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SEOUL SOCIAL ECONOMY CENTER

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INNOVATION AND KNOWLEDGE TRANSFER ON THE SOCIAL AND SOLIDARITY ECONOMY

The Experience of Health Cooperatives and Social Economy Enterprises in Québec's Health Sector:

THE ENGAGEMENT OF CITIZENS AND WORKERS IN THE GOVERNANCE AND MANAGEMENT OF HEALTHCARE SERVICES

Prospects for Collaboration and Knowledge Transfer between the Republic of Korea and Québec

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INTRODUCTION

This report was commissioned by the Social Economy Center (SEC) of Seoul. Its main objective is to give the international reader an overview of the experience of health cooperatives in Québec, particularly over the last 25 years. Among other things, it underscores innovations generated by the social economy to realize the delivery of quality healthcare services responding to some major challenges, notably healthcare access in remote areas and the supply of services to vulnerable populations, for example, people living with Hepatitis C or AIDS.

The social economy plays a significant role in the health and social services sector internationally. To varying degrees, most countries with public healthcare systems or hybrid systems have social economy enterprises that partner with the State in the provision of healthcare services or financial mechanisms. That indeed has been the case in the United States since the inauguration of the Affordable Care Act ("Obamacare") in 2010, whose implementation was accompanied by recognition of the role of healthcare mutual funds in the American healthcare system. Due to its collective ownership and dedication to community, the social economy is particularly well-suited to inducing the participation of all stakeholders, while mediating sometimes divergent interests, respecting State priorities, and achieving the common good. The "relational" and community-based aspect of social economy enterprises is also particularly well-suited to the health sector.

Québec today spends more than 11%[1]: of its GDP on healthcare, one of the highest levels in Canada and among OECD countries.(Korea is currently about 7%.) If nothing is done, this share of GDP will continue to increase exponentially. The studies that underscore the importance of greater investment in health promotion, disease prevention, and acting on the determinants of health are now beyond counting. Nevertheless, one reform after another, Québec's healthcare system grows more and more centralized and its citizens gradually are getting turfed out of forums where they once had a voice. Investments in disease prevention and health promotion are often deferred in favour of investments in technical facilities, specialists' salaries, and pharmaceutical products, all three of which capture an ever-larger share of the healthcare budget. In the meantime, the role of the average citizen in the organization and management of healthcare is generally confined to that of taxpayer and consumer. We are in the midst of a power struggle between a curative approach – biomedical, hyper-specialized, and driven by corporate interests – and a holistic, better yet "ecosystemic" approach, which while recognizing the necessity for an effective curative system, prioritizes action on the determinants of health in order to reverse certain trends. On another level, since they go forward at the scale of local clinics, health cooperatives are diametrically opposed to the hospital-centric model.

1 Institut de la statistique du Québec, 2017

This state of affairs is nothing new. Over the course of its evolution, Québec's public healthcare system has been characterized by a persistent tension between the private interests of certain medical societies (general practitioners and specialists, pharmacists, etc.) and the interests of the public (both as patients and as taxpaying citizens). In Québec, the health cooperative movement has been built one co-op at a time. One common factor has energized many of these projects: the sense that ordinary citizens, communities, and certain medical professionals (notably specialized nurse practitioners and certain physicians) have been sidelined from the decision-making process to the benefit of a political and medical elite that looks after its own interests first, and sometimes at the expense of solutions that nonetheless are working fine elsewhere. For many of these actors, health cooperatives have been a way to forge democratic institutions that enable an alternative development of the healthcare system. They recognize how essential health is to the harmonious and sustainable development of neighbourhoods, towns, and regions and consider it natural and essential for average citizens to have a place at the decision-making table, as they do in other matters. This capacity to act is especially important in communities whose access to the healthcare network (geographic or administrative) is more difficult, or such as find themselves gripped by problems to which the system responds badly (at-risk populations, mental health, significant numbers of newcomers, etc.).

First of all, this report explains the workings of Canada's and Québec's healthcare system. The authors then present seven case studies of organizations, the majority of which go beyond the purely curative model and attempt (sometimes by their own means, sometimes in partnership with the State) to steer the healthcare system towards a more holistic approach, one that makes room for more disease prevention and health promotion, for a greater role for nursing professionals, and for participation by members of the general public.

As with global warming, the challenges facing our healthcare system enjoin us to fundamental change. We hope that this report lays the foundations for discussion, dialogue, and collaboration between the actors in our respective networks so as mutually to inspire us and ensure that the social economy and civil society can play their role in the transformation of our healthcare system.

ABBREVIATIONS

AMP: Activités médicales particulières [Special Medical Activities]

CDR: Coopérative de développement régional [Regional Development Cooperative]

CH: Centre hospitalier [Hospital Centre]

CHSLD: Centre d'hébergement de soins de santé longue durée [Residential and Long-Term Care Centre]

CLD: Centre local de développement [Local Development Centre]

CLSC: Centre local de services communautaires [Local Community Service Centre]

CQCM: Conseil québécois de la coopération et de la mutualité [Québec Council of Cooperation and Mutuality]

CSSS: Centre de santé et de services sociaux [Health and Social Services Centre]

DRMG: Département régional de médecine générale [Regional Department of General Medicine]

ETP: Équivalent temps plein [Full-Time Equivalent]

EESAD: Entreprises d'économie sociale en aide domestique [Social Economy Domestic Help Providers]

FCSDSQ: Fédération des coopératives de services à domicile et de santé du Québec [Québec Federation of Homecare and Health Service Cooperatives]

FIQ: Fédération interprofessionnelle de la santé du Québec [Québec Interprofessional Health Federation]

GMF: Groupe de médecine de famille [Family Medicine Group]

KHWSCA: Korea Health Welfare Social Co-operatives Association

MRC: Municipalité régionale de comté [Regional County Municipality]

MSSS: Ministère de la Santé et des Services sociaux [Ministry of Health and Social Services]

PREM: Plans régionaux d'effectifs médicaux [Regional Medical Manpower Plans]

RAMQ: Régie de l'assurance maladie du Québec [Québec Health Insurance Plan]

RISQ: Réseau d'investissement social du Québec [Québec Social Investment Network]

SADC: Société d'aide au développement de la collectivité Community Futures Development Corporation

Unless otherwise indicated, the Canadian dollar is the unit of currency in this document.

CHAPTER 1

Context

THE CANADIAN HEALTH SYSTEM

Canada adopted a universal system of health insurance in 1957[2], one inspired in large part by the British model named after its designer, Lord Beveridge. Essentially, the system is financed by public funds that are used to reimburse costs generated by public institutions and private businesses (for-profit and non-profit) working under contract with the State and physicians. As a country comprised of ten provinces and three territories (with a total population of 36.7 million in 2017), Canada thus has 13 health systems, each financed by one of these jurisdictions and by a federal government subsidy.

These systems provide "medically necessary" services, principally hospital and medical services such as those specified in the *Canada Health Act*.[3] It stipulates that all residents of Canada, without distinction as to race, belief, gender, social-economic status, place of residence, or other attribute, have the right to receive insured health services free of charge at the point of service.

Furthermore, the funding, administration, delivery models, and range of public health services vary between each province and territory. In recent years, numerous steps have been taken to enhance the control of First Nations (indigenous peoples) over their local and regional health systems, most strikingly the creation of Nunavut in 1999, an immense territory whose political and administrative affairs – including health – are controlled by the Inuit[4].

Taxation at the provincial, territorial, and federal levels is the principle source of healthcare funding in Canada. wThe public portion is approximately 70% of total expenditures, the balance being divided between fees paid by service users[5] and by supplementary private health insurance, some of which is provided by cooperatives and mutuals, like Desjardins and The Co-operators. The remaining expenditures are covered by social insurance funds, primarily through worker benefits and charitable donations.

In regard to magnitude, 2016 health expenditures in Canada are estimated to have been $228 billion, that being 11.1% of GDP or $6,299 per person.[6]

General practitioners (family doctors) are the gateway to the health system, although very recently nurse practitioner clinics have begun to provide this entry point as well, if at a small scale[7]. The majority of doctors are self-employed[8] and paid fees for service, while a minority are employees, for example,

2 Under the Hospital Insurance and Diagnostic Services Act, which received royal assent May 1 of that year, the federal government committed to assume 50% of the costs of provincial and territorial hospital insurance plans. The Act came into force July 1, 1958. https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/health-care-system/canada.html.

3 https://laws-lois.justice.gc.ca/eng/acts/c-6/

4 https://www.gov.nu.ca/programs/health

5 For a private ward in a hospital, for example.

6 https://secure.cihi.ca/free_products/NHEX-Trends-Narrative-Report_2016_EN.pdf

7 As exemplified by the Solidarity Cooperative SABSA, see p. 26.

8 In accordance with very strict regulations negotiated between doctors associations and provincial or territorial authorities.

of community health centres (some of which are health cooperatives and community clinics). A very small percentage of practices are totally private, operating outside the system of fee-for-service reimbursement or salaried employment[9].

Hospitals provide nearly all emergency care, secondary and tertiary, including most medical specialties and surgical services. Primary care is provided by clinics in the public network or those owned by doctors, pharmacies, or community-based and social economy organizations, including cooperatives. Across Canada, both public and private (for-profit and non-profit) organizations operate long-term care centres, seniors' residences, and similar facilities

Upon consideration of the issues facing Canada's health systems (given the variation that each provincial and territorial system may entail), a few outstanding features emerge:

- The increasing cost of care, especially with respect to medication
- Long waiting times
- The sector's labour shortage

Since it is known and documented how service consumption increases with age, an aging population puts still more pressure on these systems. That means that in certain provinces health expenditures are approaching the symbolic threshold of 50% of total public expenditures.

As a consequence there is pressure to make the health system more efficient. In 2016, the Canadian Institute for Health Information identified five priority areas in this regard[10]:

- Performance monitoring for accountability and decision-making
- System-level integration in healthcare governance and delivery
- Partnerships outside the health sector to improve population health
- Physician engagement and remuneration
- Flexible funding

9 In 2016, somewhat more than 360 of Québec's doctors (of a total of about 23,000) were estimated to have this status, or around 1.5%. https://www.journaldemontreal.com/2016/04/08/le-nombre-domnipraticiens-qui-choisissent-le-prive-continue-daugmenter

10 https://secure.cihi.ca/free_products/improving_health_system_efficiency_en.pdf

RECENT DEVELOPMENTS IN QUÉBEC'S HEALTH SYSTEM

Québec is the only francophone province in Canada and its most extensive in terms of land mass. In 2017 the population numbered close to 8.4 million. The current health and social service system was established in 1971 following the passage of the first *Act Respecting Health Services and Social Services* in Québec's National Assembly. Québec's system is public, the State acting as the primary insurer and administrator[11].In 2018-19, expenditures in the realm of health amounted to $38.5 billion, of which 19.9% represented compensation of physicians, both general practitioners and specialists[12].

Since the passage of the Act in 1971, numerous reforms have steadily transformed Québec's health system. The most recent, in 2015, led to the establishment of large institutions integrating multiple missions:

> These institutions are known either as integrated health and social services centres [CISSS] or integrated university health and social services centres [CIUSSS]. Integrated centres located in health regions where a university offers a complete undergraduate medical program or operates a centre that is designated as a university institute in the social field are called integrated university health and social services centres[13].

By 2017, there were 22 integrated centres, including nine integrated university health and social services centres. The primary missions integrated within these institutions are as follows:

> The mission of the **local community service centre**[14] (CLSC) is to provide the population of its area with common, primary health and social services, as well as preventive, curative, rehabilitative and/or reinsertion services and to carry out public health activities.
>
> The mission of the **hospital centre** (CH) is to provide diagnostic services, as well as general and specialized medical care. There are two categories of hospital centre:
>
> • general and specialized hospital centres
>
> • psychiatric care hospital centres

11 http://publications.msss.gouv.qc.ca/msss/fichiers/2017/17-731-01WF.pdf

12 www.budget.finances.gouv.qc.ca/budget/2018-2019/fr/documents/Sante_1819.pdf

13 http://publications.msss.gouv.qc.ca/msss/fichiers/2017/17-731-01WA.pdf. The citations on the page following also derive from this source.

14 This phrase and others have been bolded to make each mission readily identifiable.

The mission of the r**esidential and long-term care centre** (CHSLD) is to provide temporary or permanent lodging, assistance, support and monitoring, as well as psychosocial, nursing, pharmaceutical, medical and rehabilitation services to adults who, because of their loss of functional and/or psychosocial autonomy, are no longer able to remain in their normal living environments.

The mission of the **child and youth protection centre** (CPEJ) is to provide psychosocial services (including emergency social services) to youth who need them in situations defined by the Youth Protection Act (CQLR, chapter P-34.1) and the Youth Criminal Justice Act (SC 2002, chapter1).

The mission of the **rehabilitation centre** (CR) is to provide adaptation and/or rehabilitation and social integration services to individuals that require them due to physical or intellectual disabilities, behavioural, psychosocial or family problems, dependency on alcohol, drug or gambling issues, as well as any other form of dependency.

