Primary Health Care at the Crossroads

The community alternative vs. market forces

By Jean-Pierre Girard

Regardless of where one lives in Canada, it is impossible to avoid the debate on the future of the country's health care system. Not only do the media regularly feature front-page stories on various crises taking place in our hospitals and clinics, but most Canadians, at one time or another, experience the deficiencies of our system: some find it difficult, if not impossible, to get a family doctor, others experience long delays to see a doctor or spend endless hours waiting in clinics. The point here is not to paint the gloomiest possible picture (Canada's health care system has undeniable strengths, including access to a basic basket of services for all citizens, regardless of social status or income) but to highlight areas of serious dysfunctionality.

Over the years, many federal and provincial working groups and commissions of inquiry (e.g., Kirby, Clair, Romanow) have been asked to study the system and to recommend new models of health service delivery that are tailored to current needs.

In one recent report[1] on which I collaborated with a professor of health administration at the *Université de Montréal*, my colleague and I wrote that:

> "… the reflection underway seeks not only to find the most suitable delivery models, but also to re-evaluate the contribution of the state. One of the recommendations most frequently made by the various commissions is that primary services must be expanded and better coordinated. Other recommendations deal with the need to rethink the delivery of primary services by capitalizing on public/private sector partnerships. Such measures are essential if we wish to resolve long-standing problems of access and continuity of care, as well as to address the problem of escalating health care costs."

We might also add that, in light of the Supreme Court of Canada's recent ruling in the Chaoulli-Zeliotis case,[2] along with the Québec government's subsequent decision to allow certain surgeries in the private sector and its appointment of Claude Castonguay in 2007 to re-examine the issue of health system funding, the door is now open to fundamental changes in the system's financial structure, as well as to greater public/private sector coexistence.

Given the current potential for change, citizens and interest groups have ample cause to exercise vigilance in this area. However, one fundamental aspect of the reorganization of health services seems to have been systematically ignored, and that is the ever-increasing ownership and management of clinics by large supermarket and pharmacy chains.

Why would a large pharmacy chain like Shoppers Drug Mart or a supermarket chain like the Loblaws Group be interested in owning and administering health clinics? Several reasons spring to mind. For one thing, few doctors are interested in taking on management duties in addition to their medical practice; indeed, this disinclination has become all the more prevalent with the increasing presence of women in the profession (issues of family-work balance, pregnancy leave, etc.). Another factor is the fierce competition that exists in the area of distribution: any large pharmacy that can set up operations near a clinic is guaranteed to have a very busy and highly profitable prescription department!

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Furthermore, this business model offers consumers the advantage of being located near many other businesses, allowing them to save time by concentrating their purchases at the same location. This is commonly referred to as "one-stop shopping." A doctor's clinic located a stone's throw away from a pharmacy and a host of other businesses: what more could one ask for in a consumer society that places such a premium on saving time? As for doctors, freedom from clinic administration and personnel management duties offers the promise of being able to practice their profession according to a schedule that suits them.

Unintended Consequences

In a small research project[3] undertaken with other colleagues and supported by (among others) the *Centre de bioéthique de*

l'Institut de recherche clinique de Montréal, we were able to demonstrate that this new model first emerged in Québec in the 1990s with the province's largest pharmacy chain, the Groupe Jean Coutu. Other competing chains replicated the model; outside Québec, the Loblaws Group and the Shoppers chain also pursued a similar path. This should surprise no one: in a hypercompetitive market, any innovation likely to increase market share is inevitably taken up by competitors. Competitive benchmarking is made possible through strategic watch systems.

Does this model produce only benefits? Hardly! From my understanding of the situation in Québec – and there is no reason to assume that things are different in other jurisdictions that have adopted a similar approach – this model raises a number of crucial questions. As we stated in the report we prepared for the Centre de bioéthique, this model

> "emerges in markets thought to be financially viable, with a base of at least 10,000 inhabitants. If nothing is done, this may result in a high concentration of doctors in centres that have at least that many inhabitants; the resulting doctor shortages in smaller communities will then constitute a daunting obstacle to local development strategies."

