The Co-op Experiment

Renewing Medicare through co-operative local initiative

By Brian Ferguson

When Medicare was first introduced it was understood as a public insurance scheme. Indeed, under Medicare provincial governments effectively took over the existing doctor-sponsored nonprofit insurance plans and extended them to the uninsured population. In the years since, the role of the government has expanded to include both the system's day-to-day operations and long-term planning.

Instead of acting just as an insurer and an external assurer of quality, government has effectively become the system's manager and administrator. As a consequence, decision-making authority in the system has moved farther and farther away from its delivery end, in the process overloading the decision-makers.

A health care system is too complicated a thing to be micro-managed by a centralized bureaucracy. As decision-making authority has moved to the various Departments of Health, the system's decision-making capacity has *diminished*. The people responsible for actually delivering care and the people who are the ultimate recipients and beneficiaries of that care have been effectively removed from the management and information system.

As a result, the groups with the authority to run the system have become overwhelmed by the volume of information they must process. Developments at the operations end of the system only register when things reach a state of crisis. In the absence of visible crisis, management assumes that everything is fine.

Another inevitable consequence of increasing centralization in health care is the evolution of a conviction that "one-size-fits-all," that is, that not only should all Canadians have access to the same essential set of medical services, but that the mode of delivery of those services should be exactly the same in every part of the country. Regional differences are not allowed to lead to regional variation in the way health care is delivered. This tendency is exacerbated under Medicare, because the original concern that nobody should be denied necessary care for financial reasons has transformed into a concern that nobody should be allowed to get better care than anyone else for financial reasons. From the centralizing point of view the easiest and most effective way to ensure that nobody gets *better* care than anyone else is to ensure that nobody's care is *different* from that of anyone else.

This, then, is the source of one of the most serious flaws in Medicare as it stands – lack of flexibility. It is increasingly difficult to match supply to demand at the local level, which thereby reduces the efficiency of the system as a whole.

Normally, supply and demand are brought together in a market. In the case of Canadian health care, there are two barriers to market solutions. One is that politicians tend to object to the very idea of markets for health care, and therefore move to block them whenever they start to appear. The idea that any mechanism other than government could do a good job of delivering care has become too dangerous for any politician (or at least any politician whom wants to win an election) to espouse. We have reached the point where any deviation from the way Medicare was designed in 1968 will be labeled "Americanization" of the system and rejected out of hand. The other is that markets require signals: for a supplier to be willing to set up a particular operation in a particular area s/he needs some indication that the gamble is a reasonable one.

By what means can neighbourhoods and towns signal suppliers that a serious market for a particular type of health care exists in a particular area? The consumer health co-op is one such device. It cannot fix all the problems that beset our health care system. But within a policy and regulation environment that recognizes the value of local authority and innovation, and anticipates its disadvantages, community co-ops could return to our health care system much of the flexibility that centralization has stamped out of it.

Recognition of Local Markets

The most obvious advantage of the co-op form is that it is local. Any local health clinic, whether private, public, or co-op, needs capital funding. By establishing a consumer health co-op, members of a particular community signal the types of service

needed locally by demonstrating a willingness to help finance them. The co-op form, in which members buy shares (and may also pay an annual subscription) is a way of drawing on local sources for capital.

This can be problematical in the context of Canadian health care. It amounts to private local funding, which can be seen as an opportunity for richer communities to get access to better health care than poorer communities. It can also, though, offer poorer communities a mechanism by which they can pool resources in order to make available locally services that the central authorities are not prepared to fund.

The co-op structure can also be thought of as a form of private insurance for smaller communities. It is insurance in kind rather than in the form of cash payments. Traditional insurance, in which the insurer covers the cost of care when you need it, cannot ensure that the care is available in your community. By buying co-op shares and paying an annual co-op subscription, members are essentially paying insurance premiums directly to the supplier, giving him a guaranteed income, in return for which s/he guarantees to make specified services available locally.

This form of insurance – prepaid medical practice – could be managed through structures other than a co-op. Municipal doctors and the Check-Off System are two examples. (See pp. 18-19 of this edition.) The advantage of the co-op over both these alternatives is that co-op membership is voluntary. Therefore, the co-op must be so structured as to persuade enough local residents to buy shares and pay a subscription to make the co-op viable. That creates an additional incentive for the co-op to pay close attention to what the local community wants, perhaps even more of an incentive than is felt by a municipal government whose powers to tax and spend may place it at one remove from the community will. The sale of shares in a health co-op to the local community, while a market-type activity, is also a form of direct democracy.

