THE FEASIBILITY OF HEALTH CARE COOPERATIVES IN RURAL AMERICA: LEARNING FROM THE PAST TO PREPARE FOR THE FUTURE

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Abstract

The decline in federal financial support for rural health care may lead rural health care consumers to turn to a once-prevalent private sector model for health care services: health care cooperatives.

This study examines the feasibility of health care cooperatives in rural America and whether the corporate structure of a cooperative is a feasible option for rural residents in communities that lack access to primary health care services. The paper will familiarize readers with the concept of cooperatives and will provide a background for anyone thinking about establishing a rural health care cooperative. The history of health care cooperatives and similar health care systems is reviewed, as are current and past examples of health care cooperatives. As an example of one state's history of cooperatives, experiences in North Carolina will be briefly discussed.

Also discussed are several issues that must be considered before developing a health care cooperative: whether the practice will be prepaid or fee-for-service; the importance of professional legal, financial, and organizational assistance; and the personnel practices of the cooperative.

Rural health care providers and consumers may find cooperatives a suitable and efficient option for securing health care services for their communities. In establishing a cooperative, organizers must consider whether the corporate structure of a cooperative fits the needs of their communities and of the patients who would join and be served by the cooperative.

The views and recommendations expressed in this report do not necessarily reflect the views of the Department of Health and Human Services and the Administration.

THE FEASIBILITY OF HEALTH CARE COOPERATIVES IN RURAL AMERICA: LEARNING FROM THE PAST TO PREPARE FOR THE FUTURE

As rural America enters the 1990s, the state of its health can be said to be in critical condition. Rates for chronic health conditions and for mortality from injuries and accidents are higher in rural (nonmetropolitan) counties than in metropolitan areas.[1] Rural residents are more likely to report that they are in fair or poor health and are more likely to be uninsured or self-insured than urban residents. Rural hospitals also are in trouble, and a growing physician shortage worsens all of these effects. Although about 25 percent of the nation's population live in rural areas, only 12 percent of all physicians practice in rural counties.[2]

While many of these health care trends worsened, federal support for rural health care declined in the 1980s. When compared to urban hospitals, rural hospitals were paid less by federal reimbursement for Medicare. Small rural hospitals have the lowest Medicare Prospective Payment System operating margins of all hospitals in the nation. Federal funding for the National Health Service Corps, once the backbone of physician recruitment for many rural practices, decreased sharply during the 1980s. The number of Corps scholars available for placement fell from about 1,400 in 1985 to 222 in 1989.[3] Although Congress reauthorized and strengthened the Corps in 1990, only 47 scholarships were awarded in 1989 and only 72 in 1990. The Corps' near-demise will affect rural communities for many years.

In the past, federal programs have supported rural health care, including grants for primary health care centers and physician recruitment. But as this government support weakens, rural communities are being forced to act

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[1] Unless otherwise noted, "rural" is defined as areas outside the Metropolitan Statistical Areas designated by the Bureau of the Census. For detailed statistics on the state of rural health, see Catherine H. Norton and Margaret A. McManus, "Background Tables on Demographic Characteristics, Health Status, and Health Services Utilization," *Health Services Research*, Vol. 23, No. 6, February 1989, pp. 725-756.

[2] *Physician Characteristics and Distribution in the U.S., 1990 Edition*. Department of Physician Data Services, American Medical Association, 1990, pp. 13, 29.

[3] *The Rural Health Challenge*, Staff Report to the Special Committee on Aging, U.S. Senate, Serial No. 100-N, October 1988, p. viii.

locally to solve their many health care challenges. Some rural leaders are looking to an old idea to solve new problems. This "innovation," which could again prove beneficial to rural communities, is the creation of primary health care cooperatives.

The purpose of this paper is to familiarize readers with the concept of cooperatives and to serve as a starting point for anyone thinking about establishing a health care cooperative in a rural area. This paper will examine the history and current examples of health care cooperatives in rural America. By examining the history of cooperatives, readers may better understand the dynamics and purpose of such organizations. To give an example of one state's history of cooperatives, experiences in North Carolina will be briefly discussed. The paper also will discuss the issues that must be considered before developing a health care cooperative: whether the practice will be prepaid or fee-for-service; the importance of professional legal, financial, and organizational assistance; and the personnel practices of the cooperative. To begin an examination of health care cooperatives, the foundations of cooperatives will first be explained.

Cooperative Structures and Health Care Delivery

Corporate structures known as cooperatives have been common in rural America throughout this century. More than 6,000 agricultural cooperatives currently serve millions of members, and rural cooperative electric and telephone systems provide service to almost 12 million consumers.[4] A cooperative structure has proven feasible as a blueprint for many other forms of rural enterprise, such as housing, finance, and consumer goods.

Under a cooperative structure, consumers who join the cooperative as members control the management and operation of the business enterprise. The members delegate to administrators the specific functions they wish the cooperative to carry out.[5] According to the U.S. Department of Agriculture's

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[4] Gene Ingalsbe, "Cooperative Facts," U.S. Department of Agriculture, Agricultural Cooperative Service, Cooperative Information Report 2, October 1989, p. 15.

[5] Richard B. Heflebower, *Cooperatives and Mutuals in the Market System* (Madison: University of Wisconsin Press, 1980), p. 15.

Cooperative Service, the underlying principles of cooperatives that distinguish them from other forms of private enterprise are:

1. Member-consumers are the owners;
2. Control is based on one vote per member (or on volume provided);
3. Services are provided at-cost, on a nonprofit basis;
4. Dividends on member capital are limited;
5. Education is necessary for understanding and support.[6]

Following this model, there are two types of cooperatives: primary and secondary. In a primary cooperative, the members or consumers are individuals, such as enrollees in a health care plan or participants in an agricultural enterprise. In a secondary cooperative, the members are institutions, such as hospitals or small businesses, not individuals. For example, an independent primary health care center with individual members would be considered a primary cooperative, while a network or alliance of hospitals or primary care centers would be considered a secondary cooperative. This paper is chiefly concerned with the formation of primary cooperatives, although secondary cooperatives, which are increasingly common among health care centers and hospitals in rural America, will also be discussed.

