primarily health maintenance organizations (HMOs) and home-care co-operatives.
- ▶ Co-operatives providing health services in Canada include community health centres, health clinics, paramedics' co-operatives, and home-care co-operatives.

### Summary of Presentation

MR. GIRARD PRESENTED THE RESULTS OF A SURVEY of American and Canadian health co-operatives, as well as information from the literature on health co-operatives in both countries (full results can be found at [www.usherbrooke.ca/irecus/centre\\_documentation/coop\\_sante.html](http://www.usherbrooke.ca/irecus/centre_documentation/coop_sante.html)). He also provided contextual information on the health care systems in Canada and the United States. It is not summarized below, but is available in the PDF file of his PowerPoint presentation located at [www.usaskstudies.coop/coophc/pdf/Health\\_care\\_co-op\\_in\\_USA\\_and\\_Canada.pdf](http://www.usaskstudies.coop/coophc/pdf/Health_care_co-op_in_USA_and_Canada.pdf).

There are different kinds of health co-operatives in the United States, ranging from consumer-owned health maintenance organizations, to worker-owned home-care co-operatives, to purchasing and shared-service co-operatives. Girard estimates there are thirteen health co-operatives offering (or managing) direct-care services in the country. He invited ten to participate in the survey; half accepted.

Two consumer co-operatives that participated in Girard's survey are health maintenance organizations. They allow individuals or families to purchase health plans, as well as employers, who then offer health insurance to their employees. These co-operatives also manage clinics, pharmacies, and hospitals. These two HMOs have a total of 637,549 members and have approximately 945 physicians on staff. Although several HMOs in the US originally operated as co-operatives, many merged or were sold to commercial companies due to competition and the high cost of health care delivery.

With regard to worker co-operatives, Girard explained that it is primarily in the field of home

care that this model of co-operative has developed. This has been the result of the poor working conditions that prevail in this sector, including low wages, few benefits, and little training. The three home-care co-operatives that participated in the survey — Cooperative Home Care Associates, Manos Home Care, and Cooperative Care — employ a total of 1,560 individuals and operate at regional or local levels. They provide supportive services, such as help with housekeeping and meal preparation, and personal care.

Girard estimates that there are 117 co-operatives in Canada offering health services. These include co-operative health clinics, home-care co-operatives, and paramedics' co-operatives. About 65 percent of these organizations are in the province of Québec, while the remainder is spread out across the country. Girard notes that although there is no national-level organization representing these co-operatives, federations do exist at the provincial level. These are the *Fédération des coopératives de services à domicile et de santé du Québec*, the *Fédération des coopératives des paramédics du Québec*, and the Saskatchewan Community Health Co-operative Federation.

He also notes that health co-operatives in Canada are bound by the *Canada Health Act*, which may prove challenging to the co-operative form. For example, because services provided by co-operative health clinics must be offered universally, it can be challenging to attract and retain members since membership is not required in order to use the co-op. Individuals who use the services of the co-operative may remain clients/patients, rather than deciding to pay a membership fee to officially join the organization.

Girard went on to provide examples of different kinds of health co-operatives in Canada. One is the community health clinic model located outside of Québec. This includes the Multicultural Health Brokers Co-operative ([www.mchb.org](http://www.mchb.org)), an Edmonton organization that provides brokering services between health institutions and immigrant families. It offers interpretation services and cultural information that may improve health care services for new Canadians, and links recent immigrants to appropriate service providers. Its programming also includes health education, parenting support, prenatal education, and postnatal support services.

A second example of a clinic outside of Québec is the Nor'West Community Health Centre in Winnipeg ([www.norwesthealth.ca](http://www.norwesthealth.ca)). Its services include medical care, counseling, education, and community outreach. This co-operative provides services to about four thousand individuals and employs fifty-four people.

In Québec, co-operative health clinics serve a different purpose. They are organized with the objective of providing low-cost space to general practitioners in an effort to attract and retain doctors in primarily rural communities. Most of these clinics use a multistakeholder form of governance and focus on primary care.