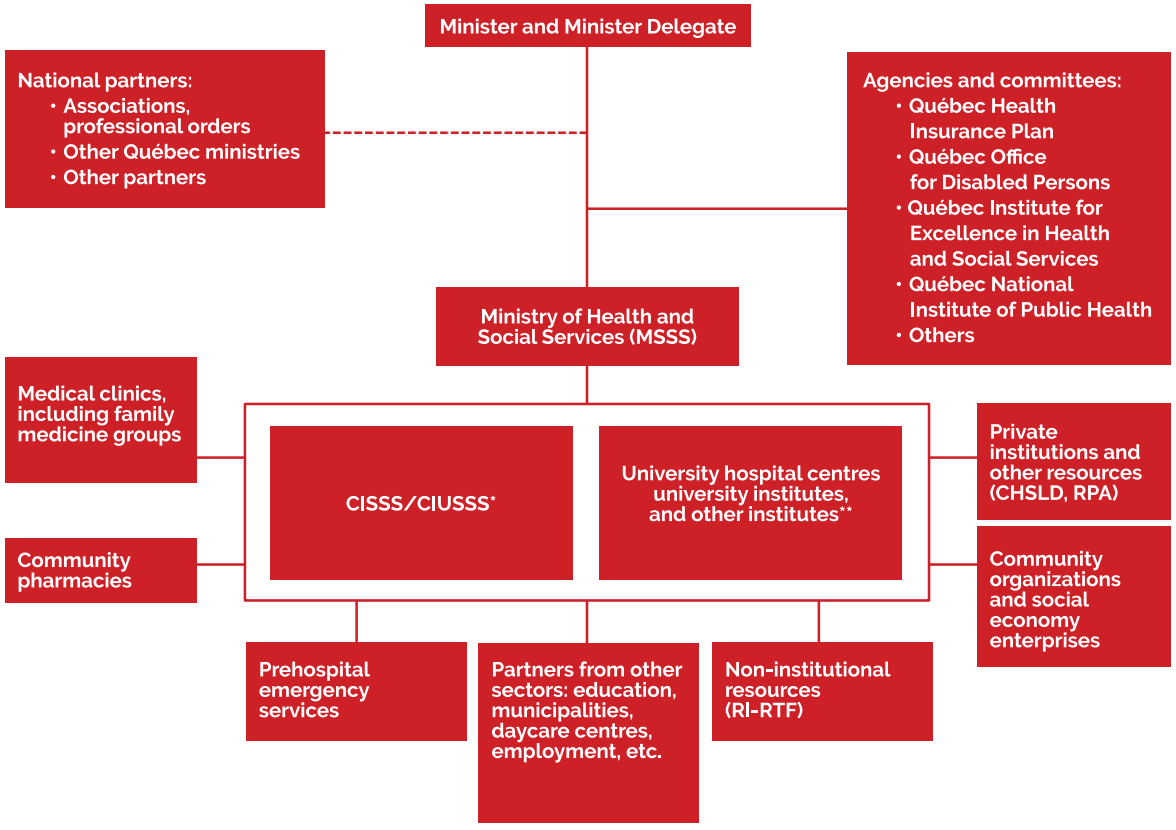

Figure 1 – Structure of the Health and Social Services System

Complementing the supply of healthcare services is a network of clinics, some belonging to pharmacies, others to physicians or even (through health cooperatives) to citizens. They may number a 1,000 more, the majority concentrated in urban areas. Since 2002, the Ministry of Health and Social Services (MSSS) has launched a voluntary program encouraging physicians within any given area to organize as Family Medicine Groups (GMF) in order to provide care population-wide. In exchange for additional resources, like a nurse and computer system, a dozen doctors will combine as a GMF and provide extended access to the residents of a municipality or suburb, like service access on evenings and weekends in addition to regular office hours. People are invited to register with the GMF, which may be located in any of the aforementioned types of clinic, including a health cooperative.

Finally, marginal to these clinics are what the MSSS terms "super-clinic networks." Here is a brief summary of their function[15]:

In conjunction with GMF service provision and in order to respond quickly to the needs of unregistered patients, or those of registered patients unable to see their own family doctor, the Family Medicine Group Network Program is designed to increase service provision to all clients, registered or unregistered. GMFs qualifying for the designation as networks, or super-clinics, receive additional funding and professional support to strengthen the safety net and keep emergency services as a last resort. Two goals are fundamental to the network designation:

- To facilitate, in conjunction with GMF services, access to primary services for all clients and thereby prevent simple urgent and semi-urgent cases from going to emergency departments.
- To ensure access to integrated outpatient services regarding specimen collection, medical imaging, and specialized consultation.

15 http://www.msss.gouv.qc.ca/professionnels/soins-et-services/groupes-de-medecine-de-famille-gmf-et-super-cliniques-gmf-reseau/

THE EMERGENCE AND DEVELOPMENT OF HEALTH COOPERATIVES IN QUÉBEC: BACKGROUND

In 1944, during the era of private medicine and before the establishment of Québec's public health system, a health cooperative was established in Québec City expressly to make health services accessible to persons unable to afford medical fees. It was called the Coopérative de santé de Québec [Québec Health Cooperative], and for Dr. Jacques Tremblay, its main proponent, four major principles were paramount[16]:

- *Team-based medical practice*, which delivers the best care to patients by bringing together a group of specialists, thereby saving time and energy.
- *Preventive medicine*, which seeks to preserve health (rather than treat avoidable diseases at great expense) and emphasizes prevention (rather than costly treatments).
- *Periodic payment* by all members (the healthy and the sick) of an equal contribution towards the total cost of medical care. This guarantees appropriate care to each member while freeing doctors of the worry of unpaid bills and fee collection.
- *Democratic control* applies to how the cooperative is managed, but certainly not to the diagnostic and treatment methods selected or prescribed by doctors. Healthcare consumers may choose among the doctors working in the cooperative, just as they would among private practitioners.

With the growth of the welfare state in the 1960s and 1970s, this cooperative was converted into a mutual insurance company. It is now known as Assurance SSQ[17].

As urbanization accelerated in the 1960s, and after years of domination of education, health, and many other aspects of society by the Catholic Church, an idea began to take root. Coaxed along by social activists, the idea was for local people to take charge of social issues, including health. As one champion of these organizations succinctly observed[18], people wanted radical change in the way health was addressed:

Unveil a new vision of health, a new model of healthcare delivery, a new configuration of relationships between people, professionals, and managers.

16 Girard, Jean-Pierre (2006) *Notre système de santé, autrement*, Montréal, BLG, p. 43

17 https://ssq.ca/fr

18 www.dabordsolidaires.ca/impression.php3?id_article=93

Subsumed within this critique of the hospital-centric model or "bio-medical" approach was the idea of social determinants of health, like work, living conditions, social networks, etc.

With added inspiration from the so-called "free clinics" (a movement of about 200 clinics in the United States initially targeting drug-involved youth) citizen activists set up people's clinics. They were helped by young medical graduates who likewise were inspired by this approach to social medicine. Nearly a dozen such clinics were established, principally in Montréal.

In the meantime, in the late 1960s a commission of public inquiry into health services tabled a report recommending the establishment of a network of public clinics that would promote the participation of average citizens, the Centres locaux de services communautaires (CLSCs) [Local Community Service Centres]. In the years to follow, this network would develop in part through the absorption of the people's clinics, which offered a suitable basis for the change sought after. Unfortunately, subject as they were to State regulation, both central and administrative, the CLSCs in time would lose touch with communities and with engaging average citizens in governance. These features literally vanished! In 2018, all that remained of that original aspiration was the name, representing one mission among many in a vast structure (CISSSs and CIUSSSs).

Only one of the original clinics opposed absorption and fought to preserve its independence, the Point-Saint-Charles Community Clinic, located in a working-class neighbourhood in southwest Montréal.

Through decades of relentless advocacy to maintain State funding for its mission, this clinic would manage to preserve its original features to the present day[19].

The current health cooperative model in Québec traces its roots back to 1995 and Saint-Étienne-des-Grès, a little municipality about 140 kilometres northeast of Montréal, which was left hanging by the retirement of its resident medical practitioner. They explored some alternatives, but none proved workable. The State refused to open a point of service for the regional CLSC in town; physicians refused to open a clinic there.

It was then that the manager of the local branch of the Desjardins credit union proposed that the residents organize a cooperative that itself would undertake the construction of a building. The cooperative would offer office space in the building to physicians and other health professionals and generate revenue from the rent.

Between the original concept and the cooperative's grand opening, the project consumed more than 2,000 volunteer hours, of which a large proportion were donated by staff and administrators of the local credit union. In addition, the Desjardins Movement supported the project with financial donations and the municipality contributed significantly with landscaping, a long-term lease, and a deferment of municipal taxes[20]. On top of all that, residents subscribed more than $125,000 in shares to capitalize the cooperative initially. Yet barring the leadership role played by the credit union manager, coupled with his credibility and expertise, the project would never have seen the light of day. Public health authorities were at best indifferent, if not hostile to this citizens' initiative, the first of its kind in Québec.

And so began Les Grès Health Cooperative in 1995. Here is how the project looked then and how it has evolved since[21]:

> *At first there were just two doctors, but soon they numbered three, then four, then six, and finally 12. All were family doctors who also practiced part-time at the hospital (either in emergency or in patient care on the floors above). The medical clinic was located in a building that belonged to Les Grès Health Cooperative. Within its walls were a pharmacy, a dentist, an optometrist, psychologists, a physiotherapist specialized in global postural rehabilitation, and osteopaths.*

19 See details below, p. 37

20 Since then the building's floorspace has been doubled and the municipality again leant its support, by locating the town library there.

21 http://www.cliniquemedicalelesgres.ca/equipe/historique/

Since then this model has spread across Québec, generating a lively interest in places subject to the same issues as Saint-Étienne-des-Grès: the lack of medical resources or inadequate service. This dissemination of Saint-Étienne's experience has benefitted from a variety of networks, including those of Desjardins Credit Union, municipalities, and regional development cooperatives (CDRs)[22]. Nevertheless, the proponents of multiple projects, confronted by a shortage of medical personnel, soon had to redouble their creativity in order to attract doctors. Failure to do so meant that a number of projects never got off the ground. Others incorporated, but had to close after spending several fruitless years in doctor recruitment. With time, a second business model was devised, involving physicians in private practice who want to sell their clinic to a cooperative in the interests of sustainability.

Meanwhile, many projects had been contending with a financial structure that could not support organizational viability, the anticipated rents having failed to cover costs. In these instances, contributions were sought from partners, sometimes the municipality or local credit union, or from local development agencies, like Québec's local development centres (CLDs)[23] or regional county municipalities (MRCs)[24]. Notwithstanding these contributions, revenue streams proved insufficient and the financial participation of members was required. Thus, in addition to purchasing a qualifying share, the latter were called upon to make an annual contribution, varying between $30 and $90, depending on the cooperative. It must be said that in every case the imposition went forward, so every individual would have access to medical services. To have done otherwise would have been deemed in contravention of universal accessibility, one of the five principles of the Canada Health Act.

In 2008 the Robert-Cliche Solidarity Health Cooperative was incorporated (see p. 19 of this report), the first such cooperative to be implemented at the level of an MRC. This defused the tensions that sometimes ensue between neighbouring municipalities that each want to house a health cooperative.

2011 brought the establishment of a very different model – SABSA, a cooperative comprised of nurse practitioners. (See p. 26 of this report.)

Finally, came the incorporation of a federation of health cooperatives in the 2000s.

In summary, in the last 23 years, beginning with the incorporation of the first health cooperative in 1995, the health cooperative model in Québec has met with many advances and adjustments, as well as the occasional reverse. In that vein, at least three health cooperatives in the Outaouais region have had to shut down for lack of doctors. The case of the Aylmer health cooperative is instructive. It was incorporated through the conversion of an existing clinic into a cooperative – the first of its kind in Québec. After 11 years of operation, there was a wholesale exodus of its doctors to another clinic. The day following, members were left with an empty building and had to close down.

Or again, there was the University of Sherbrooke health cooperative, incorporated in 2007. The goal of this highly original project was to promote healthy lifestyles in the university community: students, staff, and professors. It ceased operations a few years later due to an absence of tangible local support and adequate funding.

22 These coopératives de développement régional are funded by the Québec government and support the development of new cooperatives.

23 Centres locaux de développement were entities funded by the government of Québec and abolished in 2015.

24 Municipalités régionales de comté are associations of municipalities in a given region, with a budget allowance.

CHAPTER 2

Case Studies

THE CASE STUDIES, IN BRIEF

The following cases are among the most inspiring in Québec.

- **Robert-Cliche Solidarity Health Cooperative:** Launched in 2008 to forestall an expected shortage of general practitioners in the Robert-Cliche MRC, from the start this cooperative captured the energy and imagination of local stakeholders, the CLD and Desjardin Credit Union. Over its brief history popular interest in membership has never slackened. Moreover, it has woven a powerful collaborative web with public health authorities and become a magnet for general practitioners across the county as well as those practicing further afield. It is one of the first in Québec with a mandate to manage a GMF service agreement.
- **Contrecœur Solidarity Health Cooperative:** Incorporated in 2002 with the support of the leading local stakeholders – municipality, Desjardins Credit Union, and CLD – what sets this cooperative apart is the variety of health professionals to which it offers people access. It too has a mandate to manage a GMF service agreement, but distinguished itself in recent years under the name "Reversa." This clinic takes an educational approach, bringing together a nutritionist, nurse, and kinesiologist to "stamp out" the Type B diabetes epidemic that is affecting people not just locally but across Québec.
- **SABSA Solidarity Cooperative:** The first of two nurse practitioner cooperatives in Québec, SABSA was launched in Québec City in 2011. Despite the indifference of public authorities, this cooperative is noteworthy for the demonstrable impact it is having on at-risk populations suffering from hepatitis C or AIDS.
- **Basse-Lièvre Health Co-op:** This urban cooperative clinic arose when a group of residents and doctors purchased an existing clinic. Numbering 23 doctors, 3 nurses, and 14 employees, Basse-Lièvre and another health cooperative with a similar focus are members of a GMF with four points of service.
- **Nord de la Petite Nation Health Cooperative:** Incorporated in 2013 in a rural area devoid of social and health services, this cooperative clinic, like SABSA, takes the nurse practitioner model as its point of departure. In 2015 the cooperative received start-up support from the Fédération interprofessionnelle en santé du Québec (FIQ) [Québec Interprofessional Health Federation).

- **Point-Saint-Charles Community Clinic:** A non-profit organization in terms of legal status, since its launch in 1968 this clinic has managed to stay true to the ideals of the "people's clinics": the practice of social medicine for and with the local population. It is the only clinic in Québec to be recognized as an independent community agency with a CLSC mandate, so its mission is eligible for funding from public authorities. There are a handful of similar clinics in other parts of Canada, among them NorWest Cooperative Community Health (Winnipeg, Manitoba) and Saskatoon Community Clinic (in Saskatchewan).
- **Royaume de Saguenay Solidarity Homecare Services Cooperative:** Unlike the other cases, this one does not concern a corporation providing healthcare services, but rather homecare services and mainly for seniors, for example, cleaning and meal preparation. It is the biggest of its kind in Canada and is outstanding for the proliferation of its contracts and productive agreements with regional health authorities.