The final design of a health care cooperative is influenced as much by the economics of health care as by the framework of cooperative organization. In a typical cooperative, members of the organization join by paying membership fees, and those fees entitle them to participation in whatever economic endeavor the cooperative pursues. Any profits are returned to the members in the form of "patronage" dividends. However, in a typical health care cooperative, a group of members pay agreed-upon monthly fees to an association that they control. These fees can be partially or entirely paid by employers as a health care benefit. In return, members receive agreed-upon

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6 "Cooperative Principles and Legal Foundations," U.S. Department of Agriculture, Agricultural Cooperative Service, Cooperative Information Report 1, Section 1, June 1989, p. 3.

medical services through an identified staff of physicians and nurses.[7] These cooperatives typically do not pay out patronage dividends but operate at-cost and use any surplus to expand health care services. The four basic principles of a health care cooperative are prepayment, group practice, comprehensive and preventative health care, and democratic control by members.[8]

More than one hundred health care cooperatives have been formed in rural America during this century. But as of 1988, only 13 health care cooperatives, serving about 1 million members, were operating in the United States,[9] with the largest cooperatives actually found in urban settings. The nation's largest consumer-governed health care organization is Group Health Cooperative of Puget Sound, in Seattle, Washington, which had almost 440,000 enrollees at the start of 1990.[10] However, in various forms and with varying levels of success, rural medical cooperatives have experienced periods of popularity throughout the 20th century. Today, modified versions of the pure cooperative model are resurfacing as corporate vehicles to bring needed health care services to medically underserved regions of America.

History of Health Care Cooperatives in the United States

In 1928, the Committee on the Costs of Medical Care (CCMC), a research group set up with funding from private foundations, began a thorough study of the American health care system, the most extensive ever conducted at that time. The CCMC's 1932 report promoted the formation of group practices through local initiative, a recommendation sharply criticized by the American Medical Association.[11] The CCMC specifically called for the development of hospital-affiliated group practices and prepaid financing of

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[7] Ewell Paul Roy, *Cooperatives: Development, Principles and Management* (Danville, Illinois: The Interstate Printers and Publishers, Inc., 1981), p. 196.

[8] These principles were devised by Michael Shadid, M.D., who is recognized as the founder of health care cooperatives in the United States. Shadid's model will be discussed later in this paper.

[9] Ingalsbe, p. 15.

[10] "Fact Sheet," Group Health Cooperative of Puget Sound, January 1990.

[11] See Alice Sardell, *The U.S. Experiment in Social Medicine: The Community Health Center Program, 1965-1986* (Pittsburgh: The University of Pittsburgh Press, 1988); and Rosemary Stevens, *American Medicine and the Public Interest* (New Haven, Connecticut: Yale University Press, 1971).

health care.[12] While this recommendation did not have widespread lasting effect, it came at the start of a 15-year period that saw the formation of innovative medical practices in rural America.

The first recorded medical cooperative was formed in the fall of 1929 in rural Oklahoma by Dr. Michael Shadid.[13] More than 2,000 families put up $50 each and paid annual membership fees of $25 to build and equip the Community Hospital, whose staff provided members with free medical and surgical care. During the 1930s and 1940s many others appeared across the nation, particularly in the Plains states, where cooperatives were a natural product of the region's populist traditions. As of 1950, most of the 101 rural health cooperatives that had ever existed had been established in the Southwest, with half of them in Texas, where laws promoted the formation of health care cooperatives. But shrinking federal support and the financial uncertainties caused by their small size worked against the continuation of many cooperatives. By 1949, only 54 cooperatives remained in operation.[14]

In the 1930s, Shadid presented cooperative medicine as an alternative to the radical idea of state medicine, which was being hotly debated at that time. Cooperation was a compromise that satisfied both capitalists, who favored private control of medicine, and the more socialist-minded, who sought communitarian solutions to the shortages of medical care in rural regions. In his book *Doctors of Today and Tomorrow*, Shadid laid out the advantages of the four principles of cooperatives:

1. Through group practice, doctors and patients benefited from shared knowledge among specialists.

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12 Sardell, p. 31.

13 Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, 1982), p. 302. See Starr for a brief description of cooperatives and their role in the development of physician authority in medicine.

14 Helen Johnston, *Rural Health Cooperatives* (Washington, D.C.: Farm Credit Administration, U.S. Department of Agriculture; and the Division of Medical and Hospital Resources, U.S. Public Health Service, June 1950), p. vii.

2. **Periodic payment** prevented people from delaying medical care because of cost and thus people would seek care before dire illness left them no other choice.
3. **Preventative medicine** was a cardinal principle; the cooperative structure allowed physicians to emphasize preventative care and thus practice without regard to their own self-interest.
4. **Consumer control** frees physicians from nonmedical concerns and provides patients with control over their health care system.[15]

Shadid said the cooperative system benefited both patients and physicians by weakening the rise of commercial medicine and meeting the demands that led to talk of state medicine. Shadid asserted that the medical doctor was the only professional who could truly help patients maintain or recover health. He chastised physicians who performed medical procedures for financial rather than patient benefit and said cooperatives and prepaid care would eliminate the perverse incentive to do unnecessary procedures. He maintained that the cooperative model gave doctors freedom: freedom from financial insecurity, freedom for study and leisure, freedom for consultation with colleagues, and freedom of conscience.[16]

Despite Shadid's attempt to present cooperatives as a long-term savior for physicians against corporate or government medicine, the medical profession was hostile to his ideas for cooperative practice. Beginning in 1939, medical lobbies succeeded in securing laws in 26 states that effectively barred consumer-run medical service plans.[17] For example, Oklahoma's medical society fiercely opposed Shadid's attempts to establish a cooperative in Elk City, a town of 6,000 in western Oklahoma. The doctor's practice would have failed if not for the support of the Oklahoma Farmer's Union, a populist farmers' group that helped Shadid secure a loan for this enterprise. However,

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15 For details see Michael Shadid, M.D., *Doctors of Today and Tomorrow* (Superior, Wisconsin: Cooperative Publishing Association, 1947), pp. 161-175.