A second Québec-specific example is the worker-owned paramedic co-operative. There are eight in the province that provide emergency medical services to about 145,000 people every year. They have 1,070 worker members and contract with the government to provide these services.

Finally, Girard profiled home-support co-operatives in the province. Although there are a few similar organizations in other provinces, including Nova Scotia and Saskatchewan, Québec has a network of forty-eight co-operatives that are supported by the government through the Financial Assistance Program for Domestic Help Services, which is administered by the provincial Ministry of Health and Social Services. These co-ops provide services such as housekeeping, meal preparation,

and help with errands, and the ministry pays a portion of the hourly fee. The balance is paid by the consumer member, with the total amount depending on the income level and health status of each individual. Girard states that the advantage of the co-operative model is that it allows users to help define the kinds of services offered, and notes that given the number of elderly members of these co-ops, the organizations will likely have to expand their portfolio of services to include personal care and respite services for family members.



A health co-operative in Québec



Coop La Seigneurie, Vaudreuil, Québec

## Co-operative Clinics in Saskatchewan: Their Evolving Role in Primary Care

*Presenter: Anne Doucette, president, Saskatoon Community Clinic  
and the Community Health Co-operative Federation*

### Key Points

- ▶ There are currently four co-operative health clinics in Saskatchewan. These clinics are represented by the Community Health Co-operative Federation.
- ▶ While provincial governments support the concept of community health centres, they have not championed the co-operative model and have instead developed health centres through regional health authorities.
- ▶ The co-operative model of care delivery has a number of advantages, including the ability to tailor services to clients' needs and at-risk populations, the ability to create partnerships between consumers of health services and their providers, and the ability to provide opportunities for individuals to participate in health care delivery as it affects themselves and their communities.

### Summary of Presentation

MS. DOUCETTE BEGAN HER PRESENTATION by describing the origins of health co-operatives in Saskatchewan as well as their current status. Health co-operatives in this province were formed as a result of a doctors' strike in 1962, when many doctors halted service delivery in reaction to the provincial government's introduction of publicly funded medical care. These doctors were concerned that such a system would constrain their ability to control their medical practices. In response to the strike, groups of citizens formed consumer-controlled health care co-operatives; doctors working for the co-operatives were aligned with the new government policy.

Today, four of these clinics remain in Saskatchewan; all provide comprehensive, client-centred, primary care. Three are urban (in Prince Albert, Regina, and Saskatoon) and one is rural (in Wynyard). The urban clinics have 91,000 active clients, 250 full-time equivalent staff, annual budgets totaling CDN \$19.14 million, and 19,500 members. These clinics receive core funding from the provincial government; further, this funding is global, meaning that each clinic has the latitude to decide the kinds of services it should provide. The result is that the clinics are able to tailor services to the needs of their general client base, as well as to specific at-risk populations such as low-income households, seniors, Aboriginal people, and individuals with chronic diseases.

Health care co-operatives in the province formed the Saskatchewan Community Health Co-operative Federation, which represents the interests of health co-operatives to the government, facilitates communication between member co-operatives, and initiates joint programming or administrative services such as common data management systems.

Ms. Doucette explained the position of health co-operatives vis-à-vis regional health authorities in Saskatchewan, of which there are twelve. They plan and deliver health services in their respective jurisdictions; many have developed small community health centres. These centres commonly feature nurse practitioners and are located in community settings; however, they are not co-operatives. They are governed by the boards of the health authorities, which are appointed by the provincial government. Moreover, these centres are not comprehensive in terms of the kinds of services they offer to clients.

Ms. Doucette concluded her presentation by describing the benefits of the co-operative model of primary care delivery. These include the opportunity the model provides for creating partnerships between consumers and health providers, for inspiring individuals to become involved in their own health and the health of their communities, for delivering services efficiently, and for delivering holistic, comprehensive care tailored to the needs of clients and members. Ms. Doucette also argued that health care co-operatives mobilize their members, understand community development, have a strong social conscience, have the capacity to respond creatively to community needs, and are an important part of the co-operative network.