ROBERT-CLICHE SOLIDARITY HEALTH COOPERATIVE, BEAUCEVILLE, QUÉBEC

Established in 2008, this health cooperative has several distinguishing features. It was the first in Québec to be incorporated at an intermunicipal level, with very strong local consensus. It has developed an excellent collaborative relationship with the regional health authorities. It has won over the area's general practitioners. Finally, it is a pioneer in the management of GMF service agreements.

The historical trajectory of this cooperative is highly instructive. Early in the 2000s, consultations with the population of Robert-Cliche MRC, 75 kilometres south of Québec City, made manifest the urgency of enhancing doctor recruitment. For many years, not a single physician had chosen to open a practice in the area and others were approaching retirement, an event which could have very negatively impacted local access to primary healthcare services. It was resolved to incorporate a solidarity cooperative in the health sector as a means of mobilizing people, coordinating recruitment efforts, and retaining doctors.

Unlike other cases in Québec, this cooperative was not to go forward at the local level, but at the level of the MRC – a judicious choice, for it pulled the stakeholders together while diminishing intermunicipal tension in regard to attracting medical resources. Unsurprisingly, the MRC supported the project. Its spearhead was to be the agency responsible for supporting development across the county, the Robert-Cliche CLD[25].

Vigorous engagement of members of the general public, substantial financial participation by many local agencies (including Desjardins Credit Union), and the dynamic leadership of the cooperative's leaders together achieved a stunning success. Having rapidly earned the confidence of local stakeholders, the cooperative developed service agreements with the existing doctors and regional public health authorities that yielded it management fee revenues and human resources. By multiplying its efforts, moreover, the cooperative has met the challenge of recruiting new physicians, perhaps 15 since 2008. The role of the general manager in the project's success is not to be underestimated. Significantly, this person had worked in the CLD beforehand and therefore knew the project in its infancy.

Overall, as of 2017 the cooperative was coordinating a very effective primary healthcare system in the MRC: a dozen doctors in two clinics; a dozen other employees, seconded to or employed by the cooperative in supporting roles (secretary, administrative officer, nurse, social worker); and a solid reputation across Québec as a health cooperative. On May 4, 2017, the membership breakdown was as follows:

25 http://www.cldrc.qc.ca/

4,501[26] *user-consumer members* – people who utilize the services provided by the cooperative.

11 *user-producer members* – physicians or other health professionals within the cooperative who provide professional services.

21 *supporter members* – members in good standing who provide the cooperative with financial (or other) support by sponsoring programs, or supplying equipment, facilities, services, etc.

18 *worker members* – people who work for the cooperative[27].

The cooperative's local activities are framed by what it terms "development values," namely:

Recruit and attract human resources in primary healthcare: become competitive and attractive, both at the technical level and in terms of work environment, to facilitate the recruitment of general practitioners and health professionals in Robert-Cliche MRC.

The participatory approach: a fundamental cooperative principle, prioritizing empowerment, commitment, and partnership among citizens, primary healthcare service providers, and the various workers engaged in local socio-economic development in relation to the organization of outpatient healthcare services in Robert-Cliche MRC.

Health promotion, disease prevention, and raising awareness of health and health lifestyles: all factors key to keeping people healthy.

Likewise, the cooperative prioritizes the following goals:

Active participation in the reorganization of points of service through technical modernization and utilization of information and communication technologies.

Support health professionals in the delivery of healthcare by coordinating administrative activities.

Establish conditions conducive to maximizing the work of general practitioners and other health professionals while maintaining quality workplaces and working conditions.

Engage the greatest possible number of people in the organization of outpatient healthcare services in Robert-Cliche MRC by inviting them to become members: user-members (average citizens); producer-members (health professionals), and supporter-members (businesses or organizations).

Develop a service offering adapted to the needs of the clientele, especially to help reconcile their work and family lives.

The business model of the cooperative involves the provision of primary healthcare services at two clinics through a variety of health professionals, mainly physicians. The latter receive fees for service through the public health insurance plan and pay rent to the cooperative as well as the wages of medical secretaries. Since the doctors are compensated through the public system, people pay no fee for an appointment.

No one has to become a member of the cooperative in order to see a doctor. One benefit of membership pertains to the walk-in clinic, however. A member can get notification of the approximate time of an appointment there rather than having to arrive at the door at opening time and then hang around for hours. Cooperative membership has other benefits as well:

- Discounts from participating merchants.
- Free Wi-Fi and iPad availability – members may use an access code and borrow an iPad while they wait.
- Children under 18 years of age whose family doctor practices at the cooperative have the benefit of all member privileges once one of their parents joins up. This is especially advantageous at the walk-in clinic[28].

26 An indication of just how deeply the cooperative had penetrated an MRC whose total population was 19,288, according to the 2011 Census.

27 Words have been italicized as per the cooperative's website: http://www.coopsanterc.com/fr/membres

28 http://www.coopsanterc.com/fr/adhesion

People residing outside the MRC can and do get appointments with the cooperative's physicians and other health professionals, behaviour that testifies to the high regard in which the cooperative's services are held. More broadly, there is the overall evaluation of organizational performance undertaken by the board of directors and listing the cooperative's key stakeholders, i.e., average citizens, physicians, and supporter members. Similarly, there also are accountability mechanisms, both the cooperative and physicians being legally responsible for the management of the GMF service agreement. The same applies to an agreement with an integrated university health and social services centre (CIUSSS, see p. 11) regarding staff secondments.

FINANCIALS

The financial statements for December 31, 2016 show total revenues of $538,000. The main revenue sources were as follows:

- Annual contributions (paid by members): $258,000
- Rent (paid by tenants): $99,000
- Service revenues, inclusive of ancillary fees, such as immunization, blood tests, nitrogen treatment, as well as advertising revenue: $76,000

As noted above, from its earliest days the cooperative has been the recipient of numerous contributions. Those of Desjardins Credit Union are of particular note: since operations commenced, Desjardins has disbursed to the cooperative an estimated $200,000. This support derives from the business which these very citizens do with this financial services cooperative. Desjardins maintains a budget (donations, sponsorships, a community development fund) for investment in support of local activities that are deemed a priority.

In 2016 the cost of membership was $100, $70 in refundable shares and $30 in what is deemed a "contribution." The level of the annual contribution subsequently has varied from year to year, according to the cooperative's needs as determined by the board of directors. In 2017, it was $90.

IMPACT

The cooperative has had a major impact on this area. In 2016 there were 35,000 medical appointments and 12,000 active patient files in an MRC with a total population of around 20,000. The cooperative unquestionably has lived up to the challenge posed by its main purpose: to ensure that primary healthcare services are provided with the necessary resources. This is no small accomplishment, and by stabilizing and enhancing these services, the cooperative has certainly contributed to local population retention. It is a known fact that as people age, they tend to consume more health services. This raises the issue of accessibility. The absence of suitable services (especially medical resources) may compel them to relocate to urban centres better equipped in this regard. Furthermore, clinic appointments in 2003-2007 reveal how big an issue the availability of such services can be for the working population. Workers or working households may be discouraged from settling someplace that has inadequate services or restricted hours of business. Once again it is plain that the cooperative is helping the county retain its current residents and maybe even attract new ones!

CONTRECŒUR SOLIDARITY HEALTH COOPERATIVE, CONTRECŒUR, QUÉBEC

Contrecœur Solidarity Health Cooperative is located about 60 kilometres from Montréal in the municipality of the same name, population 6,250. The biggest health cooperative in the greater Montréal area, it was incorporated in 2002 thanks to the determination of one person to enhance the delivery of primary healthcare services locally. From the first the cooperative forged a close partnership with the municipality and drew support from the local Desjardins Credit Union and from organizations that back collective entrepreneurship. All recognized the cooperative as a key project for the community. Step by step, it has evolved over the years and today delivers a range of healthcare services.

In 2016 the cooperative embarked on a new health promotion project targeting obesity in persons suffering from Type 2 diabetes and the metabolic syndrome. Under the name of Reversa Clinic[29], it has hired a consulting physician and a nurse, and also calls upon the services of a kinesiologist and a psychologist. The main idea is to tackle the eating habits of the project's participants. At the start of the program, each undergoes a comprehensive health examination. Participants then are formed into groups of 15 and hold follow-up meetings every two weeks with the nurse.

One participant's program looks like this:

- seven meetings with nurses
- two meetings with a kinesiologist
- one meeting with a psychologist

By virtue of some additional training, since June 2017 the project's physician also provides WEB based coaching.

Social media and Facebook are used for follow-up and promotion. The cost of participation is $750 per person[30], but membership in the cooperative affords a $100 discount[31].

On top of Reversa Clinic's popular program, the cooperative provides certain services directly to clients through a nurse[32]:

- Cleaning ears
- Blood pressure
- Health report cards - blood sugar and cholesterol levels, blood pressure and Body Mass Index (BMI)
- Wound care
- Counselling

29 http://www.cliniquereversa.com/

30 As of January 2019.

31 See program impacts, p. 25.

32 See http://www.coopcontrecoeur.com/nos-services

Other services are provided by health professionals who rent space from the cooperative, namely:

- A chiropractic clinic with two chiropractors.
- A clinic providing medical consultations with or without an appointment[33] In 2019, it had a total of ten doctors in two locations.
- The Optimal Health Clinic (for healthy lifestyles) is staffed by a diabetes educator, a kinesiologist, and a nutritionist.
- Two specialists in orthotics and prosthetics.
  - Group Chantal Tremblay, a team of four psychologists, including one child psychologist, one neuropsychologist, and a doctoral student. They offer the following

  1. General psychological services
  2. Services in substance abuse, gambling, and addictions
  3. Neuropsychological assessment
  4. Special assessment and follow-up services for Attention-Deficit Disorder with (ADD/H) or without hyperactivity (ADD/WO)

Furthermore, in accordance with the implementation of the Québec Health Record project of the MSSS[34], the cooperative has been digitalizing patient records for several years. As of December 2018, 75% of existing patient records had been digitalized, and the records of all new patients are digitalized once they register.

Twelve employees are involved in the administration and maintenance of the cooperative. There are 2,500 user members and three supporter members. In 2016, 5,560 patients received the services of general practitioners, and there were 14,348 appointments.

MISSION AND VISION

As indicated in the 2017 Annual Report, the cooperative's mission reads as follows:

> *It is the mission of the Contrecœur Solidarity Health Cooperative to provide accessible primary healthcare services that reflect the needs of the local community. It aims to promote participation by members of the general public in the overall enhancement of individual and collective health.*

The same document states the cooperative's goals:

- Mobilize individuals who are interested in a holistic, people-centred, and community-based approach to health.
- Provide members with a vast range of healthcare services, both conventional and alternative, through an integrated, multidisciplinary approach.
- Develop services in response to the needs of the local population by encouraging member participation in the cooperative's organization.
- Encourage member empowerment in regard to their personal health through the implementation of programs targeting disease prevention and the promotion of healthy lifestyles.
- Create quality working conditions that promote better and more effective service provision.

33 These doctors encourage patients who have not already joined to become cooperative members.

34 See https://www.quebec.ca/en/health/your-health-information/quebec-health-record/

BUISINESS MODEL

The cooperative's business model involves the management of office space in a building occupied by a variety of health professionals and the provision of services itself. Except for medical consultations and other services covered by the Québec Health Insurance Plan (RAMQ, which is part of Canada's national health insurance plan), professional services must be paid for directly by the client. Since August 2017, the cooperative has been mandated to manage a GMF service agreement, which returns to the cooperative about $80,000 in management fees annually. Like other health cooperatives with this mandate[35], the cooperative has to manage administrative staff and is reimbursed accordingly.

Practically speaking, this reduces the cooperative's costs of managing a second secretary and the rental of office space.

Approved by the Fédération des coopératives de services à domicile et de santé du Québec (FCSDSQ) [Québec Federation of Homecare and Health Service Cooperatives] and the RAMQ, this type of management agreement helps to stabilize health cooperatives' revenues and thereby resolve financial worries.

FINANCIALS

As of November 30, 2017, the cooperative's financial picture looked like this:

- Revenues: $460,000[36],
- Expenses: $436,000[37],
- Qualifying shares[38]: $320,000
- Class A preferred shares[39]: $182,000
- Negative reserves: $174,000

The reserve therefore is negative, but crucially, the cooperative's level of capitalization (a total of $502,000) gives it room to manoeuvre and avoid any liquidity crisis. Reversa's success in terms of member registrations, together with the revenues generated by the GMF service agreement, have already helped improve the cooperative's financial health. This should be sustained in the years to come. For years, a golf tournament enabled the municipality to remit the cooperative an annual sum of money ($5,000 in 2018). This funding will not recur, however, in view of the marked improvement in the cooperative's financial situation.

35 See the Robert-Cliche Health Cooperative case study, p. X.

36 The primary sources are rental revenue of $183,000 and member contributions of $148,000. Annual membership dues are currently fixed at $70, tax included.

37 The main expense item are administrative personnel salaries, $176,000.

38 Shares to qualify as a member of the cooperative. They are share certificates valued at $10 each. Each member subscribes to eight shares, for a total of $80.

39 These are held by three partners: Investissement Québec, the municipality of Contrecœur, and the CLD. The shares of the latter corporation will be reimbursed in their entirety in 2019.

IMPACTS

The impact of this primary healthcare service centre is palpable and statistically demonstrable. A comparison of the years 2014 and 2016 in the cooperative's 2016 annual report shows off what has been achieved in terms of several indicators:

INDICATOR/YEAR	2014	2016
Patients with a family doctor	3,702	5,560
Appointments with a family doctor	6,512	14,348
Patients in care	470	1,435
Walk-in patients	2,066	3,456
Patients seen by a nurse practitioner	375	721
Patients seen by a nurse for blood tests	966	1,296

Reversa's activities are meeting with great success as well. The program's first cohort commenced in February 2017 and preliminary observations suggest a drop in the medication consumption and in the weight of a many participants.

THE FUTURE

In the short term two projects are on the drawing board: organizing an international conference in Montréal in June 2019 concerning the model put forward by Reversa, and exploring the implementation of social geriatric activities in order to address the issue of aging populations.