16 Shadid, p. 185.

17 Starr, p. 306.

pressure from the state medical society hampered Shadid's efforts to recruit competent physicians to his practice.

It is surprising that Shadid's arguments, which protected and enhanced physician control of medical practice, failed to win more support among the medical community in the early 1930s. The reforms of the New Deal had created momentum for state-controlled medicine, a feared prospect for a medical field beginning to cement its professional power nationally through the American Medical Association. Shadid made the argument that in cooperatives, physicians would retain control of medicine, which was a facet absent from any government medical scheme. His appeal on behalf of cooperatives incorporated the central principle of the medical profession: physician authority.

Although Shadid's own cooperative had trouble growing, his idea and model did not. In the late 1930s, the Pacific Supply Cooperative, a farmer's group, sponsored a regional tour by Shadid to talk to farm cooperatives about forming health care cooperatives.[18] Soon after Shadid's initial efforts in Oklahoma and his tour of discussions, the number of health care cooperatives increased, particularly in urban centers.[19] Although medical cooperatives began as a rural movement, most of the surviving cooperatives are in large urban centers, such as the Group Health Cooperative of Puget Sound (which was founded in 1947 and whose leaders were influenced by Shadid and his model); the Group Health Association of Washington, D.C.; the Health Insurance Plan of New York; and the Group Health Plan of Minnesota.

In the 1930s and 1940s, however, Shadid's model was implemented in other Oklahoma and Texas towns, and the federal government used a New Deal program, the Farm Security Administration (FSA), to encourage the formation of rural health cooperatives. The FSA's broad goal was to alleviate the poverty of the nation's farmers. The FSA also developed a medical

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[18] John W. Hatch and Eugenia Eng, "Community Participation and Control: Or Control of Community Participation," in Victor Sidel and Ruth Sidel, eds., *Reforming Medicine: Lessons of the Last Quarter Century* (New York: Pantheon Books, 1984), p. 232.

[19] *Ibid.*, p. 232.

program, which at its peak served more than 600,000 people in one-third of America's rural counties. The FSA medical program answered the needs of both patients and physicians. The Depression had caused a significant drop in physician income, particularly among rural physicians who saw their revenues drop by as much as 50 percent.[20] Despite reservations, physicians chose to participate in the FSA program in order to have a reliable income stream. Because of economic hard times, patient payments to doctors were increasingly in the form of fried chicken and black-eyed peas instead of cash.[21]

The FSA provided low-interest loans and education to farm families, and its medical program encouraged the formation of cooperatives, an outgrowth of their interest in establishing agricultural cooperatives. The medical program followed a group prepayment model in which loan recipients pooled their money and formed health associations. These associations, administered by community members, paid participating physicians, who provided a range of primary and acute care to participating families. The physicians, in turn, submitted bills for services rendered to medical review boards, which reimbursed physicians for care. Participating families paid membership fees according to ability to pay and to the type of services included in their association's medical package.

The FSA program was decentralized, and control remained in the hands of local physicians and consumers. Since any excess funds not given out through the association were returned to physicians on a prorated basis, the FSA program contained strong incentives for physicians to focus on preventative care. Given its goals and structure, the program followed the basic principles of health care cooperatives: group practice, prepayment, preventative care emphasis, and community (though not solely consumer) control.

But when the wartime boom of the 1940s led to greater prosperity and increased incomes in rural America, the incentive for physicians to

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[20] Michael Grey, "Poverty, Politics, and Health: The Farm Security Administration Medical Care Program, 1935-1945," *The Journal of the History of Medicine and Allied Sciences*, Vol. 44, July 1989, p. 324.

[21] See Grey for details of the FSA program's development.

participate in the prepaid program declined. Many rural families found new work in the wartime defense economy, and their increased income gave them more health care options. Farm families also prospered during the 1940s, as they consolidated and enlarged their farms.[22] The base of the FSA medical programs eroded, leaving them weaker. Many of the small cooperatives in the 1940s became actuarially less sound and economically unviable as they lost the population base needed to support prepaid practices.[23]

With farm families enjoying greater income, many physicians expected these families to again pay for medical care on a fee-for-service basis. Families who had repaid their FSA loans were asked by some physicians to leave the prepaid program.[24] Once the economy had returned to a state of steady growth, physicians sought to return to fee-for-service and head off any continued government involvement in the delivery of medical care. Nonetheless, the experiences of the FSA medical program influenced health reforms in the 1960s and 1970s, most notably the formation of Community (or Neighborhood) Health Centers and the medical programs of the Office for Economic Opportunity.[25]

In the 1950s, labor unions in Philadelphia and Chicago set up health plans that pooled resources of several different unions, breaking with past practice that had previously limited union programs to single organizations. By 1960, some estimated that the health care needs of five million Americans were being served by medical centers that had a cooperative organization.[26] These health care organizations had varying degrees of cooperative structure, yet all had the essential ingredient of health care cooperation—consumer control.