## Does Governance Matter? Innovation in Saskatchewan Community Clinics, 1962 – Present

*Presenter: Dr. Brett Fairbairn, professor of history; fellow in Co-operative Thought and Ideas with the Centre for the Study of Co-operatives; provost and vice-president academic, University of Saskatchewan*

### Key Points

- ▶ Governance arrangements are important in the ability of organizations to innovate.
- ▶ Factors to consider when looking at governance and innovation include who makes decisions within organizations and the framework individuals use to make these decisions.
- ▶ Examples of innovation in community clinics include the remuneration of doctors, the interprofessional approach used in care delivery, the focus on prevention and health education, patient advocacy, as well as outreach and community development.
- ▶ Innovations seem to emerge in small units, and a focus on community needs contributes to creative approaches to service delivery.

### Summary of Presentation

DR. FAIRBAIRN ASKED THE FOLLOWING RESEARCH QUESTION: “Do governance arrangements make a difference to innovation in services?” He explored this question by looking at community clinics in Saskatchewan from 1962 to the present day. These clinics are co-operatives; their history and features are described in more detail in the presentation by Anne Doucette entitled *Co-operative Clinics in Saskatchewan: Their Evolving Role in Primary Care*.

Dr. Fairbairn explained that different factors should be considered when examining how governance may relate to innovation. These include which socio-economic groups are involved in decision making as well as the extent to which these potentially different groups may be involved. Determining which stakeholders provide input into an organization (that is, staff, recipients of services, and/or community advocates) is also important. Dr. Fairbairn also stated that the framework in which decisions are made within an organization should be considered. This could include a local or community framework or one pertaining to the clients or users of an organization.

Dr. Fairbairn then described the context in which innovations may occur in community clinics

in Saskatchewan. Clinics are small in scale, focus on practical community needs, and feature a consumer-oriented framework of decision making, although staff provide input into these organizations as well. Dr. Fairbairn also noted that the clinics face restrictions in their ability to innovate: they have limited resources, they have traditionally operated somewhat in isolation from the rest of the health system, and their size may impede innovation.

But do these clinics innovate? Dr. Fairbairn provided six examples. One is the adoption of alternative ways to remunerate doctors. Doctors in Canada are commonly reimbursed using a fee-for-item-of-service arrangement; rates are negotiated between provinces and territories and the medical associations in these jurisdictions. The clinics have innovated by placing their doctors on salary; contracts are negotiated between the doctors and the board of each clinic. Further, when the clinics were first established and global funding was not yet available, doctors pooled what they earned through the fee-for-item-of-service system in order to pay for the salaries of other staff as well as capital costs.

A second innovation is the interprofessional approach to providing care. Clients not only have access to doctors but to different services within each clinic, including counseling, physical and occupational therapy, and services provided by nutritionists and diagnostic technicians.

A third innovation is the focus on prevention and health education. Clinics in Saskatchewan feature resource centres, health checks and workshops, and member newsletters with health information. They also offer self-help support groups for victims of family violence and other matters.

A fourth innovation is the role the clinics play in patient advocacy; clinics feature patient advocates who handle complaints on behalf of service users.

A fifth innovation is introducing new programs or services that are then adopted by the rest of the province. For example, the community clinic in Saskatoon introduced a nonprofit drug plan in the 1960s, which was then adopted and implemented in the mid-1970s as a provincial drug plan. Two clinics introduced the provision of foot care, which was followed by a provincial chiropody program launched in 1984.

The sixth innovation is that of community outreach and involvement. The Saskatoon Community Clinic opened a second site in a city neighbourhood characterized by high poverty and poor population health. The Prince Albert Community Clinic operates a bus that provides clients with transportation to and from clinic appointments, while the Regina Community Clinic once operated two child-care centres.