With its resources, Contrecœur Solidarity Health Cooperative now is understood not just as local but as a regional centre of primary healthcare services. Such are its reputation and its influence, both of which have spilled out over the borders of the municipality in which the cooperative made its début.

SOURCES

Interview with the cooperative's executive director, Chantal Dubuc, December 12, 2018, in addition to an extensive exchange via email.

Website: http://www.coopcontrecoeur.com/

SABSA SOLIDARITY COOPERATIVE, QUÉBEC CITY, QUÉBEC

Established as a non-profit cooperative in 2011, SABSA (service à bas seuil d'accessibilité [low-threshold services]) set up shop in a working-class neighbourhood in Québec City to assist the vulnerable, especially people suffering from hepatitis C and HIV AIDS. The project was extremely unusual in the fact that it conferred its primary role to practitioner nurses, not traditional nurses. In 2014 and 2015 substantial financial support from the nurses union enabled the cooperative to enhance its efforts, specifically, get more accessible premises and supplement its service offering with an outpatient clinic for neighbourhood residents. In 2016, the cooperative stabilized its situation through a successful social finance campaign that raised $250,000. An intensive media campaign also garnered the cooperative recognition from the public healthcare network, which supplied funding for certain of the cooperative's activities without compromising SABSA's organizational autonomy and unconventional (i.e., decentralized and participative) approach to management. In 2017, with a team of paid staff (5) and donors (10), the cooperative conducted 3,655 consultations with a total of 1,349 patients. (For 515 of these, it was their first appointment.) SABSA's services are in conjunction – not competition – with the healthcare system. Moreover, they come free of charge. As of January 2018, the cooperative had 19 worker members, 273 user members, and 301 supporter members.

A team from the universities of Montréal and Laval commenced a longitudinal study of the cooperative in 2014. Its interim report, published in March 2017[40], affirmed that SABSA

> "constitutes a remarkably effective model of care not only in terms of accessibility, but also continuity of services. This effectiveness derives from a model of practice that combines swift, unscheduled consultations with a patient follow-up service in order to respond to patient needs in a comprehensive manner."

BUISINESS MODEL

Since 2011 SABSA has altered the focus of its operations. Here are its main strategic parameters – its mission, goals, philosophy of care, and values – as stipulated in the 2016 annual report that frames its service offering:

MISSION :

To provide outpatient healthcare services tailored to a vulnerable clientele by a multidisciplinary team.

40 Contandriopoulos D., Duhoux A., Perroux M., Lachapelle K., Laroche D. & Lardeux A. (2017, v2). Coopérative de solidarité SABSA, Descriptif de milieu. Projet de recherche ESPI. Montréal.

GOALS :

To enhance and promote access to care and to preventive or curative healthcare services.

To empower individuals with respect to their own health.

To promote the cooperative movement to our members.

PHILOSOPHY OF CARE :

SABSA Cooperative's nurses and various intermediaries provide quality services in health promotion and disease prevention as well as in primary healthcare, led by a philosophy that is both ***humanistic and pragmatic.***

The priorities and concerns expressed by individuals are what frame the starting point of ***humanistic care****. It involves guiding, counselling, supporting, and encouraging individuals and those close to them to take responsibility for their health and quality of life. It also involves encouraging them to participate in the care plan itself and treating them as full partners in the decisions that affect them.*

SABSA Cooperative also is an advocate of ***pragmatic care*** *targeting* ***harm reduction*** *and undertaken in multidisciplinary collaboration and partnership with diverse community organizations.*

The pragmatic approach involves providing (without judgment) knowledge, resources, and support to individuals who are often marginalized, especially those suffering from drug dependency. The aim is to reduce the risk of people doing injury to themselves or to others. It also is to diminish the negative repercussions of behaviours injurious to health, rather than to eliminate those behaviours. As much as pragmatic care targets harm reduction, it nevertheless does not reject the notion of abstinence.

Values

- *Respect :*
  - We receive each individual with care and courtesy, regardless of their differences and limitations.
  - We bear in mind that every individual is unique.
  - In recognition of the genuine decision-making power of every individual, their choices are respected.
  - We uphold the confidentiality and privacy of individuals in care.
- *Compassion :*
  - *We listen.*
  - *The significance that the individual attaches to lived experience is the starting point for our care.*
  - *We demonstrate openness and empathy.*
- *Faith in individual potential:*
  - *We believe that every individual has to capacity to surpass themselves.*
  - *We recognize and commend the effort, strengths, and contributions of each individual.*
- *Dedication :*
  - *We endeavour to surpass ourselves and through our actions demonstrate persistence..*
  - *We undertake with discipline and integrity the ongoing enhancement of our abilities in order to provide care effectively and safely.*
- *Empowerment :*
  - *It is our hope that each individual takes responsibility for their own health and that all members take part in the life of the community.*

It is against this backdrop of rules and principles that the cooperative presents the following service offering:

- Follow-up treatment for HCV (the hepatitis C virus) and HIV AIDS.
- Outpatient nursing clinic.
- Health education program.
- Assessment and consultation services.
- Nursing care (e.g., screening, vaccination, teaching, etc.)
- Nursing and psychosocial follow-up.
- Referrals.

Many aspects of this service offering are noteworthy; the most significant of all bar none is its humanistic approach. The client is not confronted by an impersonal organization. In addition, unlike clinics where physicians are paid fees for service, the compensation of nurses at SABSA begets no pressure to conduct more consultations per hour. Nurses take the time to listen to and talk with patients, which also reflects SABSA's commitment to integrate a psychosocial component into therapy. Some of the service provision is by volunteer nurses, who are not subject to pressure either: they give of their time by choice, not obligation.

No employer is leaning on them to pick up the pace of consultations or to confine themselves to this or that procedure, regardless of its pertinence to the patient's well-being.

The commitment to listen to patients finds expression as well on the board of directors, which includes a representative of service consumers.[41]

Ultimately, there are many "grey areas" among the cooperative's various intermediaries (paid staff, volunteers) that demand a great deal of flexibility, so people do a lot of talking. In a word, things are stimulating, if volatile!

A point of clarification in regard to the business model: in its provision of services without charge and without physicians being present, plus its acute sensitivity to vulnerable populations, SABSA was one of just two cooperatives of its kind among the health cooperatives active in Québec in 2018. The others frequently solicit members for annual contributions in addition to working with the professional delivery of physicians' services.

Finally, SABSA takes part in an annual public vaccination campaign for which, unlike nursing clinics, it receives no funding and charges no fee.

GOVERNANCE

As a solidarity cooperative, SABSA has three member categories. Its member base as of December 31, 2017 was the following:

- 19 worker members
- 273 user members
- 301 supporter members

The breakdown of member representatives on the board of directors is as follows:

- 3 worker members
- 1 supporter member
- 1 user member

41 See the following section on governance for more details.

As of December 31, 2017, the cooperative's chair was occupied by a worker member and volunteer (a nurse). The board's operational culture emphasizes consultation and participation, the polar opposite of a bureaucratic process or technocratic mindset. In the words of its coordinator, the organization runs on "good old common sense."

Besides managing emergencies like the social finance campaign, and seeking recognition from the public healthcare network, the board focuses on the cooperative's service offering.

Like other cooperatives, SABSA convenes an annual general assembly of members who jointly elect the members of the board.

FINANCIALS

The cooperative has realized prodigious growth in its revenue. In 2013, it operated with no more than $30,000 in annual revenues, whereas in 2015 and 2016, revenues were in the range of $500-$550,000. Additionally, there were contributions in the form of service worth $66,000 and $179,000 in 2015 and 2016, respectively. In 2017, revenues reached $370,000.

For 2017, contributions from private businesses generated about 21% of revenue, a fundraising campaign or donations 25%, grants 11%, conferences 2%, and contributions in the form of service 41%.

IMPACTS

The impact of this cooperative is apparent at many levels. With 3,000 registered patients, of whom 60% have no family doctor, SABSA is helping look after people often ignored by the healthcare system. More specifically, the proper monitoring of persons living with hepatitis C is an indication of the effectiveness of the model. Since gastroenterologists do not want to have to deal with unstable individuals, SABSA does, their disorganization notwithstanding. This too demonstrates the cooperative's effectiveness.

SABSA incontestably demonstrates its importance as an alternative primary care resource as well: only around 5% of cases require referral to a doctor or other health professional[42].

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The aforementioned interim report[43] has this to say in regard to interprofessional collaboration and the key role played by the nurse practitioner:

> *The provision of care depends mainly on nursing practice, but also on extensive interprofessionalism. The primary care specialized nurse practitioner (PCSNP) is the centre of gravity in the delivery of healthcare, conducting nearly 85% of consultations. Nevertheless, the clinic is very well integrated into the regional healthcare network. Many general practitioners and specialists collaborate with SABSA Solidarity Cooperative members on a regular basis.*

42 One could also argue that the many consultations conducted by primary care specialized nurse practitioners have reduced the number of people going to emergency departments and consequently realized significant economies in hospital registration costs.

43 This research should be completed in 2019.

Furthermore, in regard to integrated care, the report highlights the following contribution:

> *SABSA Solidarity Cooperative works and cares as a team on the basis of a holistic understanding of the patient who is a stakeholder in the therapeutic relationship. The service offering integrates common primary care, disease prevention services, screening, and patient education. Trust-based relationships have been established between SABSA Solidarity Cooperative professionals and those from other sectors (including general practitioners, gastroenterologists, pharmacists, and CLSC nurses) and from community organizations independent of SABSA Solidarity Cooperative, which serves to complement the supply of healthcare and increase its continuity.*

Last but not least, the report estimates that in 2015, the cooperative's work brought about "... direct savings of over $120,000 in relation to medical care not billed to Québec's social and healthcare network[44]".

This fact is likely to gain prominence during the next election campaign, when people inevitably will go looking for interesting ways to contain the costs of the healthcare system, while allowing physician compensation to capture more than 21% of the health budget[45].

What is more, the research process did not include an assessment of socio-economic costs. (Medical leaves, work absences, overcharging and over-prescribing by physicians, lack of access to care for vulnerable populations – all entail costs to the State).

In terms of the impact of this model of care on the health of individuals, in 2016 the cooperative commenced a collaborative research protocol with the pharmacy faculty at Laval University. Based on a sample of 130 individuals treated at the cooperative, the study Soigner et guérir l'hépatite C chez les individus vulnérables [Caring and Curing Hepatitis C with vulnerable individuals] describes SABSA's experience and effectiveness.

REFERENCE

Interview with Emmanuelle Lapointe December 2018, in addition to numerous exchanges via email. (She collaborated in the foundation of SABSA.)

44 This represents a minimum amount because the researchers did not have access to the RAMQ databank. There likewise were annual savings of $60,000 for the physician's supervision of the PCSNP. In addition, the cooperative paid for medical supplies and the FIQ issued it a grant – yet another source of savings for the State.

45 There is some evidence that over the decade 2004-2014 compensation of general practitioners rose by 54% while that of specialists grew by 66%: http://iris-recherche.s3.amazonaws.com/uploads/publication/file/Re_mune_ration_des_me_decins_WEB.pdf

BASSE-LIÈVRE HEALTH COOPERATIVE, GATINEAU, QUÉBEC

EMERGENCE

Located in the Buckingham area of the city of Gatineau, Basse-Lièvre Health Cooperative arose on account of a marked deterioration in local primary medical services. Historically, the area's clinics had always been very responsive to public demand in a population numbering about 23,500. As in other parts of Québec, however, measures designed to promote medical practice in hospital settings, and a general lack of support for family clinics, brought about a significant degradation in Buckingham's clinics. Unlike other places, an area in which 15,000 patients already had no family doctor experienced in 2010 the permanent closure of one of those clinics, with a net loss of five general practitioners. What few clinics remained were supported by doctors approaching retirement. As a consequence, they were not accepting new patients and understood how difficult it would be to sustain these clinics over the long term.

In the face of this dilemma, a few physicians and local residents got together to explore long-term solutions. The idea of a health cooperative came under consideration and an interim committee was set up to determine if the idea made sense, and if it did, to make it happen.

As is often the case in projects of this kind, one factor critical to success was the quality and diversity of the interim committee, which brought together many leaders from the local community and business sectors, the cooperative movement, and the health sector. The Outaouais-Laurentides Regional Development Cooperative (CDROL) was appointed to support the completion of a feasibility study to determine the best approach to implementation. In addition to identifying needs and an implementation strategy, the study was to use the data collection process to train interim committee members and raise the awareness of local stakeholders. The feasibility study went forward in three stages. At each stage, committee members received an update so they could master newly-collected data and integrate it into a process of community dialogue.

In December 2010 and January 2011, a survey was distributed to local residents for the purposes of assessing their healthcare needs and receptivity in regard to the health cooperative project. In less than ten days more than 1,100 people filled out the survey. Residents' interest in the cooperative was made clear to the interim committee – 90% of respondents expressed a desire to join a health cooperative if one was established. The need was urgent: more than 58% of respondents indicated how difficult it was for them to access health care. Nearly two in three asserted that they currently accessed care at the hospital's emergency department.

After months of community mobilization, public meetings, and consultation with local stakeholders, the feasibility study was tabled. The preferred scenario was for the cooperative to take over the Buckingham clinic, located on the second floor of a pharmacy in the centre of town.

This offered multiple advantages. The clinic was already known to the public; barring a succession strategy, it was at risk of closing within three years; it was under-utilized and had scope for expansion; finally, it was part of the Basse-Lièvre Family Medicine Group (established in 2008), which would impart continuity of care for the patients and additional institutional support for the professionals.

The purchase became official August 1, 2012. Right off the bat, the board gambled on imposing an annual $30 contribution to ensure the cooperative's sustainability and to support its development – while in the same breath declaring that it would do everything in its power to phase out the contribution and anchor the clinic's sustainability in rental revenue. The challenge was met with the cooperative's abolition of the contributions in 2016.

The cooperative grew very rapidly, to the extent that in 2014 major renovations were undertaken, adding 14 examination and minor surgery rooms, for a total of 30 spaces. No less than nine physicians were to join the cooperative in its first years. (In December 2018 the total was 23.) In addition, a nutritionist, a massage therapist, two psychologists, a social worker, a pharmacist, an audioprosthetist, and a foot orthotics service lease premises.