The passage of both Medicare and Medicaid in 1965 were obviously major reforms in the financing of medical care. Their passage coincided with the beginnings of the first significant government innovation in the *delivery* of

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[22] Grey, p. 346.
[23] Starr, p. 321.
[24] Grey, p. 346.
[25] See Starr and Stevens, *passim*.
[26] Jerry Voorhis, *American Cooperatives* (New York: Harper & Brothers, 1961), pp. 34-35.

health care since the end of the FSA program—the Great Society's Neighborhood Health Center program (which later became the Community Health Center program).[27] This reform had several broad objectives, among them many cooperative principles: an emphasis on primary care (as opposed to hospital-based tertiary care); an emphasis on group practice that included paraprofessionals; and the inclusion of the poor and consumers in the design and control of local health care. Yet there was an added element in this blueprint for health care services. In addition to being a means of bringing health care to poor rural and urban residents, the Community Health Center program also sought to use the establishment of health care centers as a "point of entry for ... broader social change."[28]

The Community Health Center program survived the demise of its bureaucratic parent, the Office of Economic Opportunity, and grew to include an added program to serve migrant farm workers through Migrant Health Centers. The "maximum feasible participation" clause of the OEO's community programs established a precedent for community involvement and allowed local residents to gain leadership experience. The principle of consumer participation in government medical programs has been firmly established through the CHC program, which continues its success today. In the late 1980s, more than 800 Community/Migrant Health Centers were serving roughly 4.2 million people. In 1989, the more than 350 Community Health Centers in rural America provided care for 2.7 million patients.[29]

Given their similarities in structure, a fusion of the Community Health Centers model and the Shadid model of rural health care cooperatives is feasible for today's rural health delivery problems. Both of these community-oriented models emphasize (1) community health services, (2) community economic development, and (3) community participation.[30] The three elements of this type of health care delivery system provide a foundation for

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27 See H. Jack Geiger, "Community Health Centers: Health Care as an Instrument of Social Change," pp. 11-32 in Sidel and Sidel, eds., *Reforming Medicine.*

28 *Ibid.*, p. 13.

29 "Perspective Papers: Rural," Paper series, National Association of Community Health Centers, 1990, p. 3.

30 Sardell, p. 53.

local consumers hoping to increase medical care access and economic opportunity in their communities.

In addition, cooperative medicine could prove suitable for rural communities in the 1990s as federal subsidies for rural health care shrink. Support for cooperative medicine may be substantial in rural communities, where residents are likely to be familiar with the cooperative concept through agricultural cooperatives in their regions. Cooperatives may also prove more successful in rural communities where there are fewer physicians to oppose them. That is, physicians in rural areas, by virtue of their isolation from a larger professional medical community, are already more integrated into local communities. The formation of a cooperative would not be viewed as a threat to physicians' private control of medical care to the same degree in this setting as in an urban physicians' group struggling to help its members fight off state control. Rather, a rural physician may view a cooperative as a means of solidifying fiscal stability in his or her practice by making certain that the community has a vested interest in the practice's financial success.

Many different forms of cooperatives have recently reappeared in health care delivery, as seen in the history described above. In the following section, different examples of cooperative health care structures will be discussed. As an example of cooperative development in a southern state, the particular experience of North Carolina is examined, followed by a description of secondary cooperatives. Later, some of the considerations involved in setting up a cooperative will be discussed. Under a cooperative model, certain aspects of health care delivery, such as personnel and finance issues, differ from the traditional nonprofit community health care center. Once these and other issues are taken into account, the feasibility of health care cooperatives will be discussed.

The State of Cooperatives in the United States Today

Three Current Examples of Cooperatives in the United States

Even though large, successful health care cooperatives are primarily found in urban areas, some rural leaders have shown renewed interest in health care

cooperatives. Below are three examples of cooperative development. One program in Montana, despite optimistic planning, failed to develop because of a lack of community support. Another quasi-cooperative model in Atlanta plans a satellite in rural Georgia. A third example given is of a Wisconsin practice that began in a small metropolitan area as a pure cooperative model in the 1970s but has evolved into an HMO while retaining some cooperative features.

In a recent attempt to establish a rural cooperative, Montana residents of Fairfield and Augusta and the surrounding service area (a total of about 12,000 people) tried to combine the best elements of Preferred Provider Organizations, Health Maintenance Organizations and cooperative management. The health program leaders spent two years planning and organizing their project and held town meetings to educate the community, according to James Eskridge, an official with the Sun River Electric Cooperative. The electric cooperative, along with community leaders, began the process of developing the health care cooperative.[31] The cooperative, designed by local leaders and a local family practitioner, was based on a PPO model. Preferred providers in the two towns' clinics would receive a guaranteed patient base in return for agreeing to give cooperative members a discount. Health care coverage was to be provided through a standard indemnity plan.

Cooperative members would join by paying an initial, one-time $175 fee and paying annual $50 member dues.[32] Members would receive the following benefits: lower insurance premiums, reflecting an enlarged service area; greater access and lower health care costs, due to expanded, lower cost services created by the local cooperative; a 20 percent annual rebate on medical care; and a return on their membership investment.[33]

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[31] Interview with James Eskridge, Sun River Electric Cooperative, Fairfield, Montana, March 1990.

[32] Of the initial fee, $165 would be refundable after the third year of the cooperative's operation if the member left the program.

[33] Sophie M. Korczyk, *Health Care Needs, Resources, and Access in Rural America: Making the Connections, Finding the Solutions*, A National Rural Electric Cooperative Association Report, November 1989, p. 48.

Although an economist with the USDA's Agricultural Cooperative Service concluded that the plan was financially viable, community support for the cooperative declined a few months before its clinics were set to offer services to cooperative members. This community discontent caused the Sun River Electric Cooperative Board of Directors to withdraw its support for the project. The clinics were purchased by physicians, who will provide services on a private, fee-for-service basis. Eskridge, who plans to remain involved in health care issues, cited the lack of community support as the major cause of the plan's demise, although he views the model as financially and medically viable.