Furthermore, the development of this model along the lines of the walk-in clinic runs counter to the public discourse on the need for patient follow-up; it also does nothing to address doctor shortages or the needs that exist in the area of prevention. Finally, the new leadership role of large chains, particularly pharmacy chains, in the development of clinics will require greater vigilance regarding the role and influence of the pharmaceutical industry. That industry's propensity to promote the medicalization of all aspects of life and its close ties with pharmacies and physicians should leave none of us indifferent to the potential for conflict between these private interests and the public good.

Based on 2004 data, close to 20% of general practitioners were working in this kind of clinic at that time. Since this model was rapidly becoming more popular during this period, there is every reason to believe that an even greater number of doctors are now working in these settings. I have no statistics on the situation elsewhere in Canada, but we can only assume that the trend is accelerating there as well. Based on unconfirmed information, patient visits can take place at a dizzying speed in some of these clinics: one doctor may see as many as 18 patients in a single hour! Has medical knowledge become so advanced that doctors can now diagnose problems and propose solutions in as little as three minutes?

Another Option

The situation actually borders on the comical. Politicians and commentators debate the risks of a 2-tier health system and continue to establish commissions and study groups; meanwhile, a business model that has the backing of powerful interests is permitted to introduce a mercantile logic into primary health services with complete impunity. What will happen when more formidable players such as Wal-Mart and Costco decide that they want to own and manage clinics? While we are at it, perhaps we should simply invite these large chains to administer our hospitals as well!

Clearly, this makes no sense! In a society that promotes freedom of association and commerce, innovation in the health care system clearly needs to be encouraged, but surely the business model need not be the exclusive or dominant model. A matter of opinion?

In fact, it isn't. A number of factors argue in favour of looking at other options.

- *A broad, up-to-date vision of health.* More than 30 years ago, the World Health Organization (WHO) and various public authorities began to recognize that health is the product not only of health resource availability, but of many different factors of an environmental, social and educational nature. How then can a practitioner presume to solve a person's problems in the space of a 3-minute consultation? A case of magic pill syndrome perhaps?
- *A multidisciplinary approach to health.* It has been amply demonstrated that it is preferable to rely on a range of expertise than on a single expert: physicians, psychologists, and social workers, etc. or physicians and alternative medicine practitioners, etc.
- *Health cannot be reduced to the curative aspect; prevention is also important.* It has been clearly shown that investing in the promotion of healthy lifestyle habits constitutes a form of long-term insurance. People with a healthy lifestyle (physical activity, good nutrition) have a far greater chance of enjoying a healthy old age, while those who neglect their health are likely to experience an extended period of failing health as they age.
- *Citizen involvement in health services.* Since the 1978 Alma Ata forum in the former U.S.S.R., the WHO has been tirelessly promoting the same message: primary health care systems have much to gain by engaging citizens in efforts to define, administer, and evaluate health services. Rather than having a

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La Corvée de Saint-Camille

In the small town of Saint-Camille, in the Eastern Townships, the co-operative *La Corvée Coop de Solidarité en Soins et Services* has received numerous prizes for its community-based initiatives. In 2003, the *Association de santé publique du Québec* awarded La Corvée its prize for excellence and innovation in health promotion. The communiqué states that La Corvée has achieved remarkable success in mobilizing the community around two major challenges: *population aging and the exodus from rural communities*.

La Corvée has succeeded in slowing down the latter by keeping the elderly of Saint-Camille in their community through the development of a housing co-op (above) with its own clinic; complementary services delivered by alternative therapists; health-promoting recreational activities; community gardens maintained by people of all generations; rest and play areas; a community kitchen and a community meeting place. Participants help to maintain and improve these amenities, according to their individual capacities. (below) The podiatric nurse at La Corvée clinic. Photos courtesy of La Corvée. ■

standardized set of services, there is also much to be gained in providing services that are tailored to local needs. On another level, citizen engagement is also synonymous with empowerment. It allows people to feel that they are in control of their lives and able to influence the course of events, as opposed to feeling controlled by events and subjugated to a system. This concept is sometimes referred to as social capital.