Dr. Fairbairn concluded his presentation by questioning whether community clinics are still capable of being leaders in innovation, noting that more mainstream institutions are now interested in community-based and interprofessional approaches to delivering services. Moreover, clinics are now more integrated than they once were with the rest of the health care system. In some preliminary reflections on this question, Dr. Fairbairn explained that governance does appear to matter. Innovations seem to emerge in small units, and a focus on community needs contributes to creative approaches to service delivery. He also stated that the involvement of clients and advocates has created an incubator for innovations in community clinics in Saskatchewan.

## User Participation and Quality of Home Support Services

*Presenter: Dr. Catherine Leviten-Reid, postdoctoral fellow,  
Centre for the Study of Co-operatives, University of Saskatchewan*

### Key Points

- ▶ Home support co-operatives play an important role in providing assistance with instrumental activities of daily living in the province of Québec.
- ▶ Individuals receiving assistance from these co-operatives are very positive in how they rate the quality of services received.
- ▶ Board composition seems to be important in the delivery of services: a positive association was found between the percentage of consumers on the board of directors and the overall quality ratings.

### Summary of Presentation

Dr. Leviten-Reid asked the following research question: “Is there a co-operative difference in the delivery of care services?” The outcome of focus was quality, and the sector examined was home support, which includes help with preparing meals, house cleaning, running errands, and doing light maintenance work around the home. The rationale for asking this question is mainly because governments are frequently contracting with the private sector or collaborating with private organizations to deliver care. Depending on the jurisdiction, care may be provided by for-profit providers, nonprofit providers, or co-operatives.

Data was collected in the province of Québec from eighteen randomly selected home support agencies and 831 randomly selected individuals receiving their services. Of these eighteen, half were nonprofit and half were multistakeholder co-operatives featuring worker and consumer representation on the boards of directors.

Dr. Leviten-Reid provided some information about the policy environment out of which these home-support agencies were developed. There are approximately a hundred of these home-support organizations in the province; about forty-five are co-operatives. Some are multistakeholder, some are governed by consumers, and a small number are governed by workers. There are also about fifty-five community-based nonprofits that vary in terms of who is on the board of directors.

These organizations began delivering services in 1997, following the 1996 provincial summit on jobs and the economy. At the summit, government representatives, women’s organizations, labour

unions, and nonprofit organizations decided that nonprofits and co-operatives could create jobs in underdeveloped but growing markets such as environmental enterprises and home support, areas that would not overlap with services already offered by the public sector. A year later, the provincial government introduced a Financial Assistance Program for Domestic Help to subsidize the services offered by these home-support agencies. Users of the services pay a portion of the fee, with the amount varying depending on their income, age, and how much help they receive from their family.

Dr. Leviten-Reid also discussed the practical and theoretical rationale for why one might compare the services offered by nonprofit and co-operative organizations. Home-support organizations incorporated as co-operatives self-identify differently, generally associating with a network of home-support agencies called the Federation of Home Support and Health Co-operatives of Québec. They follow internationally recognized principles such as democratic decision making and education about co-operatives. The involvement of members in governance is also a fundamental feature of these home support co-operatives. Further, co-operatives are new to the home-support landscape. This kind of care has historically had significant involvement from the nonprofit, non-co-operative sector, which includes organizations that do not feature user involvement in governance.

Theoretically, services that are produced jointly by government and users of services are labelled as “co-productive,” and advocates of this process argue that it should lead to services that are better tailored to the needs and preferences of consumers. Other scholars talk about stakeholder control and claim that those people with the greatest stake in the organization must also have the greatest role to play in its oversight.

Dr. Leviten-Reid used regression analysis to see whether organizational form helped determine quality of services. Other factors taken into account included age, gender, perceived health status, and the numbers and kinds of services received. Dr. Leviten-Reid found that the co-operative form was not a predictor of either two measures of quality used in the study. This means that there was really no difference in the quality of care provided based on organizational form (co-operative versus nonprofit).