In an example of a quasi-cooperative, the Health Promotion Research Center of the Morehouse School of Medicine is implementing a pilot project to establish a community-oriented practice in Joyland/High Point, a poor, predominantly black neighborhood in Atlanta. The model centers on community involvement and empowerment, and organizers hope to expand its implementation in rural settings. The Morehouse model seeks to perfect the health care experiments of the 1960s and places great emphasis on involving the community, whose representatives make up at least 60 percent of the health center's governing board of directors. The program forms a coalition between community consumers and representatives of public and private resources.[34]

Developers of the Morehouse model say it is impossible to enhance the health status of the poor or others who lack power unless authority over resources is transferred to them.[35] Thus their project emphasizes working with communities and consumer representatives as a means of improving health care access. Although their first program was based in an urban neighborhood, in early 1990 the Health Promotion Research Center, which was formed almost four years ago, inaugurated a health center following its model in two poor rural communities in Siloam (Greene County) and Waycross (Ware County), Georgia. The two communities, which have

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[34] Ronald L. Braithwaite, Frederick Murphy, Ngina Lythcott, and Daniel S. Blumenthal, "Community Organization and Development for Health Promotion Within an Urban Black Community: A Conceptual Model," *Health Education*, December 1989, Vol. 20, No. 5, p. 60.

[35] *Ibid.*, p. 57.

sizable black populations, have implemented community-run health promotion centers using private foundation, state and federal funds as the main sources of financing. With the help of community organizers, the community has identified the health care priorities that will be the focus of the centers.

Adopting goals similar to those of the old Neighborhood Health Center program, the Morehouse model hopes economic development will be an offshoot of its health care program. The health center model, once implemented, can also serve as a base for leadership development in impoverished communities. While not a pure cooperative model, the Morehouse project serves as a current example of a project working to secure consumer involvement in the operation of a health care program.

The Group Health Cooperative of Eau Claire, Wisconsin, was initially established as a pure model health cooperative that sold voting shares. However, the selling of shares failed to raise adequate capital for the enterprise, so the group soon evolved into a prepaid, non-profit health maintenance organization. Founded in 1972, it remains true to its cooperative ideals in that all prepaid members, 18 years old and older, are entitled to vote in annual elections for the consumer-run board of directors. To guard against providers taking control of the cooperative, only consumer members of the cooperative can serve on the board.[36] The cooperative has about 20,000 members who use its four medical centers and one dental clinic. Two of its medical centers are located in rural communities, Rice Lake (population 8,000) and Chetek (population 1,000).

Cooperative Experiences in North Carolina

Although the 1930s and 1940s were decades of growth for rural cooperatives, health care cooperatives did not survive those decades in North Carolina. As in the rest of the nation, interest in prepaid group practice waned after the crisis of the Depression passed into the wartime and postwar prosperity. In

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[36] Information on the Group Health Cooperative of Eau Claire comes from an interview with Claire Johnson, the cooperative's executive director.

the recorded proceedings of Rural Health Conferences held by the N.C. Medical Society in the early 1950s, discussion of the problems in rural health care finance included talks on service benefits and expanded indemnity insurance but not prepaid plans.[37]

According to the state's Office of Rural Health and Resource Development, there are no pure cooperatives providing health care to rural North Carolinians. However, North Carolina has dozens of community-oriented health care practices, many of which are group practices controlled and led by community boards of directors. There are 36 federal Community/Migrant Health Center sites and 50 state Rural Health Centers, which are primary care practices established by the Office of Rural Health; many of the state centers also are joint C/MHC projects. Many of the state Rural Health Centers follow three of the four precepts of Shadid's health cooperative: group practice, emphasis on preventative medical care, and consumer (community) control. The only principle missing is an element of periodic payment or prepayment. All 50 centers are fee-for-service practices, and some have only one physician.

Some centers have tried other elements of pure cooperatives. For example, the Saluda Medical Center in Polk County, N.C., sold shares to local residents to raise money for the construction of the health center's current building. The community established a separate nonprofit corporation that bought back the shares at 80 percent of their value. Once the building was constructed in the early 1970s, a physician was recruited. Organizers of the building project said the idea of selling "shares" was an effective marketing tool to raise the capital needed for the project.[38]

The Hot Springs Health Program began during the era of the Great Society programs as a community-oriented practice staffed by a nurse practitioner who had once conducted a health fair in the small Appalachia community in western North Carolina. The program has since grown to include four medical centers with eight doctors who handle the majority of Madison

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37 *Proceedings from the 5th Annual Rural Health Conference,* N.C. Medical Society, Raleigh, N.C., October 15, 1952, *passim.*

38 Interview with Torlen Wade, Assistant Director, N.C. Office of Rural Health and Resource Development, Department of Human Resources, March 1990.

County's health care needs.[39] Patients pay the practice on a fee-for-service basis, but the program gives a 10 percent discount to families who have paid a set deductible, which varies according to family size. For example, if the deductible for a family of four is $100, then after that family spends $100 on Health Program services, they receive a 10 percent discount on all subsequent services. The discount rewards program "members" who use its services extensively, which is a basic premise of a cooperative.

Secondary Cooperatives in Rural America

A recent survey conducted by the University of Minnesota found 127 hospital networks or consortia serving hospital groups around the nation. Almost 40 percent of these consortia were founded less than three years ago.[40] There also exist numerous networks of health care centers across the nation. Consortia and networks have formed for various purposes, including cooperative debt collection, group purchasing, and joint recruitment and training of personnel. Some rural consortia are urban-based satellites, and others are spin-offs of hospital associations.

The Rural Wisconsin Hospital Cooperative is a pure form of a secondary cooperative, founded in 1979 and made up of hospital members. The purpose of the cooperative is to develop joint ventures that benefit all the hospitals but are not controlled by any single facility. In 1983, the Cooperative developed the HMO of Wisconsin, the third largest rural-based prepaid plan in the nation. The HMO eventually became an independent, for-profit group.