The cooperative has a board of nine, seven user members and two supporter members (both physicians). There are 14 paid employees who are not cooperative members.

BUSINESS MODEL

Like the vast majority of health cooperatives in Québec, Basse-Lièvre's business model involves managing office space in a building that houses a variety of health professionals. Most of its revenues stem from leases and from the secretarial service the cooperative provides to the professionals.

IMPACT OF THE GMF

Since start-up, the physicians practicing at the cooperative have been part of the Basse-Lièvre GMF. This generates a number of benefits for both the cooperative's user members and its physicians. Sharing patient care among 35 physicians at four locations benefits everyone concerned. The participation of other professionals (social workers, nurse clinicians, psychologists, occupational therapists, physiotherapists, pharmacist, etc.) gives access to expanded services that take into account the psychosocial dimension of health.

The GMF supports the implementation of programs for disease prevention, health promotion, and outreach as well as group courses on various aspects of health, such as chronic illness (diabetes and hypertension), pervasive development disorders (PDD), and the taking of hazardous drugs. Participation in the GMF also has enabled the digitalization of new patient records, older records being digitalized incrementally. The GMF itself having taken on disease prevention and health promotion services on the strength of public funding, the cooperative has not made the same commitment.

SERVICE VOLUME

Professionals	2017
23 doctors	53,000 appointments (82,000 in the GMF)
Nurse clinician	3 nurses
Nurse practitioner	None since 2016
2 psychologists	No Data
1 occupational therapist	No Data
1 psychoeducator	No Data
1 audioprosthetist (twice a month)	No Data
Staff	14 persons

	2017
Revenue	$654,363
Rental revenue	$563,000
Donations, fundraising, other revenues	$77,700
Share capital	$5,660
Membership	1,722

NORD DE LA PETITE NATION HEALTH COOPERATIVE, CHÉNÉVILLE, QUÉBEC

This is one of two neighbourhood cooperatives based on the services of nurse practitioners specialized in primary healthcare (PHCNPs)[46]. This clinical model enables healthcare to be provided a PHCNP without the presence of a physician at the cooperative. The practice of PHCNPs involves a partnership with a physician who collaborates with the PHCNP to provide advanced practice nursing in combination with certain medical activities.

The cooperative is the second institution in Québec to provide the services of a specialized nurse practitioner paid by the State and practicing in partnership with a remote care physician. The mandate was offered to the cooperative in recognition of the lack of access to primary medical services in the surrounding area. It was launched thanks to a significant commitment by local municipalities, the MRC, and the local Desjardins Credit Union, as well as support from the Québec Interprofessional Health Federation (FIQ).

EMERGENCE

The cooperative project started in autumn 2011, when residents and municipal counsellors in Nord de la Petite Nation joined forces to look for common solutions to the shortage of medical resources in that area. An interim committee was set up to examine various scenarios for a health cooperative best able to respond to local needs. The committee engaged the Outaouais-Laurentides Regional Development Cooperative to support the process and with ongoing local participation generate a feasibility study identifying a variety of possible approaches. The study was tabled in 2013.

Originally, the project drew support from nine municipalities in the northern part of Papineau MRC (today there are ten), which all wanted to rectify a common deficit in primary healthcare services. Certain features of this sub-region in combination placed enormous pressure on healthcare: an elderly population; high rates of chronic illness; low population density; plus transportation problems and a complex road network. In 2012, 29% of the population had no family doctor and to this day, no Family Medicine Group operates in the MRC. What few physicians practice there do so in isolation and are not accepting new patients. In 2014 no less than 24,000 people – many of them from this very area – travelled from Québec to Ontario to get health services. In the same year the government of Québec spent $24 million at the hospital in Hawkesbury, Ontario, paying for the services extended to Québecers.

In 2012 a survey of 230 residents confirmed that the project enjoyed significant support and identified the population's main needs. As in the vast majority

46 The other is SABSA Solidarity Cooperative.

of cooperative projects in Québec, the support of the local Desjardins Credit Union was there from the start and has been ongoing. In 2015 the cooperative established its first facilities in Chénéville, where the municipality made premises available at a reduced rate in a former convent that also housed the municipal library and the offices of an ophthalmologist.

PARTNERSHIP WITH THE QUÉBEC INTERPROFESSIONAL HEALTH FEDERATION (FIQ)

The FIQ[47], Québec's main nurses union, decided in 2014 to study the health cooperative model and weigh the possibility of developing neighbourhood cooperative clinics based on the services of specialized nurse practitioners (SNPs). FIQ's goal was to demonstrate the significant contribution that SNPs can make towards unclogging the health system while responding to the needs of the most vulnerable populations. Lise Villeneuve, President of the Nord de la Petite Nation Health Cooperative and herself a retired nurse practitioner, took part in these discussions. They were to change the course of events for the cooperative and give rise to one of two outpatient clinics supported by the FIQ. (SABSA was the other.)

So it was that in June 2015 the FIQ officially declared its support for the cooperative, in the form of an action-research project that would cover the salary of a part-time nurse practitioner. Still, despite the presence of a partner physician to provide general oversight over the SNP's work, recruitment proved a problem. The opposition of the health minister of the time to SNP-led clinics nearly brought an end to both projects. Eventually, pressure from the FIQ and the impressive results of the SABSA project enabled an agreement to be reached with the minister. Both projects could go forward and count on a share of public funding. In 2016 the cooperative then received support from the local CISSS, which hired an SNP to work one day a week over 18 months, caring for about 25 patients a day. Since January 8, 2018, one SNP (also paid by the CISSS) has been at the cooperative three days a week.

In August 2018 the cooperative expanded its premises. It now houses a specimen collection centre, an acupuncturist, a therapeutic massage therapist and osteopath, and a massage therapist-reflexologist, as well as chiropody services (since November 2017).

47 See http://www.fiqsante.qc.ca/a-propos-de-la-fiq/ : "FIQ is a trade union organization with nearly 76,000 members (nurses, practical nurses, respiratory therapists, and clinical perfusionists) working in health institutions across Québec. FIQ is a feminist organization (over 90% of members are women), committed to the defence of its members but also to that of patients and the public health system."

DIGITALIZATION OF MEDICAL RECORDS

In January 2017 a $10,000 grant from the FIQ enabled the cooperative to proceed with the digitalization of patient records. Now the SNP and referring physician can look at the same information in real time, which makes work far easier for them both. The digitalization of records also frees up vast amounts of space on cooperative premises and thereby boosts rental revenue.

SERVICE VOLUME

Professionals	March 2017-February 2018
Physician (1 day a week)	264 appointments
Specialized Nurse Practitioner (3 days a week)	850 appointments
Specimen Collection Service	433 samples
Therapeutic massage and osteopathy	293 appointments
Acupuncture	115
Massage therapy-Reflexology	88
Chiropody	15

	2017
Revenues	$36,116
Revenus de location	$16,316
Dons, collectes de fonds et autres revenus	$19,800
Capital social	$37,500
Nombre de membres	750

POINTE-SAINT-CHARLES COMMUNITY CLINIC, MONTRÉAL, QUÉBEC

While this story is unique to Québec, its like is now found in other parts of the country[48]. It concerns a clinic located in a working-class neighbourhood in southwest Montréal, Pointe-Saint-Charles, with a population a little over 13,000 (2011 census), some of whom are disadvantaged. The majority of residents are francophones but there is also a significant anglophone community of Irish and English origin.

Providing services in both these languages, the clinic has more than 140 employees and is 100% publicly funded. Governance is in the hands of average citizens, both at the level of the board of directors and at the annual general meeting. The clinic reaches more than 30% of the local population annually. In addition, it neatly balances a curative with a preventive approach to health care, while recognizing the importance of the determinants of health (housing, education, environment, etc.). These it seeks to address in concert with local community organizations.

To properly understand a case this unusual – and inspiring to advocates of citizen empowerment in regard to health – you have to fathom its historical background. According to an overview, the clinic originated in 1968 in the following way[49]:

The Pointe-Saint-Charles Community Clinic was set up by medical, nursing, and sociology students of McGill University who were concerned by the inadequacy of medical services in the neighbourhood. These students drew inspiration from the people's clinics then active in some disadvantaged neighbourhoods in the United States. According to this model of community medicine, there is a link between poverty, living conditions, and health. Neighbourhood residents quickly became integral to the project.

It was the first community clinic to be established in a working-class neighbourhood in Québec. Family medicine was practiced; local people could get medical services without charge; moreover, the clinic tackled the root causes of disease.

In addition to the medical students, the staff at that time consisted of a nurse, a part-time doctor, and a psychologist. The clinic's medical practice sought the linkage between health and social problems and made it a priority to act on their root causes.

48 Notably at NorWest Co-op Community Health in Winnipeg, Manitoba and in three clinics in Saskatchewan.

49 Website of the Pointe-Saint-Charles Community Clinic: https://ccpsc.qc.ca/fr/historique

About six years later, in 1974, the clinic fought bitterly for recognition as an **autonomous community agency with the mandate of a CLSC**. As a result, while the clinic is subsidized like a CLSC, it can retain its grassroots decision-making structure – in other words, its sovereignty and independence. As mentioned in Chapter 2 (see p. 14), its case is unique; all the other community clinics were integrated into the CLSC structure, and having assimilated its strict bureaucratic and statist logic, lost their civic base and their autonomy.

With this recognition and the accompanying funding in place, the clinic was ready to expand its service offering and through this, to strengthen its staff team with the integration of still more varied health professionals: a nurse, a special needs teacher, social workers, as well as community organizers. Why? Because choosing to address the determinants of people's health compels action that improves those determinants, like making housing available that is quality, affordable, and without bedbugs. As a result, the clinic's staff climbed in number from 30 to 90 between 1974 and 1986.

What bears emphasizing is that over the entire history of the clinic 1968-2018, its officially-recognized special status was regularly challenged by successive governments, whether Liberal or Parti Québécois. Its nonconformity was deeply resented!

In response, the clinic would regularly mobilize its local supporters and elected officials to civic action – petitions, assemblies, demonstrations – to proclaim loud and high the allegiance of the residents of Pointe-Saint-Charles to "their" clinic.

That was the case in 1977-1979 when the Parti Québécois was in power. The health minister, who at first absolutely insisted on integrating the clinic into the CLSC structure, had to beat a retreat before the marshaled forces of public indignation, saying,

> *"Given your existence prior to the implementation of the CLSC, the Ministry of Social Affairs has confirmed its intention not to assimilate you with this type of institution, rather indeed to respect the specificity of your organization."*

History repeated itself in 1990-1992, this time with a Liberal Party government. Following the passage of a bill concerning health and social services, the clinic stood to lose its unique features. The reaction was not long in coming:

> *The Clinic and neighbourhood residents mobilized to an unprecedented degree: public assemblies of 600 people or better; a petition signed by nearly half the neighbourhood's adult population and brought to Québec City by a local delegation supported by municipal elected officials; testimony before the parliamentary commission; street theatre; demonstrations in front of the offices of the Regional Health Authority and the Ministry of Health and Social Services, etc."*

Once again, the minister had to recoil before the popular uproar and maintain the unique status of the clinic within Québec's constellation of health institutions. To be sure, henceforth the clinic was to be funded by the Regional Health and Social Services Agency in Montréal and not directly by the Ministry. But this was to have little real impact on its operations apart from having new administrative contacts and regulations to deal with.

Yet again, nothing was set in stone. In 2005, the Agency re-opened the funding agreement. It took two years of hard bargaining to preserve the clinic's funding.

Specifically, it was agreed that the clinic was to:

- *keep its alternative status as an autonomous community agency with the mandate of an CLSC and within the framework of Québec's health system;*
- *continue to receive such budgets as are provided to the CSSS[50] for the CLSC mission, and to receive such budgets as are provided to the CSSS for the development of service agreements with neighbourhood community groups;*
- *receive all the data necessary for participation in working committees of the Agency or the CSSS pertinent to our CLSC mission;*
- *develop a partnership agreement with the CSSS to assure our population access to services that the Clinic does not offer (for example, secondary health services).*

In short, unlike other CLSCs, which at that time were funded by the CSSS, this agreement stipulated that the clinic was to continue to receive funding directly from the Regional Health and Social Services Agency.

In 2014, a new reform of Québec's health system upended the existing structures and fused them into megastructures, the CISSS and CIUSSS. (See p. 11.) Good news for the clinic – nothing indicates that its annual management agreement and service funding will again be called into question. Evidently, a lesson has been learned from the many past battles fought by this organization to defend and maintain its status.

THE CLINIC IN 2018

Imbued with its 50-year struggle for survival, as well as a unique civic identity and the dedication of 140 staff, the clinic defines its mission, mandate, and values as follows[51]:

OUR MISSION

The Pointe-Saint-Charles Community Clinic is a health agency controlled by the women and men of this community. Its goal is to offer preventive and curative services and with community members organize around health issues to improve the quality of health for everyone in the short and long term.

OUR MANDATE

The Community Clinic has the status of a community agency (a private agency operating under agreements with the Ministry of Health), but the mandate of a CLSC, as defined by the Health and Social Services Act. Local citizens are the ones who determine the Clinic's direction and services and ensure that it addresses the neighbourhood's health and social service needs. The participation of community members in the clinic's management is an expression of the vision of the local population and the values that they champion. Fundamental to these perspectives is one central conviction: that ***health is an essential and non-negotiable social right.***

OUR VALUES

Every effort is made at the Clinic to ensure that the values, dignity, and independence of each person are respected. It is in a spirit of mutual respect that community members as well as staff collaborate to address people's expressed needs as effectively as possible. It is when we listen to people that we realize that those who are directly affected are also the ones best-equipped to describe the services they need. Accordingly, the Clinic emphasizes education and taking charge of one's personal and collective problems from the perspective of community empowerment and solidarity. The Clinic therefore also strives to demystify professional power, and bring about a sharing of power and knowledge between health workers and local residents. This approach enables average citizens to regain control of their own health.

