

*Health co-ops
around the world*

USA



Coordination of the global project

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Nova Scotia Co-operative Council
MAKING A DIFFERENCE IN NOVA SCOTIA COMMUNITIES

The views expressed in this report are not those of IHCO

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Introduction

Health co-ops around the world are a series of publications showing the contribution of health co-ops in the health system from a national perspective. The project has been conducted under a mandate of the International Health Co-operative Organisation (<http://www.ica.coop/ihco/>).

Each case includes a snapshot of the national health system, information on the presence of health co-operatives and practical references. It is based on a survey conducted in 2007 with the kind collaboration of many people involved in health co-ops and other relevant organisations located in targeted countries. The series includes the following national cases:

- ✓ Canada
- ✓ United States of America
- ✓ Benin
- ✓ Uganda
- ✓ Mali

The relation between this research project and the very important study conducted in 1995 and 1996 by the United Nations (published in 1997 under the name *Cooperative Enterprise in the Health and Social Care Sector A Global Survey*), as well as the methodological framework are presented in the document:

- ✓ Global background and trends from a health and social care perspective.

Country Statistics¹

Total population: 298,213,000

Gross national income per capita (PPP international \$): 41,950

Life expectancy at birth m/f (years): 75/80

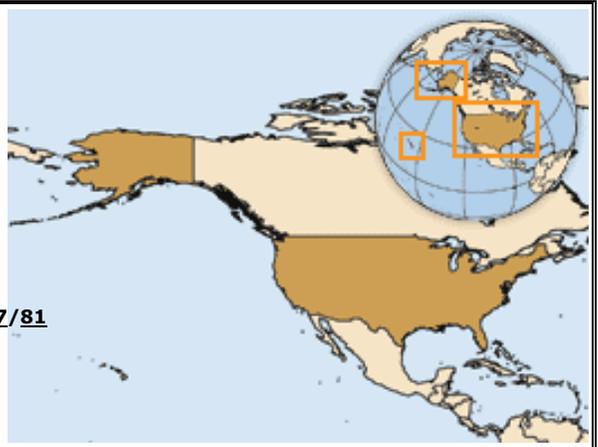
Healthy life expectancy at birth m/f (years, 2002): 67/71

Probability of dying under five (per 1 000 live births): 8

Probability of dying between 15 and 60 years m/f (per 1 000 pop.): 137/81

Total expenditure on health per capita (Intl \$, 2004): 6,096

Total expenditure on health as % of GDP (2004): 15.4



Figures are for 2005 unless indicated. Source: [World Health Statistics 2007](http://www.who.int/countries/usa/en/)

¹ Statistics from WHO: <http://www.who.int/countries/usa/en/>, viewed 15/02/07.

Snapshot of USA's Health System²

Organizational Structure of the Health System

The United States' health system is actually a cluster of health systems of diverse complexity. Federal, State, and local governments have defined, often in concert with one another, their roles in protecting the public's health. State public health departments are not under the jurisdiction of federal health agencies and administrations, and, in many states, city and county local public health departments are not under the jurisdiction of state public health departments. As a rule, direct health care services are provided by the private sector. Many of these governmental and nongovernmental services share public funds, technical advice, regulatory standards, and health research provided by federal, state, and local governments.

Health Care Financing and Expenditure

The government provides health insurance coverage to qualified people living in poverty (primarily through Medicaid) and to those 65 years and older (primarily through Medicare), as well as to the military. In 2004, about 88% of persons covered by private health insurance were on some kind of employment based plan. The proportion of the population with government health insurance coverage increased from 24.7% in 2000 to 27.3% in 2005. This change in government coverage was primarily due to the increase in the percentage of the population with Medicaid coverage, which rose from 10.6% in 2000 to 13.0%, or 38.1 million persons, in 2005. Medicare coverage for the elderly remained relatively stable throughout the reporting period, with 42.5 million beneficiaries in 2005. About nine million members of the U.S. military receive health care through the military health program, TRICARE.

Total health care expenditure represented approximately 15.2% of the GDP in 2004. Government expenditure represented 44.7% and private expenditure 55.3% of the total expenditure on health.

Health Care Provision

Responsibility for individual health care issues is decentralized. The government provides health insurance to highly vulnerable groups, such as some families in poverty, the disabled, and the elderly. Most persons, however, acquire private health insurance coverage through their employers or on their own. Still, 46.6 million of American citizens were uninsured in 2005.³ Direct health care services, including primary, secondary, and tertiary care, are provided primarily by thousands of private sector

² Based on the snapshot model of the European Health Systems Observatory. Information for the snapshot was extracted from "Health in the Americas 2007 – USA Country Profile". The statistics in the boxes are from WHO - core health indicators.

