Health Co-ops in Québec

15 years of progress, adaptation, & learning

By Jean-Pierre Girard

It's an impressive accomplishment. In 15 years Québec has witnessed the launch of more than 50 health services co-operatives, about 40 of which are active. They aren't confined to rural areas or small centres, but have spread to the cities as well. Like it or not, health services co-ops are no longer the "hiccup" they were taken for in the 1990s. They are now card-carrying members of Québec's health network. In light of that, it is interesting to retrace their route to date and to dwell on some of the ongoing projects.

It begins in St-Étienne-des-Grès

Late in 1995 and early in 1996 something new appears on the radar screens of the systems monitoring Québec's health network: a health services co-op. Well, "new" to those unaware of its predecessor, the co-operative *Services de santé du Québec*, a child of the years preceding the Quiet Revolution. Founded in 1945, it vanished in its original form with the coming of the universal health insurance program Medicare early in the 1960s.

The new arrival is in St-Étienne-des-Grès, a municipality of 3,600 residents less than 20 kilometres from the city of Trois-Rivières. It comes as a shock to the closed world that is the health sector. Between the public clinics (*Centres locaux de services communautaires*), and the offices, clinics, and hospitals that generally are the private property of doctors, a new player shoulders its way – a clinic owned by citizens, and what's more, co-operatively! You can't but admire the extraordinary determination of the director of the local *Caisse Desjardins*, Jacques Duranleau, and the unwavering support of Mayor François Chénier, for throwing themselves into this mad adventure. Mad, since these pioneers have no precedent from which to draw inspiration, apart from the Services de santé du Québec.

The St-Étienne project is remarkable in several respects. It scores a first by introducing the co-operative as a form of clinic ownership. By bringing local citizens together this structure gives them the opportunity to play a role in the organization's governance from the get-go. Citizens can thus have a say in the organization of the co-op's health services. This is no small matter. At this very moment you see the exact opposite happening (as you always do in Quebec's public health institutions): an ever-diminishing amount of room for the citizenry on the boards of directors of these organizations. And get this – the local citizens are to participate in the administration of the public health network – a network financed by their tax dollars, no less! More than ever, a bureaucratic and technocratic logic prevails at the expense of a democratic and popular one.

As innovative as St-Étienne is in 1996, there is nothing original about its realm of co-operative activity. By providing professional office space, it offers access to primary health care services, medical consultations with a nearby pharmacy, and a range of other complementary services: psychologists, a dentist, physiotherapy, and so on. Nonetheless, the signal transmitted so powerfully by this co-op project does not escape the attention of other places facing a shortage of doctors: to be in the running for doctors, the community's forces have to be pooled around a collective project, such as a co-operative. Many places in Québec the size of St-Étienne, with populations of 4-10,000, are now suffering this shortfall in medical staff, yet are unable to account for it.

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A shortage of medical staff

With the benefit of hindsight, the shortage of doctors experienced during the 1990s and on into the 2000s is explicable. It involves an intersection of several phenomena symptomatic of both the transformation of medical practice and of policy decisions. There is the growing presence of women in the profession; the search for a better balance between work and family (thus reducing the hours spent in the office); the greater time that new doctors have to devote to tasks other than those of private practice; and, in order better to control the deficit in public finances, limits on admissions to medical schools. In addition, the introduction of a system of bonuses for doctors willing to practice in so-called "remote areas" means that the areas neither remote nor urban, like St-Étienne in the Mauricie, are simply less attractive.

If this weren't enough, the distribution of the medical workforce is disrupted by the growing presence of a new player in clinic ownership and management: pharmacy chains.

At the instigation of Québec's largest pharmacy chain, the Jean Coutu Pharmacy Group, a growing number of clinics are now owned by pharmacies. This type of pharmacy-clinic, known in English as a "one-stop shop," generally takes root in centres of 15,000 or more consumers. So it is not a model developing in rural areas or smaller municipalities. Moreover, conditions of medical practice (like the extremely competitive rents offered to physicians) can be said in effect to drain the medical resources of any given region towards these clinics, depriving small communities of their doctors.

In spite of everything, the movement spreads

Through the intervention of municipal associations and the directors of the Caisse Desjardins, as well as the Regional Development Co-operatives, the idea conceived at St-Étienne in 1995-96 will find uptake elsewhere. Gather local citizens into a co-op, raise funds, purchase or construct a building, and then go after some physicians – when the formula works, recruiting other health professionals, like nurses, physiotherapists, etc., is no problem. In other words, the doctors are like the locomotives to which the other cars of the initiative connect. But for some rare exceptions, the reverse isn't the case: few projects gain traction when doctors are not there first.

From 1996 to 2003 some projects are hatched but due to the growing challenge that is physician recruitment, only a handful take flight. After several years of fruitless effort spent trying and failing to recruit physicians, promoters fall away. One place in which this happens is Pointe-au-Père, a few kilometres from Rimouski on the lower St-Lawrence. For nearly five years (1996-2001) the locals rally 'round a health co-op project. The municipality too lends support as best it can. But the project will be abandoned for failing to recruit an MD, not for lack of a sustained effort to succeed.