The Issue of Inequality

The co-operative, with its democratic structure (generally, in the case of consumer co-ops, one member, one vote) may well be the form that has the best chance of loosening the grip of central planners on health care. It does, however, face obstacles.

The most obvious obstacle is one which we have just mentioned: the use of private finance raises the possibility that richer communities will be able to buy better health care than poorer ones. For example, co-op proponents have suggested that membership fees might be used to create a 2-part mechanism for paying physicians, with one part being a flat salary coming from the co-op's own revenue and the other being whatever s/he earns by billing Medicare. The prospect of a salary supplemental to Medicare earnings might increase the appeal of certain locations and types of practice.

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It would also raise concerns about bidding wars, with richer communities winding up with better health care than poorer ones, however. Similar concerns could arise in cases where the co-op finances office or clinic facilities. By reducing the MD's expenses of practice this approach amounts to paying the salary part of a 2-part payment structure in kind rather than in cash. Various provincial governments have considered 2-part payment mechanisms as devices for encouraging doctors to set up in rural areas. But under those proposals the government would decide which communities would be entitled to the extra support and the government would determine the amount of that support, based on what the central government, rather than the local community, was willing to pay.

Differences in private resources also requires that health co-op designers give very careful thought to the issue of membership. Consumer co-ops typically limit use of their facilities to paid-up members. In a free market, a health co-op should look a lot like a direct charge consumer co-op, with members paying an annual fee plus a price for each item or service purchased,

frequently a price below the going market price for that item. Limiting use of the co-op to paid-up members (as happens in most consumer co-ops) would clash with the fundamental objective of Medicare, that nobody be denied access to necessary medical care for financial reasons. While MDs can limit the size of their practices, they cannot do it on openly financial grounds. The democratic structure of a co-op would not alter the fact that limiting use of its facilities to paid-up members would put it in the position of behaving exactly like those private, for-profit clinics that have attempted to limit access to their services to patients who were willing to pay facility fees.*

The same issue arises when paid-up co-op members are given exclusive access to non-Medicare services: whenever private clinics have used this approach to raise additional funds they have come up against charges that the patients who pay out of pocket get better medical care. Even something as simple as entitlement to telephone consultations would become problematical if it were available only to people who were willing to pay for it. It's a sad fact, but co-op designers must not lose sight of the paranoia that underlies so much of current Canadian health policy.

On the other hand, an inability to limit access to paid-up co-op members poses dangers of a different sort. A large number of non-member patients could result in paid-up co-op members being denied access to the co-op's services, which would be a pretty effective device for discouraging people from buying shares. A co-op, like any other form of enterprise, has to keep its investors happy. The only real difference between the forms is that investors in co-ops expect to receive their returns in kind rather than in cash.

Another Option

Not all co-ops have to be shareholder-funded, however. In Australia, whose Medicare system has a great many similarities with our own, it has been proposed that communities exercise control over their own share of Medicare spending through a locally-controlled co-operative Health Maintenance Organization (HMO).

Under this proposal, Medicare would essentially transfer to each established co-op a sum equal to that which the State would likely spend on the health care of the respective members in the coming year. It would then be the responsibility of the co-op board to use those funds to provide the health care its members would need, in whatever manner best suited the co-op membership. The co-op would have complete freedom in terms of organization of delivery and the mix of health care providers it employed. There would be no external restrictions (apart from licensing ones) on the use of providers such as nurse practitioners. There would be no concerns about paying non-Medicare providers to supply Medicare-insured services.

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The local community could still contribute extra funding, perhaps by paying for the health co-op's building. There might still be questions about how much the co-op's members could contribute without appearing to be obtaining better health care simply by dint of being able to afford to pay for it. Nevertheless, it would be easier to impose restrictions on membership when Medicare services were being paid for out of a lump sum transfer from Medicare itself. The co-op could increase membership, perhaps through an annual open enrollment period. If you decided to join, the government essentially pays for your shares with that transfer, so there would be no conflicts of interest between those who could afford shares and those who could not, between investors and non-members. Additional funds could be raised through voluntary donations.

* The consumer co-op model would also suggest that any year-end surplus be divided between investment in the co-op and payment of dividends to the members. It seems highly unlikely that this would be acceptable under the legislation which currently governs health care in Canada, since anyone in receipt of dividends might look too much like someone who was earning a profit from the delivery of medical care.

It is not unusual for voluntary associations – churches, for example – to publish a list of suggested income-linked donations, relying on higher income members voluntarily to make larger donations.