Sources:

- Pan American Health Organization (PAHO), (2007), "Health in the Americas, 2007". Volume II–USA, available at: <http://www.paho.org/HIA/vol2paísesing.html>, pages 687-702.
- WHO, <http://www.who.int/countries/usa/en/>, viewed 02/2007.
- WHO - Core health indicators: http://www.who.int/whosis/database/core/core_select.cfm, viewed 05/2007.

³ Statistics from Center on Budget and Policy Priorities: <http://www.cbpp.org/8-29-06health.htm>.

hospitals and clinics throughout the country. The federal government directly funds additional hospitals and clinics that care for military personnel and veterans and for American Indians and Alaskan Natives.

In 2000, the physician density per 1000 population in the USA was 2.56 and the nurse density 9.37. Hospital beds per 10 000 population reached 33.0 in 2003.

Developments and Issues

There were no fundamental system-wide health reforms in the late 1990s, but there were some major adjustments and new commitments made to meet evolving needs. Starting in 2006, Medicare beneficiaries were offered coverage for prescription drugs; by May 2006, 90% of Medicare enrollees were receiving the coverage. Most people pay a monthly premium for this coverage, which helps to lower prescription drug costs and helps protect against higher costs in the future. Medicare Prescription Drug Coverage is an insurance plan: private companies provide the coverage and beneficiaries choose the drug plan and pay a monthly premium.

Finally, there is increasing recognition, in both the public and private sectors, that significant improvements in health care quality, continuity of care, and efficiency of care may be realized through implementation of health information technology. Several activities have been initiated to support its adoption. In April 2004, the President signed an Executive Order recognizing the need to develop and implement a nationwide interoperable health information technology infrastructure and establishing the position of the National Coordinator for Health Information Technology in the Department of Health and Human Services. It is anticipated that the new infrastructure will be developed as a joint public/private effort and that it will be decentralized by standards and address a variety of privacy and security issues.

Health Cooperatives in the USA⁴

As stated by the National Cooperative Business Association, healthcare related cooperatives have emerged in the USA as a key strategy for helping healthcare costs and insurance premiums stay affordable for consumers and small businesses as well as exercise some control over the costs of prescription drugs. They have also helped community-owned and non-profit hospitals keep their independence and home-based healthcare and assisted living improve in quality. Finally, they have allowed small independent pharmacists compete with big box stores and offer locally available prescription drugs.

In the health sector it is possible to find cooperatives of almost every type – consumer, worker, and purchasing/shared services. For this study, consumer and worker health cooperatives are of particular interest.

⁴ National Cooperative Business Association, http://www.ncba.coop/abcoop_health.cfm, viewed 01/2007.

Consumer cooperatives: Several Health Maintenance Organizations (HMOs) in USA were originally consumer-owned cooperatives. Due to competition and the high costs of health care, many of them merged or were sold to for profit health care companies. Even so, those that still exist offer their members competitive and quality services.

Worker-owned cooperatives: It is mostly in the home healthcare field that worker cooperatives have developed. Poor working conditions for employees in this field means turnover is high thus causing reduction in the quality of service. The advantage of worker-owned home health care cooperatives is that they offer better pay as they are owned by their employees. There are a number of positive results including improved living standards for health care worker-owners, higher worker retention rates, and improved quality of service.

Results of the Study

Throughout the USA, 13 co-operatives and non-profit organizations offering health services were identified in the course of this study. Of those organizations, 10 were approached to participate in this study and 5 accepted. Two are user-owned cooperatives, 2 are provider-owned cooperatives and 1 is a provider-owned mutual benefit corporation. Altogether, those cooperatives employ 11,158 people and generated a turnover of nearly 2.7 billion dollars in 2007.

The two user-owned cooperatives (consumer) operate at the state level and offer to their members a large scale of health services. One of the most important activities of those cooperatives is to manage health insurance. Some people get an individual or family plan, but the majority of health plans are sold to employers that offer health insurance to their employees. These cooperatives also manage medical clinics; pharmacies and one also owns 2 hospitals. These cooperatives have a total of 637,549 members and have on staff up to 1000 physicians.