The key difference between secondary and primary health care cooperatives is that the secondary cooperative exists as a means of providing the economies of scale which are not inherently available in rural economies. By cooperating, hospitals or health care clinics can lessen the economic effects of

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[39] For a history and details of this health program, see Christine Kushner, "The Hot Springs Health Program: A Case Study," North Carolina Rural Health Research Program working paper, Health Services Research Center, University of North Carolina at Chapel Hill, November 1989.

[40] "The Development and Characteristics of Rural Hospital Consortia," *Findings*, Division of Health Services, School of Public Health, University of Minnesota, Vol. 9, No. 1, Winter 1990.

their smaller population bases, higher per unit costs, and lower population densities that cause them to have higher costs than similar urban-based medical groups.[41] In contrast, the main reason for forming a primary health care cooperative in rural communities is typically to bring needed medical services to an area where none exist. Thus the economic incentives are significantly different from those of a secondary cooperative or network. The incentive to lower health care costs is still a goal of primary health care cooperatives yet it is not its driving force.

Secondary cooperatives can serve as a strong parent agency for primary health care cooperatives. Just as the Rural Wisconsin Hospital Cooperative spun off an HMO, another hospital network interested in primary health care delivery could use its existing structure to support a primary health care cooperative.

Considerations in Setting Up a Primary Cooperative

Prepaid or Fee-For-Service

Although a cooperative could be organized as a fee-for-service practice, many leaders in the cooperative movement tend to define a rural health care cooperative as a prepaid plan. This raises the question of whether sparsely populated rural areas can support prepaid practices. Citing one state's experience, prepaid Health Maintenance Organizations (or HMOs) have not had great success in rural North Carolina. Currently, urban residents make up 85.7 percent of HMO enrollment in North Carolina, but only 55 percent of the state's population lives in metropolitan counties. The largest five urban counties account for 71 percent of total membership. The major obstacle in reaching rural residents with HMOs is finding industries that support prepaid plan enrollment.[42] Many manufacturing jobs in rural North Carolina have low wages with health benefits that require above average copayments and deductibles. Without the support of business, prepaid plans cannot succeed. There are, however, several successful prepaid health plans in rural America

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41 Tim Size, "Principles for Effective Inter-organizational Rural Health Development," unpublished paper, Rural Wisconsin Hospital Cooperative, February 1990, p. 11.

42 Interview with Wade.

today, the largest being Geisinger Health Plan in Danville, Pennsylvania, a group HMO practice with 86,000 members.

However, as stated earlier, a health care cooperative could be formed as a fee-for-service practice that gives certain benefits, such as rebates or lower prices, to cooperative members, similar to the organizational form of the Montana health care cooperative model described earlier in this paper. It is more critical that a cooperative be controlled by consumers and widely supported by membership fees.

The Importance of Professionals in Legal, Fiscal and Organizational Aspects of Cooperatives

Depending on their structures, cooperatives have varying degrees of taxable income. The full tax and legal issues of cooperative enterprises are complex and cannot be fully considered in this paper. However, in one assessment of the Group Health Cooperative of Puget Sound, the quality of their legal counsel was seen as a key determinant of their early success.[43] The cooperative secured a firm of attorneys well-versed in laws and regulations governing cooperatives. Similar advice follows for cooperative organizers in consulting other professionals, such as accountants, management consultants or finance officers.

Most states have complex laws that restrict the corporate practice of medicine, that is physicians, and perhaps other health care providers, working for non-physicians. In many cases, physicians are required to be employed by professional associations or corporations. Anyone developing a cooperative health care program must first investigate state laws affecting physician employment and licensing that pertain to cooperative development or community-run health care organizations.

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[43] Hatch and Eng, p. 232.

Personnel Issues

Given physicians' reactions to cooperative medicine in the past, finding a physician willing to be an employee and willing to be part of a cooperative may be the most critical goal for program organizers. If the cooperative is to provide physician care, finding a physician committed to the structure's ideals will be important to the long-term viability of the cooperative. For example, a cooperative could start physicians on salaries but then gradually sell shares in the practice to participating physicians. Although not a pure cooperative, this plan offers an incentive to physicians when the cooperative is recruiting and allows a young physician with little or no initial capital to build up equity in a practice. To retain community control of the practice, the cooperative can require that they retain the right of first refusal whenever physicians seek to sell their shares.

If a full-time physician cannot be recruited for the cooperative enterprise, organizers may instead wish to provide health care through physician extenders, such as certified nurse-midwives, physician assistants and nurse practitioners. These health professionals, who must have physician supervision, can give flexibility to the cooperative and increase its cost-effectiveness. Physician extenders also can expand a physician-based practice by allowing a greater array of services to be offered.

Recruiting a physician for a cooperative venture is a real concern, particularly given the already critical shortage of physicians in rural areas. Some means of providing financial incentives to physicians is needed for recruitment. However, the rural physician shortage is not entirely a financial problem. Concerns over rural school systems, professional opportunities and other factors all lead to problems in recruiting physicians to rural areas.[44] A cooperative structure may be attractive to physicians interested in community-oriented health care. A cooperative lends itself to having

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[44] For details on provider shortages in rural America, see Hormoz Movassaghi and David Kindig, "Medical Practice and Satisfaction of Physicians in Sparsely Populated Rural Counties of the United States: Results of a 1988 Survey," *The Journal of Rural Health*, April 1989, Vol. 5, No. 2, pp. 125-135; also James K. Cooper, Karen Heald, Michael Samuels, and Sinclair Coleman, "Rural or Urban Practice: Factors Influencing the Location Decision of Primary Care Physicians," *Inquiry*, 12 (1975), pp. 18-25.

particular financial incentives for physicians to improve their performance and patient care. However, some means of incorporating physician medical authority into the consumer-run board of governing may be needed to secure long-term physician retention.