In 2003 the Aylmer health co-op project, for which I co-wrote the business plan, represents a new step in the development of the formula in at least two respects. It is the first case in which an existing clinic is sold to a co-op – and in an urban context, moreover. They perceive that it's simply easier to buy an existing clinic with its physicians in place than to bend over backwards in order to entice some. One of the principal instigators of this project, if not the principal one, Dr. Bernard Gélinas wanted to make sure that the clinic preserved its strong connections to the community, originally the town of Aylmer, later integrated into the city of Gatineau (population 200,000), just across the river from Ottawa.

The project stretched from 2001-03 before officially opening its doors in 2004. Today this co-op has become the largest in Québec, with membership approaching 10,000. Like the vast majority of health co-ops in Québec, Aylmer Health Co-Op uses a co-operative model that encompasses at least two member categories, as befits a solidarity co-operative. Permissible under co-operative law since 1997 this disposition has proved well-suited to rallying diverse stakeholders around a co-operative's mission, especially for projects that blend the social and the economic.

With the support of, among other things, the federal government's Co-operative Development Initiative 2004-08, the *Conseil de la coopération du Québec*[1] will redouble research projects, surveys, consultations, and forums to boost understanding of the solidarity model, its success factors, and to raise its profile among other actors in the health world – the Ministry, the medical community, institutional associations, etc. During this time, the Conseil sets up a health committee as a way to promote the synergy of the sector's actors and to arrive at a common outlook on the sundry works in progress.

[1] Now the *Conseil québécois de la coopération et de la mutualité*, bringing together the province's co-operative and mutual federations.

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In addition to four family doctors, the Health Solidarity Co-operative in Contrecoeur (2005) offers such services as a psychotherapist, a chiropractor, a nutritionist, and an audiologist. The co-op also employs a Han program co-ordinator. Its Centre of Industrial Medicine offers physiotherapy, occupational therapy, and acupuncture. Photo courtesy of the Fédération des coopératives de services à domicile et de santé du Québec (FCSDSQ).

(photo) "After years of suspicion, the public network seems more and more open to this new reality of health service co-operatives." In the regional municipality of Robert-Cliche, south of Québec City, the public health clinic (CLSC) and the Health Services Co-op are next-door neighbours. Photo courtesy of the FCSDSQ.

The number of health services co-op grows. In 2007, a world first: acting on the opening remarks of Rector Louis-Marie Béchard about the co-operative form, the staff and students of the University of Sherbrooke come together to create a health co-op. Gaston Stratford goes at this project with a will, and as its voluntary chair stops at nothing to make this unique experiment known. The co-op chooses disease prevention and health promotion as its niche and thereby becomes one of the few organizations to evolve in the absence of physicians. Its programs – proper diet, psychological health, physical activity – are tailored to the needs of students and staff.

The following year a new project in co-operative health services gets underway, this time in a part of Québec renowned for its entrepreneurial spirit, the Beauce. It isn't just a case of wanting to improve the level of primary health care services and physician access. No, early on the Robert-Cliche Health Co-op gambles audaciously: after the example of the University of Sherbrooke, this health co-op too chooses the path of prevention and promotion, by introducing to the area a cutting-edge program developed in Japan, the groups known as *Hans Kai*.

Nancie Allaire is at the heart of this project. First, as the commissioner of collective entrepreneurship at the Local Development Centre, she takes part in a mission to Japan that I organized in the autumn of 2007. She returns persuaded and persuasive as to the value of introducing the Hans Kai formula to her part of the country: identify 10-15 individuals who will meet voluntarily once a month to carry out auto-diagnostics for early detection of illness and to participate in information sessions.

Nancie is integral to getting the project established and applies herself to efforts to secure the financing necessary to test the Hans Kai formula. Nearly half a million dollars will be obtained for a 5-year experiment. In 2009 she becomes the co-op's director. The project owes its success also to the significant commitment of the Caisse Desjardins, as much for its know-how and assistance in membership drives as for its financial involvement. Michel Roy who is chair of the co-operative's board is also an administrator at the local Caisse Desjardins and a board member of the *Fédération des caisses Desjardins du Québec*.

The power of federation

In 2008, the development of Québec's health services co-operatives takes another twist: their consolidation into a federation. Rather than having to start from zero, the health co-ops are invited to join the ranks of an existing federation, the *Fédération des coopératives de services à domicile du Québec*. Founded in 1996, the federation already numbers about 30 co-ops, principally engaged in the supply of domestic services but equally to assist those experiencing a loss of autonomy and to offer services to active households, that is, to young families. Upon opening its doors to these new co-ops, the federation assumes the name by which we know it today, the *Fédération des coopératives de services à domicile et de santé du Québec*.