Canada already possesses the foundations of an alternative health system. Saskatchewan, for example, has had a network of community clinics since the 1960s and a few such networks can also be found in other provinces. Some have the legal status of not-for-profit organizations, while others are organized as co-operatives. These organizations are largely funded through public sources and are informed by the principles outlined above. In place of the fee-for-service system, physicians in these organizations receive a salary, an arrangement which encourages them to spend more time with patients. The health aspect is reconciled with other social dimensions.

Health co-operatives first emerged in Québec in the mid-1990s. There are now more than ten of these clinics in operation and approximately ten more are in the process of being developed. With few exceptions, these organizations were created in reaction to doctor shortages in various regions. As explained in greater detail in a document published in an earlier issue of *Making Waves* magazine,[4] the primary force that drives popular mobilization around a health co-operative project is the need to attract physicians to one's community. Accordingly, the practice of medicine may not necessarily be different in these collectively owned and managed facilities (in other words, they are not necessarily more open to multidisciplinary approaches, health promotion, etc.) In these co-operatives, physicians remain independent entrepreneurs who rent office space and are remunerated on a fee-for-service basis by the public system.

Still, these organizations constitute a step forward when compared to the large commercial chain model, for the following reasons:

- *Positive impact of citizen awareness and mobilization*. Citizen awareness and popular mobilization to influence the organization of health services have a positive effect on communities. Rather than remaining in an expectant or, worse still, a defeatist mind-set, people come to understand that if they take action in sufficient numbers things can change! Empowerment is a powerful antidote to fatalism!
- *Space for debate and democracy*. Health co-operatives are created through a process of sharing, debating and defining a project, and adopting a strategy. Without diminishing the importance of leadership, the basis for these actions is democracy and the rule of one member, one vote.

- *A project with a focus on users rather than profit.* Co-operatives seek to resolve problems of access to services. Although economic viability cannot be ignored, profitability is measured in social terms: the goal is to ensure that as many people as possible have access to high-quality services. This is very different from the approach of the large commercial chains that run clinics to boost the profits of pharmacies, most notably through the sale of prescription drugs.
- *A basis for more fruitful collaboration with doctors.* The vast majority of health co-operatives adopt the status of a solidarity co-operative. This means that they comprise at least two categories of members from among the following: user members, worker members and support members. In some co-operatives, doctors agree to join as support members. In doing so, they leave behind the status of leaseholder and opt to join in the process of co-operative democracy, based on the principle of one member, one vote. By becoming stakeholders in co-operatives, doctors can help to guide and develop these organizations. This can also help to break through the "informational asymmetry" that is typical of the patient-physician relationship.

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- *Many projects generate innovations in the community!* A close examination of health co-operative projects reveals that many of these organizations have introduced remarkable innovations in their respective communities. The earliest of these co-operatives, that of St-Étienne-des-Grès in the Mauricie region, has been tirelessly developing new products and services since it was first created in 1995: it has doubled the space available in its main building, integrated alternative medicine practitioners, launched a service centre in a neighbouring municipality, created a home for the elderly, etc. Located in the western sector of the city of Gatineau, facing Ottawa, the Aylmer Health Co-operative now has 8,000 members and has become, in a few short years, the largest health co-operative in the country. It has developed prevention programs aimed at specific populations, such as Spanish speakers and African-born French speakers. It has also entered into a fruitful partnership with the *Coopérative des paramédics de l'Outaouais* (ambulances). (See sidebar "La Corvée de Saint-Camille.")

Why the hold-up?

As we have seen, there are undeniable benefits in developing community clinics and health co-operatives. This begs the question: why are there not more of them?