Dr. Leviten-Reid also examined the potential effect of user involvement on quality, with user involvement defined as the percentage of consumers on the board of directors. She found a positive effect of consumer involvement on one of the two quality scores, specifically, the one capturing people’s assessment of the overall quality of care they received. As the percentage of consumers on the board increased, there was a greater likelihood that participants would provide a higher overall quality rating. So while the co-operative, as a legal form, was not found to be associated with quality, a fundamental feature of co-operativism, namely, user involvement in governance, had a positive effect.

Dr. Leviten-Reid closed her presentation by arguing for the continued need to do research on health and social co-operatives that explores performance outcomes.

## Looking Ahead: Public Policy and Co-operative Health Care

*Presenter: Dr. Greg P. Marchildon, professor, Johnson-Shoyama Graduate School of Public Policy and Canada Research Chair in Public Policy and Economic History*

### Key Points

- ▶ Co-operatives can play an important role in the reform of primary health care, including the provision of mental health services, health care to Aboriginal people, and alternatives to the fee-for-service model of Medicare.
- ▶ Home care is a second area in which co-operatives could play a role: innovations in Québec, the United States, and Sweden illustrate their potential.
- ▶ Very few co-operatives offer long-term care despite the current challenges in long-term care delivery, including the cost of services, quality, and continuity of care.
- ▶ Few co-operatives offer acute, ambulatory, and advanced diagnostics, even though regional health organizations may contract with for-profit or other third-sector organizations to deliver these services.
- ▶ The debate around health care reform focuses on government provisioning versus for-profit providers; the role of co-operatives and other third sector organizations is absent from the discussion.

### Summary of Presentation

DR. MARCHILDON DISCUSSED THE POTENTIAL ROLE OF CO-OPERATIVES in the reform of primary health care, home care, long-term institutional care, and acute, ambulatory, and advanced diagnostics.

The presentation began with a description of the public policy challenges in health care reform. Across countries, these include escalating costs and the rising expectations of consumers. In Canada, these include issues of governance and management in the development of health regions, the adoption of electronic health records, disagreements between federal and provincial governments, and the inability to deal with Aboriginal health care and prescription drug policy.

With regard to primary health care reform and co-operatives, Dr. Marchildon explained that the predominant model of service delivery is based on fee-for-service. He asked whether a different model could be more widely adopted across the country, and described existing alternatives such as community health centres in Ontario and CLSCs (Local Community Service Centres) in Québec.

Co-operative health clinics are another potential model; however, of the ninety-one health care co-operatives in Canada, only seven offer primary care. Most of these co-operatives are in Saskatchewan, and Dr. Marchildon stated that understanding why there are low numbers of primary health care co-operatives in the rest of Canada is important because of the potential role this organizational form could play in areas of critical need, such as Aboriginal primary health care and the diagnosis and treatment of mental health conditions.

In order to provide primary health care services to the increasing number of urban Aboriginal people, Dr. Marchildon explained that one possibility would be to form independent health maintenance organizations organized as co-operatives. This could ensure community-based direction and control and allow organizations to operate at arm's length from federal, provincial, and Aboriginal governments. Payments could be made to the co-operatives by regional health authorities based on criteria such as performance.

With regard to mental health services, Dr. Marchildon explained that while 20 percent of Canadians suffer from potentially disabling mental health conditions, cases go undiagnosed or are inadequately treated. He asked whether co-operatives could play a role here: for example, could there be experimentation with new clinics, and could teams of psychologists, advance-practice nurses, and case workers work together using the co-operative model?

Dr. Marchildon looked next at home care, arguing that while the federal government did not adopt the Romanow Commission's recommendation to add three kinds of home-care services to the *Canada Health Act* (palliative care, post-acute care, and mental health case management and intervention services), provinces can still innovate and expand in this area. In Québec, for example, a government program provides financial support to nonprofit home-care agencies, some of which are multistakeholder co-operatives that feature consumers and workers on the boards of directors. There are also international best practices: there are several worker-owned, home-care businesses in the United States and the Stockholm Co-operative for Independent Living in Sweden.