With someplace at which they can confer, the health co-ops now have in their possession a tool for facilitating their development. This resource and their increasing *savoir-faire* also expedite the creation of new health co-operatives. The co-ops are endowed with an official voice for making representations to the State and to the diverse networks and associations in the realm of health. Another tangible result: the recognition of health co-operatives by the all-powerful *Association québécoise d'établissements de santé et de services sociaux* (AQESSS) in order that services can be made more complementary. This nugget helped to improve relations with the agencies of the public health network, for example, the regional agencies and the Health and Social Services Centres.

Important issues

The health services co-operatives have had to invent from scratch a business model with which to carve for themselves some space in the universe of health services. The basic model is the one already current in private clinics: draw revenues from the rental of facilities to health professionals. Yet very soon – as early as St-Étienne – it emerged that the originality of the project's design was key to its financial viability. So projects rely a lot upon the generosity of volunteers. Capital from family and friends (better known as "love money") is also solicited systematically. Then there are the cash donations, frequently provided by the Caisses Desjardins, local development organizations, small and medium-sized business, and ordinary citizens. Aware of the very positive impact such institutions have on the community,[2]

[2]My colleague the economist Pierre Péloquin completed two inquiries, five and ten years after the foundation of the St-Étienne Health Services Co-operative, to demonstrate the impact of such a health institution on the local community. Based on data from Statistics Canada and other sources, the results confirm the co-op's very positive impact. Péloquin, "Saint-Étienne-des-Grès; deux enquêtes sur un succès d'économie sociale" (May 2009), accessed June 15, 2011 <http://www.productionslps.com/fr/user/Succes_StEtiennedesGres.pdf>.

The Gatineau Health Co-operative, which launched in January 2009, initially found itself with far more members than its medical staff could treat. A grant of $50,000 from the Local Development Centre CLD-Gatineau enabled Chair Gilles Prévost (right) to ramp up the recruitment effort with a video and representation at numerous medical conferences and career fairs. Photo courtesy of the FCSDSQ.

municipalities don't hesitate to back them up in many ways: making office space available, land leases or donations, networking, zoning, etc.

The originality of financial design pertains as much to the launch as to the co-operative's daily operations. Nevertheless it can happen that all these steps are not enough to ensure the viability of the project. So you implement a system of annual contributions. In other words, members (generally, one per family) make an annual obligatory payment varying between $30 and $100. The implementation of these mechanisms is not without its problems. For some, it resembles a duplicate imposition in the sense that it is supplementary to taxes already paid to finance the public health network. For others, the subject is a very sensitive one. For them, any relationship between contribution and access to a physician is unacceptable; it would be akin to doctor's fee.

The federation's position is clear[3]: member contributions are to improve the level of services offered and to strengthen collective affiliation to the organization. Doctors too must assume a just and equitable share. Furthermore, to avoid any sign of conflict of interest, the federation maintains that the doctors need not be on the board of the co-operative, any more than the pharmacists who lease the space.

Summing up

The path climbed by the health services co-ops in little more than 15 years is an impressive one. Starting off in St-Étienne-des-Grès with a little local flair, the idea snowballed, and has become a source of inspiration in many other places. Their intuition was right on target! What challenges will the next 15 years bring us, then? We must reckon with four imperatives:

Continue to integrate prevention with health services. The Robert-Cliche Health Co-Op, with its intuitive combination of primary health care services and the Hans Kai preventive model, is a harbinger of things to come. It is known, it is in fact a truism, that our health systems in future must give over to disease prevention and health promotion to a greater degree. According to its public funding package, the ongoing experiment with Hans Kai groups should wind up by 2014 and then proceed to wider dissemination, but other co-ops are not waiting. Thus, in the Outaouais region, Quartier Health Co-op, specializing in health promotion and quality of life, pulls together an interdisciplinary group of university professor-clinicians (but no doctor) to furnish preventive services. This co-op has also been funded to research, among other things, the introduction of Hans Kai groups to promote healthy living habits in a variety of places, including the Canadian north.

Receptivity to other health professionals and approaches. Nurse-practitioners, alternative medicine specialists – co-ops must open their doors wider to professionals other than physicians. Incidentally, that pioneer of health co-ops, St-Étienne-des-Grès, has offered access to these professionals in addition to doctors and other providers for several years.

Strengthen links with the public health network. After years of suspicion, doubt, and in certain cases, fear, the public network seems more and more open to this new reality of health service co-operatives. Carried along by the general interest and the public good, co-operative health and public authorities should strengthen their collaboration and partnership. That said, a note of caution is in order. Given the experience of the neighbourhood clinics that were converted into local community service centres (CLSCs) in the early 1970s, mind the State doesn't get too firm a grip on grassroots projects.

Promote the model more energetically, especially among the physicians of the future. Faculties of medicine make no mention of the co-op model. In light of the growing importance of health service co-ops, it should become permissible to acquaint the future practitioners of the medical arts with how co-operatives can strengthen ties with the community and mobilize resources – in short, their potential for a medical practice that is not cooped up in the multiplication of consultations, but opens onto its community. ¼

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[3] Go to the website of the Federation (www.fcsdsq.coop) for the policy framework it recommends to members (in French only).

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