This type of co-op is not new to Canada, nor is the HMO new. (Ontario's new Family Practice clinic structure works along these lines.) But establishing the HMO in a co-op form means that the clinic would be locally controlled rather than controlled from afar. Open enrollment would mean that dissatisfied members could leave a co-op and its funding would be reduced accordingly. If there were to be widespread dissatisfaction with the way the co-op was being run and if the problems could not be resolved through the organization's general meetings, members would always have the option to exit the system, an option that they do not have under the present Medicare system.

In economic terms, this form of co-op basically runs on a voucher basis: Medicare gives each member a voucher equal to their expected annual medical expenditure, and the members are free to use it to obtain their health care through whatever organizational form best suits their needs. The vouchers could be risk-adjusted, so that a co-op that had an elderly, or other high medical risk membership would not be disadvantaged. This sort of risk-based, unequal transfer wouldn't violate the principles of Medicare since the population groups that warrant larger vouchers would be the groups on which Medicare would be spending the most under the present system.

Besides giving citizens more control over the types of care that were available locally, voucher HMO co-ops create opportunities for experimentation in delivery mechanisms. The co-op would have a fixed budget for insured health care services, but would be free to experiment with the way that care was provided. (Other, non-Medicare services it could make available, perhaps on a pay-per-service basis.) To the extent that it achieved efficiencies in the delivery of care – greater use of nurses, for example – it would have "savings" to invest in an expanded range of services. The "one-size-fits-all" constraint that hinders experimentation in our current Medicare would be broken.

Making the Case

For all their appeal, co-ops are not magic bullets for the problems of health care. They face exactly the same economic constraints as do other forms of health care delivery because in practice they differ very little from certain forms of private, for-profit health clinic. They can be expected to face the same scrutiny that private clinics face, and the use of the term "co-operative" will not automatically shield them from the suspicion that they are just health clubs for rich folks.

What we need today is a more efficient health care system. Not "efficient" in the old sense of reduced budgets & suppliers of care who are told to "do more with less." Gains in efficiency are now are now more likely to come from changes in the mechanisms by which care is delivered.

Strategically, the best place to start in establishing health co-ops on a large scale is probably poorer communities, where any fees that members pay clearly reflect a willingness to make sacrifices in order to obtain better health care than the present structure supplies. There should always be local money going into local co-ops, even if they are funded primarily by Medicare vouchers, if only because community members will pay closer attention to how the co-op is being run if there is at least some of their own money at risk.

It's important to set aside some of the romance of co-ops. They have to be run on a business-like basis and require hard decisions to be made. Even though their dividend is paid in kind rather than in cash, each co-op's investors expect a dividend, and the managers have to deliver one. Managers will also have to make hard decisions about how to pay the health care workers they employ. It's quite common for people to argue that salary (or "capitation") is the best form of payment for doctors, since it frees them from the economic necessity of seeing a lot of patients in a day. However, when Finland established its

personal doctor system, with doctors paid on a capitation basis rather than fee for service, the number of patients seen by GPs in a day immediately fell, and wait times rose. The payment system had to be changed to a mixture of capitation and fee-for-service to bring access to primary care up to the desired level.

The time is certainly right for the co-op experiment. Canada's health care system as it stands is under considerable stress, in part as a result of the centralizing policies which governments have followed over the past decades. What we need today is a more *efficient* health care system. Not "efficient" in the old sense of reduced budgets and suppliers of care who are told to "do more with less." That approach to efficiency has already trimmed most of the fat and some of the bone from our health care system. Gains in efficiency are now are now more likely to come from changes in the mechanisms by which care is delivered.

This means persuading governments at all levels that it is worth experimenting with alternative delivery mechanisms, and moreover, that government doesn't have to run them. It has an important role to play in their funding and in evaluating their results, but not in their design, management, or administration. Instead, communities should be permitted to take the initiative and mould the national health system to suit their own circumstances. What works in one setting isn't necessarily what's best in another. The more people around the country who are invited and encouraged to become directly involved in experimentation in health care delivery for themselves, their friends, and neighbours, the more likely we are to increase efficiency.

Making that case won't be easy. Governments get punished when things don't work out well, and that tends to make them very risk-averse. The case for health care co-operatives will have to be empirical, evidence-based, not just theoretical. Success will require well-defined objectives in terms of the care that is to be delivered and discipline in pursuing that objective. It will have to convince policy-makers that the goal of universality is not threatened by the introduction of new delivery mechanisms, and that any proposed mechanisms have clear support in their local communities.

The ethos over the past few decades has increasingly been that centralization is good. While that is true in some areas, centralization should not be our choice by default. In health care delivery, local is good, and until we convince or oblige our political leaders to recognize that, we're just going to get more and more of the same.

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