Another potential role of co-operatives in the reform of health care lies in the domain of long-term institutional care. Although Canadians overall are living longer and healthier lives, an increase in chronic conditions such as dementia has put pressure on long-term care facilities. There are many concerns with institutional care, which include the cost (incurred by both government and individuals), the quality of care, the continuity of care, and the limited opportunities for individuals to live in facilities in their own communities or close to family. Dr. Marchildon pointed out that long-term-care co-operatives are almost nonexistent in Canada, despite the fact that other forms of third-sector organizations both provide long-term care and contract with regional health authorities to do so. One exception is La Corvée in Saint-Camille, Québec, which is a housing co-operative that provides special-needs care to seniors. Dr. Marchildon emphasized the need for research on the lack of co-operatives in long-term care.

Finally, Dr. Marchildon explored the area of acute, ambulatory, and advanced diagnostics. He explained that within the regional health authority model, services may or may not be contracted out. Saskatchewan provides most of these services directly, while Alberta has contracted with the for-profit sector. With the Local Health Integration Network model, as found in Ontario, all services are delivered under contract, most of which are with nonprofit providers. In all provinces, however, co-operatives have limited involvement in the delivery of these kinds of services.

Dr. Marchildon closed his presentation by describing the nature of the current debate about health care reform in Canada. In short, it is a debate in which the role of co-operatives is not discussed. While there are complaints about the stifling nature of publicly funded health care as delivered through government institutions and health regions, the assumed alternative is private, for-profit businesses. Dr. Marchildon argued that private, nonprofit alternatives such as co-operatives may actually be the preferable model of service delivery, even though these alternatives are not currently part of the debate.

## Conclusions

POINTS RAISED IN THE PRESENTATIONS SUMMARIZED ABOVE allow for certain conclusions to be drawn about health care co-operatives in Canada and around the world.

First is the potential for these co-operatives to play a significant role in the delivery of health care services. This potential is apparent in both the range of services co-operatives can offer and the growth of the co-operative model in places like Japan, Spain, and Quebec. This was discussed in presentations by Nobumasa Kitajima, Miwako Takato, Jean-Pierre Girard, Anne Doucette, and Dr. José Carlos Guisado del Toro.

The second conclusion is that co-operatives are not only capable of providing varied and extensive health care services, but they also produce positive outcomes. Dr. Brett Fairbairn, for example, found that the co-operative governance structure as found in community clinics in Saskatchewan leads to innovation, while Dr. Leviten-Reid found that consumer involvement in home support services is linked to quality of care.

Third, the potential to replicate the co-operative model may be facilitated by the commitment to provide technical assistance and disseminate information and research. For example, Japanese health co-operatives help establish medical facilities and dental clinics in Nepal, Sri Lanka, South Korea, and Mongolia, while the Espriu Foundation in Spain publishes *Compartir*, holds seminars, and maintains a library. The study tour of clinics in Saskatchewan that preceded this health conference is an additional example.

Fourth, the policy environments in which co-operatives develop, or fail to develop, are important to understand as we explore the potential for co-operatives in the delivery of health care services. Dr. Marchildon pointed out that co-operatives delivering primary care are clustered in a particular Canadian province, while home-care co-operatives are clustered in another. Moreover, the organizational form is nearly absent in certain subsectors of health care, including long-term care and acute, ambulatory, and advanced diagnostics. Understanding why co-operatives appear or fail to appear in different jurisdictions is important in terms of understanding the policy framework required for the future development of the model.

Finally, the co-operative model is seldom included in discussions about the future of health care services. Discussions focus either on how to improve individual health outcomes regardless of the organizational form or forms through which care is delivered, or on the relative strengths and weaknesses of public delivery versus private, for-profit delivery.