50 The Centres de santé et services sociaux (CSSS) [Health and Social Service Centres] functioned in Québec from 2004 to 2015. These were state structures responsible for a cluster of missions regarding health. (See the discussion of Québec's health system, p. 11.)

51 The words underlined or in bold have been taken directly from the clinic's webpage: https://ccpsc.qc.ca/fr/qui-sommes-nous.

These guidelines manifest daily through three overarching strategies that once again set this clinic completely apart from traditional ones:

A holistic approach to the individual and to health

> *The Community Clinic has adopted the definition of health proposed by the World Health Organization, that is, "a state of complete physical, mental and social well-being" on behalf of which the Clinic assumes a duty to intervene. In this respect the Clinic works not only for consumers, but also for their social networks and with community resources in order to raise the health standards of the entire population.*
>
> *In this manner the Clinic has always taken a holistic approach to health, blending the social and the medical. No one who visits the Clinic is "locked into" a specific program after a medical or social diagnosis. Instead, each is viewed as an individual in his or her own right, who may have different needs. So, someone who wants to ask a doctor about a sore back may be guided towards other services as well, to address other needs that have become apparent....*

Disease prevention and health promotion

> *The Clinic has chosen to anticipate health and social problems by engaging in disease prevention and health promotion. In fact, both feature prominently in the work of the clinic's various teams, for example: delivering workshops on menopause or breast cancer detection at the women's centre; organizing diabetes screening days in seniors' high rises; designing youth projects to prevent substance abuse; organizing in-school workshops to reduce adolescent pregnancy, etc.*
>
> *Disease prevention and health promotion are what make it possible to prevent the formation of neighbourhood street gangs and alleviate social isolation or psychological distress, phenomena far less prevalent in Pointe-Saint-Charles than in other disadvantaged areas....*

Taking action on the determinants of health

> *As do policies at the national and international levels, the Clinic identifies living standards in general and socio-economic standards in particular as among the principal determinants of health. That is why it mobilizes people to fight poverty. A hotbed of neighbourhood mobilization, the Clinic always has exercised its responsibility to act in the name of justice for social change and to defend the economic and social rights of the local population.*
>
> *Over the years, neighbourhood community groups and the Clinic have struggled time and again to sway policies that were impacting local people. Improving living standards was the goal; action on the determinants of health was the means....*

SERVICE PROVISION

The clinic provides a vast array of services, running from basic consultation services of the walk-in type for everyone, to specialized services for a specific group of clients, like programs for pregnant women, for schoolchildren, and for seniors in need of home support (occupational therapy, caregiver respite, nursing care, etc.).

Lastly, the clinic is a unique hub of information and resources that enable community members to find the support appropriate their needs.

ROYAUME DU SAGUENAY SOLIDARITY HOMECARE SERVICES COOPERATIVE, SAGUENAY, QUÉBEC

Since 1997 a network of about 100 entreprises d'économie sociale en aide domestique (EESADs) [Social Economy Domestic Help Providers] has been active in Québec, mainly to enable seniors to remain longer in their homes or apartments. The alternative – moving to a seniors residence – has repercussions in terms of alienation, homesickness, and the loss of social ties. Some EESADs are non-profit organizations and some are cooperatives. Most of the latter assume the form of a solidarity cooperative, usually with three member categories: user members, worker members, and supporter members.

Most EESADs specialize in aides à la vie domestique (AVDs) [help with domestic life], meaning housekeeping, meal preparation, big cleaning jobs, and helping people with errands. Very few EESADs are taking an more entrepreneurial approach by trying to expand their service offering beyond established markets and clients (range of services, locations, partners) and provide aides à la vie quotidienne (AVQs) [help with daily life]: make-up, washing, dressing, food, toileting, moving around, etc.

The Royaume du Saguenay Solidarity Homecare Services Cooperative (CSSDRS) is just such a case. It is located in Saguenay, a municipality of 145,000 people about 450 kilometres from Montréal. By multiplying its service agreements with various public agencies, the cooperative is going to vastly increase its service offering, adding a line of AVQs to its existing AVDs and thereby becoming the most significant organization of this kind not just in Québec, but across Canada. Launched in 2009 through the merger of two agencies that had been evolving in adjacent boroughs, the CSSDRS gave employment to more than 235 people and became a significant employer in the region of Saguenay-Lac-Saint-Jean. It has 9,700 members, is the proprietor of a 28-unit seniors residence, and provides 286,000 hours of service annually. Its executive director is involved in many other organizations and by this means has developed a vast network of contacts.

EESADs and the PEFSAD

The pronounced aging of the population gives rise to a thorny question: how is this reality to be addressed? In Québec, people are drawing guidance and inspiration from many studies that demonstrate how preferable it is (the state of a person's health permitting) to remain at home rather than move into a residence. A person can then maintain the web of social connections that has developed over the years in their immediate neighbourhood. The preferred way to accomplish this is by providing domestic assistance to relieve seniors of duties around the house and other daily tasks.

Until 1996, domestic assistance services varied dramatically from region to region. Sometimes the providers were community agencies or cooperatives, but subject to the vicissitudes of ad hoc funding or family resources (with all its inherent uncertainties). Sometimes the services were provided "under the table," without any performance or employment standards.

Things changed at a huge gathering in 1996 convened by the government of Québec and drawing stakeholders from the business world, union and feminist leaders, community agencies, and the cooperative sector. There the foundations were laid for two significant actions, to implement a strategy for structuring domestic assistance and (this was critical) track the financial circumstances of the households and persons involved in order to achieve universal access.

The strategy was subject to the following parameters, as two scholars were later to report (Vaillancourt et Jetté, 2009):

- The creation of long-term (not subsidized) employment.
- Positions were to be filled mainly by women[52].
- The approach would help to combat undeclared work.
- The target market was to be primarily seniors, and secondarily working households.
- The policy would support service provision by awarding it exclusively to social economy enterprises.
- Likewise the policy would support the demand for services with a funding program[53].
- The enterprises could be cooperatives or non-profit organizations in their legal status.

The strategy was to fall into two major streams, one to address supply and the other to address demand: respectively, the implementation of a process of EESAD accreditation, and the creation of a financial aid package for individual consumers, tailored to suit their financial circumstances, the Programme d'exonération financière pour les services d'aide-domestique (PEFSAD) [Financial Assistance Program for Domestic Help Services].

52 This echoed the demands presented in a report on the creation of quality jobs for women, "Entre l'espoir et le doute"("Between Hope and Doubt"), by the Policy and Coordinating Committee on the Social Economy (1996). The report was drafted in the wake of "Bread and Roses," the Women's March Against Poverty in June 1995.

53 This was to be the role of the PEFSAD.

EESAD ACCREDITATION

To avoid a multiplication of service providers, only one EESAD was to gain accreditation in any given district. (Originally, these districts mirrored those of the CLSCs.) This EESAD then would have the exclusive right to the PEFSAD. It was left to EESAD advocates to choose the organization's most appropriate legal "attire," whether non-profit or cooperative status. Close to 55% of the new EESADs assumed non-profit status. Of the remaining 45%, the vast majority were organized as solidarity cooperatives with three member categories: users (consumers), workers, and supporters.

Note that recognition as an EESAD did not necessary mean the creation of a new corporate entity (although this generally was the case). In certain cases, it simply involved the recognition of existing corporations. In 1996, three homecare service cooperatives of the consumer variety were already operating in Estrie, Rive-Sud (Lévis and its surrounding area), and Laval. As well, new corporations sometimes resulted from the merger of existing ones.

THE PEFSAD

The PEFSAD was and remains a unique and multi-faceted program that is basically intended to support the demand for and provision of a service. As Jetté and Vaillancourt have observed (2009: 10):

> "... since its creation in 1997 the PEFSAD has taken the form of a subsidy to service users and not to the enterprise itself, even though EESADs are the only ones permitted to provide services on the basis of this subsidy. That being said, the enterprise itself is the direct recipient of the monies following an assessment of the needs and circumstances of the service users. It all speaks to the singular nature of the PEFSAD, which supports both the demand for and the supply of services: support for demand, because the money is disbursed to recompense the delivery of homecare services to users; support for supply, because the program specifically targets social economy enterprises that have been subject to prior accreditation."

Since 1997 the PEFSAD has undergone certain adjustments. It is now described in the following terms[54]:

HOW DOES THE PROGRAM WORK?

The PEFSAD grants to program beneficiaries a reduction in the hourly rates charged by a program-accredited EESAD for the provision of homecare services. This reduction has two parts:

- First, there is a reduction of $4 for each hour of service rendered. This "fixed assistance" applies to everyone eligible for the program, irrespective of family income.
- Second, there is a supplementary reduction ranging between $1.43 and $11.44 for each hour of service rendered. This "variable assistance" is determined on the basis of a calculation that takes into account each person's income and family circumstances.

The maximum possible reduction or assistance for each hour of service rendered is $15.44 ($4 in fixed assistance and $11.44 in variable assistance). The program beneficiary only pays the difference between the EESAD's hourly rate and the financial assistance granted him or her.

54 This information was current as of December 2018: http://www.ramq.gouv.qc.ca/fr/citoyens/programmes-aide/aide-domestique/Pages/aide-domestique.aspx

WHICH HOMECARE SERVICES ARE COVERED?[55]

- Light housekeeping work: laundry, sweeping, dusting, cleaning (e.g., refrigerator, bath tub, pantry).
- Heavy housekeeping work: major cleaning jobs, clearing snow from the main entry to a residence.
- Clothing care.
- Non-diet meal preparation.
- Shopping and other errands.

Certain businesses do not necessarily offer all of the above.

Six EESADs were accredited in the Saguenay-Lac-Saint-Jean region in 1997.

According to the CSSDRS website:

> *The Royaume du Saguenay Solidarity Homecare Services Cooperative (CSSDRS) is the result of a merger between two social economy enterprises, one in Jonquière and the other in Chicoutimi, effective April 1, 2009. Through this transaction the CSSDRS was to become the* **largest domestic help business in Québec.**
>
> *Early in 1998, the two enterprises had been accredited by the Québec Health Insurance Plan (RAMQ) to administer the Financial Assistance Program for Domestic Help Services (PEFSAD).*
>
> *Of the two, the Saguenay Home Support Cooperative started operations first. It emerged from a project called "Défi autonomie" [The Independence Challenge]. Until 2009, it remained in complete alignment with the consensus of 1996, which was to provide help for domestic life only.*
>
> *As for Royaume Homecare Services Cooperative, from the get-go it strove to develop other services closely related to the health sector, especially help for daily life (AVQ) in people's homes and, beginning in 2000, looking after residential housing blocks*[56]*.*

The employees of the two cooperatives were unionized in 2003.

After the merger in 2009, the cooperative extended to the Chicoutimi borough the know-how acquired around Jonquière, meaning the integration of AVD and AVQ service offerings and the management of residential housing blocks. The merger also served to facilitate the integration of more specialized administrative resources. In time the cooperative took charge of human resource management and kitchen management in seniors residences and even purchased one such residence, then of 29 units. On account of this steady expansion, the cooperative reviewed its organizational structure in 2014 to eliminate one layer of bureaucracy and increase its efficiency. The penchant of CSSDRS when planning, as in everything else it has ever done, is a determination to grow ever bigger and better.

55 These are called "help with domestic life."

56 http://www.cssdrs.ca/page/historique

CURRENT BUSINESS MODEL

The website of CSSDRS describes its mission in the following terms:

> *To offer services assisting domestic and daily life to everyone wherever they live within the areas served by the Chicoutimi and Jonquière health centres. Thanks to competent and professional staff, the cooperative provides a continuity of quality services for which it is locally renowned.*

The vision of the cooperative's development is expressed as follows:

> ***A leading-edge business***
>
> *The CSSDRS is a leading-edge business both in terms of growth and the efficient management of all its resources.*
>
> ***Essential service provider***
>
> *By devising and developing business partnerships that efficiently address the exact needs of its clients, the CSSDRS has become an essential provider in the home support sector.*
>
> ***First-rate employer***
>
> *A long-term ability to motivate and mobilize staff and achieve a sense of community in an exceptional working environment makes the CSSDRS a first-rate employer.*

Services that the cooperative provides:

Domestic help

- Regular household duties
- Heavy household duties (cleaning ovens or refrigerator interiors, etc.)
- Big cleaning jobs (annually, subject to availability)

Meal preparation

- Non-diet meal preparation.

Personal care

- Personal care services include assistance with daily life, such as dressing, food, moving around, hygiene (partial or total), bathing, stimulation exercises, etc.

Companionship

- Accompanying clients on trips to the grocery store, pharmacy, bank, etc.

Respite

- Respite services enable family caregivers to have some time to themselves. Qualified staff assume responsibility for the beneficiary in terms of care and meal preparation, as well as stimulation exercises.

In December 2018, in addition to serving clients in their homes (whether houses or other accommodations) in and around Jonquière and Chicoutimi, the CSSDRS began to provide personnel management, cafeteria stewardship, and to manage overall resident services in seven seniors facilities. One belongs to the municipal housing bureau and another to the cooperative itself, the Saint-Famille Home. Of its 28 units, nine are termed "intermediate resource," that being the step prior to placement in a Centre d'hébergement de soins de santé longue durée (CHSLD) [Residential and Long-Term Care Centre], a public facility for seniors suffering a loss of physical or cognitive autonomy (e.g., persons with Alzheimer's disease). Two of the residences are for persons suffering a loss of autonomy and some of the units in a third residence are allocated to the same purpose. The other four residences are what they call "semi-autonomous." In February 2019, the signing of yet another service contract will extend the cooperative's services to a new, 26-unit residence owned by the municipal housing bureau.

There is more. The cooperative has a service contract to look after six residences, each housing nine persons suffering from physical disabilities. CSSDRS monitors them 24 hours a day, seven days a week. The residences belong to the municipal housing bureau and the services are purchased by the CIUSSS of Saguenay-Lac-Saint-Jean.

Statistically speaking, here is how things looked in December 2018:

- Membership: 9,800, of whom the vast majority are user members. The cooperative also has worker members and supporter members.
- All three member categories are represented on the cooperative's board of directors, which is chaired by a user member.