Financial Issues

Because rural areas tend to have inefficient capital markets, access to quality and affordable financing could be a major obstacle for many rural health care ventures. Numerous options exist, including the classic cooperative method of selling shares to members. But not all options are financially feasible in many cases. Access to quality financing through the National Cooperative Bank, a 10-year-old institution created by Congress to promote the growth of cooperatives, may prove a feasible alternative. Despite early funding problems, the NCB has become a valuable source of start-up capital for many types of cooperatives.[45]

The National Cooperative Bank, a leading source of financing for cooperatives throughout the United States, is itself a private, cooperatively-owned financial services company with more than $400 million in assets. The Bank and its subsidiaries lend not only to pure cooperatives but also to non-profit health care centers that have community boards. In fact, the National Cooperative Bank Development Corporation has made financing Community Health Centers a priority in the coming years.[46]

To raise crucial start-up capital, cooperatives have other finance options open to them. Selling shares and memberships to community members can be critical and important sources of start-up capital for a primary health care

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[45] As an example of NCB's many problems, David Stockman, then director of the Office of Management and Budget for President Ronald Reagan, sought to freeze the Bank's funds before it opened. The Bank won that battle only to face allegations of conflict of interest in some of its loan decisions. See The National Consumer Cooperative Bank, Hearing before the Subcommittee on Financial Institutions, Supervision, Regulation and Insurance of the Committee on Banking, Finance and Urban Affairs, U.S. House of Representatives, 98th Congress, May 24, June 14, 1983, Serial No. 98-34, Washington, D.C.: U.S. Government Printing Office, 1983.

[46] *Cooperative Enterprise*, NCB Development Corporation newsletter, Winter 1989, cover story.

center. In addition, a membership drive serves as an effective marketing tool for a newly formed health care center. The problem with these strategies is that they may fail in rural communities with high levels of poverty or where low-income families make up a disproportionate share of those who would benefit from the new health care services. In addition, to receive tax-deductible donations, the cooperative may have to set up a separate nonprofit (501c3) corporation that can accept donations.

In addition to the National Cooperative Bank, other federal programs in the Department of Health and Human Services and the Department of Agriculture provide funding for rural health care innovations. Other finance options include seeking a commercial loan for the health care facility. The disadvantage of this method is its higher costs and the problem of securing the loan.

Conclusion: The feasibility of health care cooperatives in rural America

The financial feasibility of establishing a primary health care cooperative in a rural community clearly depends on the community's particular economy and health care needs. The major problem with starting any health care venture is financing. In addition, organizing a health care center as a consumer cooperative is more difficult and complex than establishing one sponsored by a group of physicians or by an employer.[47] However, if improving local access is a goal, if reaching the uninsured and self-insured is important, then a consumer cooperative may be the best choice for some rural communities.

In a study of the financial viability of rural primary health centers, researchers found that the longer a center was in operation and the faster its practice grew, the more likely it was to be self-sufficient.[48] The study also found that hospital-based centers were more financially viable. In other words, health

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47 Art Danforth, "Financing New Health Care Cooperatives," Cooperative League of the U.S.A., September 1977.

48 Roger Feldman, David M. Deitz, and Edward F. Brooks, "The Financial Viability of Rural Primary Health Care Centers," *American Journal of Public Health*, October 1978, Vol. 68, No. 10, pp. 981-987.

care centers that are part of a larger organization, such as a hospital or a larger rural agency, receive important support from their parent agency in order to become self-sufficient. To this end, a local rural cooperative would prove an ideal parent to a primary health care cooperative.

A primary health care cooperative could feasibly be part of a larger, diversified cooperative that provides electricity and energy (such as a rural electric cooperative), agricultural services (a cooperative farm or marketing structure), or other consumer services (long-term care, for example). Secondary cooperatives, such as the hospital cooperatives discussed in this paper, also can be excellent anchors for primary health care cooperatives that enroll individuals as members. The development of a health care cooperative also could take place as part of economic development through a Community Development Corporation. CDCs are nonprofit community-based organizations that serve as financial and organizational vehicles for economic development. CDCs were created during the era of Great Society programs and have become sources of equity and debt capital for local entrepreneurs throughout the nation.[49]

Many prepaid HMOs and Individual Practice Associations have had success as part of an urban-based practice expanding into a rural community. Being part of a larger organization, whether urban or rural, would solve an important problem for small rural health care cooperatives that do not have the population or consumer base to be actuarially sound. Such linkages have proved feasible in the past. For example, many of the Community Health Centers that formed in the 1970s were sponsored by hospitals or medical schools, larger organizations that could incorporate the risks of a small group practice.

Health care access for the rural poor is a growing concern among many rural health care leaders. Unfortunately, some components of rural health cooperatives do not lend themselves to serving the poor. Many working poor rural residents do not have health insurance as a job benefit and may not be able to afford the membership fees independently. Cooperative

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[49] See Neal Peirce and Carol Steinbach, *Corrective Capitalism: The Rise of America's Community Development Corporations* (New York: Ford Foundation, 1987).

founder Michael Shadid stated that credit could not be allowed in a cooperative structure, declaring that "Credit is destructive to any cooperative."[50] He also advocated penalizing members who did not fully support the cooperative by using it for all their medical needs and called for "loyalty compelling provisions." Shadid's main concern was that full support from across the community was needed for a cooperative enterprise to succeed.

Despite many obstacles, various types of cooperatives have succeeded in poor rural communities.[51] A cooperative could serve as an effective way to organize the use of limited resources of poor communities in need of health care resources. Amundson and Hughes state that the lack of health care services does not result only from a shortage of available money but also from a failure to maximize existing health care resources, such as private and public insurance.[52] They urge rural communities to capture the private dollars and insurance dollars that leave the community when local residents seek health care in larger urban centers. Organizing a rural health cooperative is a means of securing local community ownership and loyalty, as Shadid stressed in his model. In addition, when examining the financial viability of a cooperative, planners should consider the insurance coverage of the local population as a local community resource.