My answer to this question is not based on an exhaustive study of the subject, but rather on impressions derived from comments and observations gleaned over the past ten years as I travelled across the country making presentations and participating in consultations.

Health is the purview of the state and physicians!
Regardless of the nature of the debate on the health system, I've lost count of the number of times I've heard this remark. One gets the impression that the ordinary citizen has simply been written out of the health system equation! It is true that the public system has done little to bridge the gap between citizens and the management of their health care system: few seats are reserved for members of the public on the boards of public institutions, while mergers have further reduced the number of these institutions. Because of the widespread perception that citizens have no say in the health care system and the fact that services are lacking in many communities in Canada, citizens tend to become resigned instead of taking matters into their own hands and seeking to influence the way health services are organized.

Ignorance and prejudice.
I've also lost count of the number of physicians and officials from publicly-funded health organizations who have casually admitted to me that they are completely ignorant about the health co-operative model! This is hardly surprising, given that community and co-operative models are seldom featured in doctor training programs or in reports.

But it gets worse, for along with ignorance comes prejudice! It is difficult, for example, to forget the general outcry that arose among members of Saskatchewan's medical association when community clinics were first introduced in the early 1960s. Some ten years later, the *Collège des médecins du Québec* opposed the creation of local community service centres (CLSCs), facilities which now provide both health and social services with state funding. Some even went so far as to claim that the system was being Sovietized because doctors were to be put on salary and were at risk of losing their sacred independence!

The media like to focus on the sensational!
This may be no more than an anecdote, but a few years ago a well-known television journalist from Radio-Canada interviewed me extensively on the subject of health co-operatives, with the intention of producing a feature on this topic. However, nothing came of it. Instead, they ran a story on Canadians and other

Westerners who were travelling abroad to undergo expensive operations in countries with living standards far beneath our own. Rather than show citizens getting organized and finding concrete solutions to their problems, our national broadcaster chose to air a highly sensationalistic report that may have promptly put a few politicians in hot water, but accomplished little in terms of promoting alternatives! I find it difficult not to connect this with the ideas of American essayist Noam Chomsky concerning the role of the media in manufacturing consent!

Clashing interests.
As we have seen, the large commercial chain model of clinic ownership and management differs markedly from that of community clinics and health co-operatives. A few years ago, one of these large enterprises made an offer that proved difficult to resist for two physicians practising in a health co-operative located in a community some fifty kilometres from Montréal. Some time later, the physicians left and the co-operative was forced to close!

"If we don't take change by the hand, it will one day seize us by the throat." This famous quotation from Winston Churchill is often quoted by the leaders of the co-operative La Corvée de St-Camille to illustrate the challenges that face those who advocate on behalf of a different kind of health system. I believe that co-operation, discussion, mobilization and action are urgently needed in this area. Health is too precious a resource to be left in the sole control of market forces.

References

[1] Jean-Pierre Girard, Lise Lamothe *et al*,"The Role of Health Care Co-Operatives in the Delivery of Front Line Services: Links with the Health Care System and Socio-Economic Impacts" (Ottawa: Co-operatives Secretariat, Government of Canada, 2005), 60 pp. 25 July 2007 <http://coop.gc.ca/pub/pdf/health-sante2_e.pdf>.

[2] The issue at the centre of this case was surgery wait times. The June 2005 ruling recognized the right of Québécois to purchase private insurance in order to obtain from private sector sources health care services that the public system has failed to provide in a timely manner.

[3] Franklin Assoumou Ndong, Jean-Pierre Girard, Josée Ménard *et al*, "Développement du modèle d'affaires « grandes surfaces » dans la propriété et la gestion de cliniques de santé au Québec : Recherche exploratoire." 25 July 2007 <http://www.ircm.qc.ca/bioethique/francais/quoideneuf/cliniques_rapport_2005.pdf>.

[4] See "Revolution within a Revolution: Québec's experiment with co-operative health care and social service delivery," *Making Waves*, 14,3 (Autumn 2003):13-16.

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