FINANCIALS (2017)

- Number of employees: 236[57]
- Total hours provided annually: 286,000[58]
- Revenue: $8.2 million
- Balance sheet :
  - assets[59] : $1,993,911
  - liabilities : $1,272,666
  - net worth : $721,845

IMPACTS

SUCCESS FACTORS

Certain factors have been instrumental to the outstanding growth of this cooperative:

1. **Attentiveness to members' ever-changing needs.** Since incorporation, the organization has remained attuned to members' evolving needs and upgraded the service offering accordingly.
2. **Collaboration with public health authorities:** For many years the cooperative was at work in the catchment areas of two CSSSs, and acting on their readiness to partner, swiftly concluded agreements for the co-op's services. Since 2015 both CSSSs have been merged into a single entity, the CIUSSS,[60] and the civil servants they formerly employed have been integrated into the new structure. So the good will built up by the cooperative and the old climate of collaboration still prevail, notwithstanding a shake-up in personnel and on occasion a silo mentality reminiscent of the earlier structure, i.e., resistance to a holistic perspective.

   In addition, administrative processes in the new megastructure can be lethargic, and employee work stoppages or sick leaves have been known to hamper follow-up with the cooperative.
3. **Successful knowledge transfer:** CSSDRS had two cooperative forerunners that merged in 2009. Its chief executive officer was then able to capitalize on the know-how of one of those forerunners when applying the new cooperative's business model to the territory of the other forerunner.
4. **Investment in training:** The cooperative took the bold step to invest in training so that its employees could diversify their skills, for example, from housekeeping to bathing the elderly. Practical nurses were trained, and then in turn trained the attendants who were to be entrusted with these duties. The cooperative has also committed itself to achieve certification as a "healthy business[61]."

57 The two union locals are still in place. Both unions are affiliated with the Fédération des travailleurs et travailleuses du Québec (FTQ) [Québec Federation of Labour].

58 On average, an EESAD provides around 60,000-70,000 hours of service annually.

59 Includes ownership of one seniors residence.

60 Saguenay-Lac-Saint-Jean CIUSSS, with over 8,400 staff and an operating budget exceeding $707 million, officially launched on April 1, 2015. It arose from the merger of nine public institutions: http://santesaglac.com/ciusss

61 The certification is issued by the Bureau de la normalisation du Québec [Québec Standards Bureau] to encourage healthy lifestyles within businesses: http://www.cssdrs.ca/page/entreprise-en-sante

CHALLENGES

As outstanding as it is, the development trajectory of this cooperative to date, is not without its challenges.

Contracts are more demanding: Despite the cooperative's commendable relations with its corporate customers, particularly the CIUSSS, the context now has grown more difficult. Contracts are awarded through a tendering process and increasingly the cooperative must deal with competition from both private and community-based providers[62]. In addition, AVQs are not automatically allocated to EESADs. Finally, CHSLDs purchase services on an as-needed basis instead of purchasing service packages.

Labour relations: The cooperative's outstanding growth has made it one of the most robust and dynamic small to medium-sized businesses in the Saguenay-Lac-Saint-Jean region. As a substantial regional employer, the cooperative now has to deal with higher union expectations. That being said, collective agreements with employees were signed in 2017.

Affirm the value of the work: Generally, the profession of homecare attendant is of uncertain status, which detracts from its attractiveness and eventually from the labour supply (i.e., it brings about a labour shortage). The profession has to enjoy more public respect.

Staff retention and labour shortage: EESADs have to deal with significant staff turnover. CSSDRS is no exception to the rule. Its personnel frequently leave to take jobs in the public healthcare system where working conditions (including wages) are more attractive. To increase staff retention, the cooperative therefore implemented a workplace health and wellness program which actually offers to reimburse a portion of the fees for staff members engaged in a physical exercise program or the like. The cooperative is also associated with a province-wide sports challenge started by a resident of the region[63]. Mindful of the expectations of young people whom it wants to recruit as workers, the cooperative strives to offer a supportive work environment and greater flexibility in work schedules. The issue of staff retention is magnified by a regional labour shortage. Accordingly, the cooperative recently raised staff pay by an average of 8.8%, to a level exceeding the average wages of attendants working in private residences. Moreover, between now and the end of 2019, the cooperative is expected to purchase a former convent that not only will house administrative services but also make space available to employees, perhaps for a collective kitchen or even a training studio. It is all done in the name of both retaining current staff members and recruiting new ones. The upgrading of this former convent is to achieve the highest standards in terms of sustainable development.

Communication: In view of the scale of the cooperative, communication with the various stakeholders, and especially staff members, is a challenge.

A delicate balance between multiple goals: Management has to strike a delicate balance between the delivery of high-quality services, offering working conditions that are appealing in terms of both wages and social benefits, and being a service provider of interest to the health system for reasons of competitive pricing.

62 Notably, the protocol that governs relations between EESADs in the Saguenay-Lac-Saint-Jean region eliminates competition between these enterprises.

63 *Le grand défi* Pierre Lavoie [Pierre Lavoie's Big Challenge]: https://www.legdpl.com/en/

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CHAPTER 3

Current Status and Future Prospects for Social Economy Enterprises in the Health Sector

SUCCESS FACTORS IN THE DEVELOPMENT OF HEALTH COOPERATIVES IN QUÉBEC

Among the 70 or so health cooperative projects launched in Québec (including those that never went anywhere or had to shut down) certain features stand out that have been common to success, both in terms of the projects' economic viability and their social and health impacts. Certain of these features, identified by Isabelle Garon and Jean-Pierre Girard when these health cooperatives first came under study late in the 1990s, remain cogent today. They are as follows.

- Fundamental to setting up a health cooperative is a community's heightened awareness of an unresolved problem in regard to its healthcare. Paired with such awareness must be a process for delving into the problems and discerning practical options for action by average citizens.
- A local population that is engaged and determined to act. This may seem self-evident. Yet the State's takeover of the health system, and the power exerted by physicians in the medical community and other professions, together have given rise in the general public to a wait-and-see attitude, and an impression that average citizens have no place in decisions regarding their own health. Such engagement, except when philanthropic in nature, constitutes a paradigm shift for a great many people and health system stakeholders.
- The support and collaboration of social and economic actors, municipal and regional, are essential to the start-up of a cooperative. The complexity of the health sector and the barriers to entry are such as to entail a complimentary process of mobilization and action by local social, economic, and political actors. This involves a preliminary process of awareness building, communication, and education.
- It is very important to identify and engage leaders recognized by the community. Their engagement helps mobilize the general public and captures the attention of local actors. It also has a psychological effect, by diminishing people's sense of inferiority in regard to issues that concern the health system.
- Cooperative education must be ubiquitous for the project to succeed and be sustained. The capacity of health cooperatives to act in the public health system is defined and limited by State rules that are specific and in constant evolution. The cooperative will experience a perpetual tension between an open, voluntary association and access that must be universal and open to the entire population. The cooperative advantage is therefore not so much personal as collective. Cooperative membership is more about community engagement and a movement for transforming and democratizing healthcare than simply about meeting an immediate and personal need. The ideal would be an extensive training course about cooperation that gets into its philosophical and political dimension and not just its mechanics and governance. Few projects and groups have attained this level of dialogue and collective purpose. Those groups which have, achieved a greater public mobilization and comprehension of their project.

- The project must conform to the realities of the environment in which it is to take root. Each cooperative project differs slightly on account of its location: the physical realities, the needs, and the state of the local or regional healthcare network. There is no "one-size-fits-all" model. Modification to local conditions is essential to success.
- Co-developing a feasibility study through a participatory approach (Van Den Borre) will significantly increase the project's chances of success. Among other things, a higher level of project comprehension among the various stakeholders (including professionals) will result, boosting unity and a capacity for collective action.
- If they are not involved in the project from the start, health professionals must be approached and recruited the moment the project feasibility study is finished. Proponents of the project must make sure these professionals are on-side prior to taking any concrete action. Ideally, they will form part of the cooperative's interim committee and consider themselves project stakeholders. They are not simply to serve as an economic or business connection; their participation extends to a level of social involvement made manifest in knowledge sharing and non-hierarchical relationships. This approach is not necessarily obvious to physicians. The paradigm in which they live is one of information asymmetry in respect to the patient, i.e., the physician is the one who knows. Consequently, transitioning to a more "user-friendly" way of working may be a challenge.
- The cooperative itself must be a stakeholder in the public health system, without compromising its distinctive nature. Québec's public network comprises public, private, and community stakeholders who organize and collaborate. The cooperative must operate in conformity with the applicable laws as well as in a spirit of collaboration and complementarity with these network stakeholders.
- The interim or promotional committee must develop and disseminate a thorough, compelling flyer to the area's residents, other health system stakeholders, and social agencies. The flyer is pedagogical in purpose and presentation, providing concrete answers to issues that have been raised as well to the aspirations of various stakeholders in regard to the project.

2012 RECOMMENDATIONS OF THE QUÉBEC FEDERATION OF HOMECARE AND HEALTH SERVICE COOPERATIVES (FCSDSQ)

In 2012 the FCSDSQ initiated a review of strategic guidelines in regard to the development and operations of health cooperatives. It then drafted a general framework to guide their establishment and operations:

- **A collective project.** This concerns the popular mobilization and engagement that forms the very root of a health cooperative project. Collective awareness translates into action on the necessity to assume responsibility and authority in regard to health. Average citizens get proactive about their own health as well as the health of their community.
- **Value-added.** The cooperative is contributing to a better allocation of medical resources. It should foster the enhancement of services already present in the community. Its positioning should not place it in "unhealthy" competition with other organizations, whether private, community, or State.
- **An inclusive formula.** The cooperative should enable everyone to have access to insured health services regardless of status or ability to pay. This obligation to provide access is consistent with the principles of universality and accessibility in the Canada Health Act. Obviously, having made this declaration, access to insured services will still depend on many structural factors, like the number and availability of physicians working in the cooperative.
- **A diversified service offering.** The cooperative should bring value-added to its service offering. This should not be limited to the provision of curative services, but also include services in disease prevention and health promotion. The implementation of a service component that is effective in these regards first requires an assessment of the public health issues in the region and among the cooperative's user members.

- **Annual contributions.** Analysis of the financial and social performance of the various projects indicates that annual contributions to the cooperative are often necessary for several reasons:
  - Unless the cooperative has diverse revenue streams, its financial viability and the maintenance of its infrastructure cannot depend solely on rental income.
  - Such contributions can enable the implementation of alternative services that are not insured under the public health plan.

In accordance with this recommendation, the Federation has encouraged health cooperatives to implement annual contribution policies. To be sure, the contribution's monetary value must be socially equitable and reflect not only the income requirements of the cooperative but also the income level of households in the affected communities. In no way may the contribution serve as a prerequisite for service access. Although this practice has proven essential and beneficial to several of Québec's health cooperatives, it has been contested by many members and been the subject of complaints to the authorities. It has been deemed legal so long as it does not constitute a prerequisite for access. How members view it depends on their level of cooperative education, the diversity of each cooperative's service offering, and the members' sense of belonging in regard to their cooperative.

- **The involvement of health professionals, including physicians.** Where appropriate, from start-up the cooperative should foster the involvement of physicians and other health professionals. The Federation encourages the financial participation of physicians in the cooperative. In addition to fostering their feelings of belonging and social value, such participation contributes to the cooperative's viability.
- **The integration of services.** The Federation considers it desirable for health cooperative development to go forward in collaboration with local healthcare networks and social services. Cooperative decision-makers should work towards a concerted partnership with CISSS representatives in their area. Such a course of action necessarily implies an educational component regarding the operations, role, and contributions of health cooperatives.
- **Financial partnerships.** Health cooperative representatives should appraise all the possible partners that their region has to offer: municipality, credit unions, CISSSs, local businesses, community-based and social economy partners, government ministries, foundations, and socio-economic development agencies.

BARRIERS LIMITING THE DEVELOPMENT OF HEALTH COOPERATIVES

The first thing to be said about the healthcare system of Canada and Québec is how very complex it is. To insert therein an element of autonomous citizenry stemming from the social economy, requires a thorough understanding of that system. Many barriers obstruct the entry of cooperatives wishing to provide healthcare services. What follows is an overview of these barriers:

- **Knowledge and know-how.** The health sector has many dimensions: the scientific, administrative, legal and regulatory, community-based, political, and sociological. For years average citizens have been separated not just from decisions over the organization of essential services, but from decisions affecting their personal health. When developing a health cooperative that is to deliver primary healthcare, the very first task is to gather, assimilate, and master a diverse body of knowledge.
- **Culture and politics**. In many cultures and countries the idea of average citizens orchestrating and conducting the delivery and management of healthcare is considered normal and desirable. By contrast, Québec has developed over time a culture of medicine, health, and social welfare somewhat dominated by physicians by virtue of their medical legitimacy, and by an acute bureaucratization and technocratization of the management of care. Even relative to socialist countries, Québec's system is excessively centralized, bureaucratic, and "airtight" to an engaged citizenry. This is aggravated by a polarization between the public system and labour organizations, the latter representing various types of workers and the former, associations for defending the rights of patients and taxpayers. In this confrontation, health cooperatives and the social economy in general are often treated as spectators, unrecognized and unappreciated.
- **Physician recruitment and Regional Medical Staffing Plans.** Since Québec's various regions do not all enjoy the same level of accessibility to healthcare, the MSSS annually implements Plans régionaux d'effectifs médicaux (PREMs) [Regional Medical Staffing Plans]. Their goal is to achieve greater equality of access to medical services across Québec. According to the MSSS, the way to guarantee the population of each region access to its fair share of services is to encourage physicians to set up practice in one or another region according to need. Prior to moving a practice, a physician must first ascertain if the PREM will approve the relocation. Likewise, a health cooperative's recruitment strategy must take the PREM into account. Prior to approaching a physician to undertake a substantial workload (equivalent to over 55% of his/her RAMQ activities), the cooperative must make sure there is room in the PREM's quota for that region. If the quota is full, the cooperative will have to find physicians who already are authorized to practice there, or who might gain exemption from the PREM.
- **The costs of the physical plant.** The cooperative has to find a site or building adequate to its own needs and those of physicians and various other co-occupants, while ensuring the confidentiality

and security of personal information. This generally represents a substantial cost, encompassing a significant amount of capital as well as projected maintenance expenditures.