The 3 provider-owned organizations are specialized in home care assistance. They employ 1,560 people of which 1,385 are care workers. Smaller than the consumer cooperatives, these organizations operate at a municipal or a regional scale. Cooperative Home Care Associate (CHCA), located in New York, is the oldest and biggest of these organizations with 1200 care workers. Manos Home Care operates in California and employs 175 care workers. Cooperative Care employs 85 care workers in rural Wisconsin.

Group Health

The biggest cooperative to participate in our study is Group Health, a consumer cooperative of 581,734 members operating in the states of Washington and Idaho. Annually, the cooperative generates a turnover of around 2.51 billion dollars, which means more than 92% of the global revenue of the cooperatives that participated in this study. The mission of Group Health is to design, finance, and deliver high-quality health care. The purpose of the organization is to “transform health care, working together every day to improve the care and well-being of our consumers and communities”. This cooperative started its activities in 1947. At this time, most of the middle class in the US could not afford health coverage. That is why some union members, farmers, and people from other cooperatives worked together to create a prepaid medical care system.

Today, Group Health manages health plans for individuals, family and employers. The cooperative also owns 2 hospitals, 25 medical care centers, 6 specialty care units and 8 behavioral health clinics. In addition, Group Health offers services through 15 vision centers, 5 hearing centers, and 6 speech and language clinics. Moreover, the cooperative has a contract with 39 additional hospitals to provide health care services. At the moment, Group Health employs 9,448 people and works in collaboration with nearly 1,000 physicians.

To stay up to date in medical research, Group Health Cooperative opened a research center in 1983. This research center has more than 200 employees and has published more than 2,200 reports and articles over the last 25 years. The cooperative contributes to the community through its foundation that offers financial support to Group Health patient care programs, scholarships for medical staff and grants to community-based health programs. In 2007, \$2.8 million was disbursed in research grants.

People join Group Health because the cooperative offers an integrated care system that has a good reputation. In 2007, Group Health's Medicare plan was ranked 22nd out of 192 in the U.S. People are also members of the cooperative because their employers decided to buy a health plan for all their employees. The main benefit of belonging to the cooperative is access to service for lower fees. Most of the users are members of Group Health, but some non-members use the services in emergency cases.

In the political arena, Group Health is a promoter of universal health coverage. To promote their vision about the changes the cooperative would like to see in the national Medicare system, Group Health sponsored a series of public forums on universal coverage in 2005 and 2006. As large cooperative offering health coverage and services at a state level, Group Health sees itself as an example of what a national health care system could look like.

Cooperative Home Care Associate

In the field of worker-owned cooperatives, the oldest and largest organization we approached is Cooperative Home Care Associate (CHCA), a home care cooperative based in South Bronx - New York which employs around 1200 care workers. The cooperative was created in 1985 to offer jobs with better salary and better working conditions for home care workers. Through offering better working conditions and proper training to its employees, CHCA can provide quality services to its clients, for example, by reducing the turnover of care workers.

The cooperative offers a variety of services to its clients in order to help them stay in their homes and remain in their community. The services are related to personal care (bathing, dressing, preparing meals, etc.), light housekeeping and companionship. It is possible to buy private paid home health care for a minimum of 12 hours a week and up to 24 hours a day, 7 days a week. Approximately 85% to 90% of the funding for the cooperative comes from public funding through subcontracting with other organizations like Independence Care System (ICS). In 2007, the total annual turnover of CHCA reached 35 million dollars.

There are several advantages to being a member of the cooperative. For example, when CHCA turns a profit, its workers can receive dividends. The care workers of CHCA also have access to life insurance, receive better wages and have a voice in the governance structure of their cooperative. The members also get better training and assistance from the administrative employees of their cooperative than in

other care agencies. The web site of CHCA exposes a testimony of an employee about her sense of ownership to her cooperative:

I've worked at other agencies where you didn't feel any sense of unity, where you felt just like an employee, where you got your paycheck and just went to your case... Here it's more like family. They have things that make you feel good about yourself. You always have someone to talk to if there's a problem. You feel if you have a problem, you don't go home and you're by yourself.⁵

Looking to the future, CHCA wants to become a model that could be replicated elsewhere and by other groups of care workers. The CHCA has already inspired the creation of several home care cooperatives including the Manos Home Care and the Cooperative Care. Actually, the CHCA anchors a national cooperative network employing a total of 1,600 workers and generating around 60 million dollars in revenue.⁶

⁵ CHCA, Employment, <http://chcany.org/index-3.html>.

⁶ CHCA, Home, <http://chcany.org/index.html>.

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