In their book *Rural Health Care,* Rosenblatt and Moscovice found that community ownership is a primary attribute of a viable and self-sustaining rural primary care system.[53] This sense of ownership, meaning community involvement in the planning, design and formation of the health care system, is the very definition of a consumer-run cooperative model. However, such ownership can be found in a nonprofit health care center that is run by community members but does not have the strict structure of a

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50 Shadid, p. 233.

51 For examples, see Ray Marshall and Lamond Godwin, *Cooperatives and Rural Poverty in the South* (Baltimore: The Johns Hopkins Press, 1971).

52 Bruce A. Amundson, M.D., and Robert Hughes, "Are Dollars Really the Issue for the Survival of Rural Health Services?" WAMI Rural Health Research Center, Rural Health Working Paper Series, Vol. 1, No. 3, June 1989.

53 Roger A. Rosenblatt and Ira S. Moscovice, *Rural Health Care* (New York: John Wiley and Sons, 1982), p. 93.

cooperative. The issue is whether a cooperative structure best fits the needs of that particular community.

As seen in the Montana example, obtaining community support for a cooperative is imperative for its survival in a rural area. To achieve this, cooperative organizers must convince community residents that pooling their resources and money is required to maintain consumer-controlled health services. This process takes time and often must be allowed to develop over a period of months or even years. In order to secure the formation of rural health cooperatives, funding sources must allow organizers the time to make the program work.

The lack of rural health care cooperatives in the United States is most likely tied to the many problems of rural health care in general, such as physician shortages, low population densities, high rates of indigence, and declining economies. But there also has been inadequate national support and organization. A national network promoting rural health cooperatives and providing technical assistance to interested rural leaders could provide critical support for fledging cooperative efforts. The National Rural Health Network was formed recently by the National Rural Electric Cooperative Association to serve as a national network. If properly organized, this association could provide support for a nationally organized movement to promote rural health cooperatives.

To promote the formation of rural health cooperatives on a national scale, the Office of Rural Health Policy, in the Department of Health and Human Services, should secure money to fund pilot projects in various rural communities. These pilot projects must be supported not only with money and technical assistance but also with patience. Essential community support for the project may take years to develop. In addition, any commitment to the promotion of rural health cooperatives requires a national organization providing support and assistance. The Office of Rural Health Policy, or a suitable and competent national association, could serve in this role.

A cooperative model, or separate aspects of this model, can serve many types of enterprises quite effectively. Cooperatives assure consumer support from

loyal community residents who rely on the cooperative to obtain needed services, in this case basic and necessary medical care. Corporate structures for health care systems range from physician-owned to community-owned to for-profit stockholder-owned practices. In determining which structure to choose, perhaps the best advice is to find the corporate structure that most closely suits a community's needs and proceed to plan from there.

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APPENDICES

APPENDIX A

Suggestions for Setting Up a Health Care Cooperative

1. First learn about the health care needs of the local community.
2. Secure community support at the beginning of and continuously throughout the planning and implementation process.
3. Make certain planning is logical, realistic and based on the community needs.
4. Choose the organization committee or board carefully.
5. Consult with legal counsel well-versed in laws governing cooperatives and/or health care facilities.
6. Perform a financial analysis, conducted by trained professionals, who can determine the minimum number of members and finance needed for the success of the project.
7. Have assurance of sufficient funds before starting to build any facility.
8. Educate the community to the cooperative's plan: costs, services offered, practice style (i.e. prepayment features), etc.
9. Keep the local community informed throughout the planning and implementation process.
10. Choose physicians and other personnel who understand and are sympathetic to the program's objectives.
11. Make certain that control of the cooperative remains in the local community.

Adapted from Rural Health Cooperatives, *by Helen L. Johnston, U.S. Department of Agriculture, 1950, and* American Cooperatives, *by Jerry Voorhis, 1961.*

APPENDIX B

Examples of Active Primary Health Care Cooperatives or Cooperatives that Include Primary Health Care

Community Health Center of Two Harbors (Minnesota)
Family Health Plan Cooperative (Elm Grove, Wisconsin)
Group Health Association of Metropolitan Washington, D.C.
Group Health Inc. of Minneapolis-St. Paul
Group Health Cooperative of Eau Claire (Wisconsin)
Group Health Cooperative of South Central Wisconsin (Madison)
Group Health of the Puget Sound
Health Insurance Plan of Greater New York

APPENDIX C

For More Information on Health Care Cooperatives

National Rural Health Network
1800 Massachusetts Avenue, N.W.
Washington, DC 20036
Contact: Jane Mayfield, executive director
(202) 857-4869

Agricultural Cooperative Service
U.S. Department of Agriculture
P.O. Box 96576
Washington, DC 20090-6576
(202) 245-5356

National Cooperative Bank Development Corporation
1630 Connecticut Avenue, N.W.
Suite 201
Washington, DC 20009
Contact: Margaret Cheap, president
(202) 745-4670

National Cooperative Business Association (trade group)
1401 New York Avenue, N.W.
Suite 1100
Washington, DC 20005
(202) 638-6222

Group Health of the Puget Sound (a cooperative HMO)
521 Wall Street
Seattle, WA 98121
(206) 448-6135
Contact: GHC Public Relations

Montana project:
Mr. James Eskridge
Sun River Electric Cooperative
P.O. Box 2717
Fairfield, MT 59436
(406) 467-2526

Morehouse project:
Dr. Leonard Jack, Jr.
Health Promotion Resource Center
Morehouse School of Medicine
720 Westview Drive
Atlanta, GA 30310-1495
(404) 752-1500

Eau Claire cooperative:
Mr. Claire W. Johnson
Executive Director
1030 Regis Court
Eau Claire, WI 54701
(715) 847-8552