- **Status of professional members.** The health cooperative cannot recruit physicians as "worker" or "producer" members. Québec's Professional Code does not allow physicians to join cooperatives for professional purposes. However, under the freedom of association they have the right to join a cooperative as individuals (i.e., as "supporter" members) to support its mission and take part in its democratic processes.
- **Cooperative education.** The cooperative should educate consumers in regard to cooperative principles and operations. It should also expect a certain reticence about paying for qualifying shares and making annual contributions (if any). Some people think they are being made to pay for services that usually are free. The cooperative should be clear that the sums collected are what capitalize the cooperative and pay for infrastructure that belongs to them, the members, and do not reimburse the costs of care.
- **Technology and medico-technical facilities.** Given the evolution of information technologies and medical practice, from start-up the cooperative has to choose which technologies will facilitate its own administration as well as the work of the professionals practicing there. These are major choices especially in regard to appointment scheduling, service venue management, information management and membership communications, and the management of medical records, not to mention the various types of equipment required for the efficient practice of modern medicine.

COMMON FEATURES OF SUCCESSFUL PROJECTS

To succeed, a cooperative health clinic project will remain rooted in the community while adapting to a complex and constantly evolving global environment. Cooperatives that have enjoyed a certain degree of success share the following features:

- They have boosted access to primary healthcare and other services through decision-making that has been steered by the information they derived from their members and the general public.
- They have recognized, respected, and tried to strengthen the universality of healthcare and to protect the social benefits inherent to the public system.
- Through a range of governance mechanisms, they have facilitated the active participation of consumers in the development and management of healthcare in their community.
- The vast majority have emphasized medical practice based on disease prevention and health promotion, while maintaining quality curative services.
- They have worked hand in hand with healthcare network actors.
- At a time when healthcare in Québec is being reorganized and underfunded, they have demonstrated that cooperatives constitute an alternative to the privatization of healthcare services.
- They have promoted a holistic approach to health, which entwines medical matters with the social and community aspects of patients' lives.
- They have maintained an administrative autonomy distinct from that of public authorities, but based on working with the public system in a spirit of partnership and mutual aid.
- They have tried to support the government in achieving its goals and in respect to its priorities, while defending the needs and aspirations of their members and community.

THE STRENGTHS OF HEALTH COOPERATIVES, RELATIVE TO OTHER MODELS

- They often provide outpatient services in healthcare and disease prevention in places where such services are no longer offered, or never have been.
- They often are instrumental in improving local professional retention.
- They build members' awareness of their overall health and how to manage it, and thereby increase the availability of services that the State often does not prioritize for lack of resources.
- They enable community mobilization and democratic decision-making in regard to health and social issues.
- They provide diversified outpatient healthcare services and embrace collaborators and organizations with similar or complementary missions.
- Through cooperative laws and regulations, they instill ethical norms that inhibit conflicts of interest and promote not-for-profit modes of operation.
- Their cooperative principles, culture, and traditions foster collaboration and inter-cooperation among cooperative and community partners.
- They facilitate a sharing of risks and financial burdens within the community.

CURRENT STATUS OF HEALTH COOPERATIVES IN QUÉBEC

In February 2018 the FCSSDQ gave health cooperatives in Québec a "check-up" in terms of their overall state of affairs[64].

The following general observations emerged:

> *The Federation estimates that Québec currently has about 50 health cooperatives, of which three-quarters are active. They are found in 14 administrative regions and supply the services of 200 general practitioners, 50 nurses, and several dozen health professionals to a half million people.*

Health cooperatives are still facing some major issues including:

> *attracting and retaining medical staff and members;*
> *operational funding;*
> *service development;*
> *acceptance by the community and by governmental agencies;*
> *complementarity with local healthcare networks.*
>
> *The vision put forward by the sector satisfies the criteria for place-based development and revitalization, since all health cooperatives see themselves as levers of local economic development. However much they strive for financial independence, it remains that health cooperatives belong to individuals and to their communities, and should be supported by the latter.*

The report goes on to focus on more specific matters, first off, the issue of attracting and retaining medical staff:

> *From an overview made in 2016, it is clear that the number of practicing physicians varies a great deal from one cooperative to another, from 0 to 10 for full-time and 0 to 15 for part-time. The average number of physicians per cooperative, full-time or part-time, is 2.3. Practically all health cooperatives lacking physicians are actively engaged in recruitment in response to their members' needs.*
>
> *Regardless of the physicians or other medical resources they employ, it must also be understood that nearly half of health cooperatives were started to pick up the torch from a medical practice that was about to close, and the other half provide services otherwise unavailable in their community.*

Next up, the issue of health cooperative start-up and operational funding:

> *Operational funding of health cooperatives occurs primarily through the annual contributions of user members. The annual contribution per member varies greatly from one cooperative to another, however.*

64 Fédération des coopératives de santé et de services à domicile du Québec (2018) Bilan santé 2017-2018 Coopératives de santé au Québec : Connues et reconnues du local au régional, Québec, 28 pp.

Growth in the five major expenditure items (wages and benefits, amortization, rent, repairs and maintenance, and office supplies) has outpaced that of total revenue over a 4-year time frame. This requires serious consideration. In addition, although on average the total revenue of health cooperatives exceeds $300,000, a significant number of organizations (36%) are in decline. Consequently, while the resolve of cooperative leaders to expand operations displays entrepreneurial spirit, the results of financial consolidation are slow in coming.

The next section is about service development:

Diversification may be linked to a strategy of skills enhancement in health cooperatives. Indeed, by diversifying, a health cooperative can demonstrate its capacity as an organization to innovate in order to provide members with an enhanced service offering relative to other local services. In this way, health cooperatives have managed to develop a viable service offering in synergy with services supplied locally and with member needs.

The returns on diversifying cooperative service offerings are membership growth and renewals and increased service consumption.

Some health cooperatives have undertaken to develop electronic personal health records (PHRs) outside the public healthcare network. Essentially, it is about enabling people to develop digital health tools independently of large commercial developers, like Telus. The idea is for each person to be able to compile their own health report card with their comments, prescriptions, and the like. With this digital tool, patients can more easily check their record and share it as needed with a health professional during medical appointments and follow-ups.

The issue of the "rootedness" of Québec's health cooperatives, i.e., the connection of each to the area in which it is located, was dealt with as follows:

Every community hosting a health cooperative recognizes that the provision of primary healthcare services locally, in relation to their physical location, is unquestionably a value-added benefit. Note that, according to the 2012 overview of Québec's health cooperatives, in over 40% of cases the new facilities took over from a private clinic or its equivalent.

In this context the community may develop a stronger sense of attachment to the surrounding area. So it seems clear that this phenomenon is part of a move to enhance outpatient services, particularly through health and other service cooperatives.

Then the report addresses the issue of service complementarity with public healthcare networks:

Resource levels being limited by the service area, it is a real challenge recruiting professional medical staff, even part-time. It should be underscored that even today a number of health cooperatives have no collaborative arrangement with their CISSS or CIUSSS.

Furthermore, it is important to explore the key activities performed by health cooperatives in terms of health promotion, disease prevention, and treatment in order to define a clinical and organizational project in line with the area's service offering.

The health cooperative enables a physician to focus on medical consultations and reduce the administrative costs and responsibilities usually associated with practice outside that setting.

The report's last section concerns challenges and solutions –how health cooperatives must face the former and embrace the latter. Let's look at a few:

The survey of health cooperatives carried out in 2016-2017 indicated that doctor recruitment was a major challenge facing the organization in 68% of cases, and maintaining current active membership or recruiting new members, in 28%.

SERVICE DIVERSIFICATION

Certain health cooperatives clearly lack diversity in their service offerings and therefore in their revenue streams, which could give rise to certain problems were these services to diminish or disappear.

There is also the provision of disease prevention and health promotion services, like promoting healthy lifestyles, participating in group physical activities and conferences, etc., which may enable cooperatives to attain a competitive advantage in the eyes of the public.

MEMBERSHIP

Many cooperative leaders maintain that "Membership is fragile. Never take it for granted."

One solution is to show consumers how membership would enable them to enjoy privileges that non-members do not, for example, preferred rates for services provided by other health professionals inside or outside the cooperative's facilities, discounts with local merchants, as well as other special benefits. You also have to show them that health cooperative members have a significant role to play in their businesses.

PROMOTION

Some cooperatives are little known or hardly known at all, so potential consumers do not realize the range of services available.

Don't hesitate to undertake activities that promote the cooperative's services to the general public and to current members. You have to communicate the benefits of membership itself as well as the special benefits relative to other services available in the surrounding communities.

LOCATION

Some cooperatives are poorly situated geographically (on a secluded street) or are in antiquated premises, which does nothing to attract customers. Others would like to expand but lack the space to do so.

ACTUALS

Some managers have a poor grasp of financial statements, which may give rise to errors or delays in decision-making.

… Never underestimate the importance of reviewing the financial statements regularly, ideally every month, to ensure that effective decisions are made on a timely basis. Among other things, determine the factors behind any reductions in revenues or increases in expenses.

The foregoing outline of the present state of health cooperatives overlooks one major issue, that of the "market" for primary healthcare services. Excluding the CLSCs, health cooperatives must deal with the tremendous magnetic pull that clinics owned by pharmacy chains or major grocery chains exert on physicians. Very little data is available on this subject, but concentration in this sector in recent years has brought to bear substantial financial means for "attracting" doctors clinics.

Here are some of the key developments:

McMahon Distributeur pharmaceutique has been the owner of Québec's Brunet pharmacy chain since 1987[65].

One of English Canada's major chains, Shoppers Drug Mart, goes by the name Pharmaprix in Québec. Since 2013, both chains have been property of Loblaws Companies Ltd.[66]

A major pharmacy chain in Québec, the Jean Coutu Group (PJC) was acquired by METRO Inc. in 2018[67].

It is paradoxical, to say the least, that big pharmacy chains in Québec may incorporate, while average citizens are prohibited under law from forming a cooperative and owning a pharmacy.

To conclude this outline, let it be noted that health cooperatives (unsurprisingly) are hardly acknowledged in Québec's public policies, and then only on the margins, where each organization comes under a great deal of pressure to gain local recognition and that of the federation that represents them.

65 https://www.brunet.ca/en/about-brunet/history.html

66 https://www.jeancoutu.com/en/corpo/about/history/

67 Cho, Soo-Yeon (2007). The origins and implementation of the national health insurance programs in Korea, 1961–1979. University of Missouri - Columbia.

FUTURE PROSPECTS AND THE POTENTIAL FOR COLLABORATION BETWEEN KOREA AND QUÉBEC

Korea adopted a mixed system of universal healthcare in 1989[68]. In 2004, the system evolved into one that is wholly state-run with a single payer, like that of Canada. Korea's first health cooperative emerged in 1994. The year 2003 saw the establishment of the Korean Medical Cooperatives Union, which, following the passage of the Framework Act (2012) became the Korea Health Welfare Social Co-operatives Association (KHWSCA) in 2013.

In 2018 the KHWSCA had 22 regional cooperative members, with more than 41,000 affiliated members between them. The Association currently is expanding with the launch of eight new cooperatives.

STRUCTURE OF THE KHWSCA

	Member cooperatives	Individual members	Capital ($ CAN)	Revenus ($ CAN)
2017	22	41,224	$14,164,482	$39,106,649

In 2018, eight new cooperatives were starting up.

Broadly speaking, the Korean healthcare system is very much akin to that of Canada and Québec. Our cooperatives operate in contexts that are generally similar. However, a review of the KHWSCA activity report indicates there is much greater cohesion within the Korean network as well as a far stronger emphasis on health promotion and disease prevention. The values and vision of the Korean network as defined by the Association are as follows:

- Operate medical institutions that are managed democratically by their members.
- Provide quality medical services irrespective of an individual's gender, income, or state of health.
- Endeavour to create community health groups, particularly:
  - By creating consumer communities and forums for the discussion of health-related issues.
  - By emphasizing health promotion and disease prevention activities.

68 Cho, Soo-Yeon (2007). The origins and implementation of the national health insurance programs in Korea, 1961–1979. University of Missouri - Columbia.

From the activity report, it is notable how Korean health cooperatives exercise a much more holistic vision of health relative to the majority of their Québecois counterparts. Like Japanese health cooperatives, Korean ones have paid particular attention in recent decades to the determinants of health. Such determinants as improving housing conditions, the quality of community life, and social ties all fall within their scope, just as does the training of community health leaders whose task it is to organize health promotion and disease prevention activities.

Korean cooperatives likewise emphasize services for vulnerable populations, especially seniors, people with reduced mobility, or those living with chronic illnesses, etc. They also take action at the community level by encouraging neighbourhood clean-ups and beautification, and by involving residents in the design of community projects that positively impact the health of the community.

After Canadian health cooperatives conducted a study tour of Japan in 2007[69], many Québecois health cooperatives experimented with certain Japanese models, particularly the Robert-Cliche Cooperative, which experimented with "Han"[70] groups for nearly seven years. In its early years of operation the Aylmer Health Cooperative (now dissolved) pioneered the establishment of health promotion and disease prevention programs for vulnerable populations, especially newcomers to Canada. But as this report indicates, despite the positive impact of these programs, their operations lacked State support and over the long term experienced difficulties in ensuring the continuity of their activities.

Notwithstanding these few differences, Korea and Québec have many important things in common. In addition to the fact that they evolved within analogous healthcare systems, their cooperative health and social care networks are similar in age (25-30 years) and relatively comparable in scale (30 active cooperatives in Korea, compared to 40 or so in Québec).

Another challenge shared by Korea and Québec is the aging population: with persons over 65 years of age expected to constitute 25% of the total population between now and 2031, Québec figures among the societies whose populations are ageing fastest, just after South Korea and Japan. Preparing communities to deal with this phenomenon certainly holds promise as a focal point of collaboration, as are other issues related to innovation and to the participation of average citizens in the management of local healthcare networks. More generally, there also is the positive impact of social economy enterprises on the determinants of health; how vulnerable and at-risk populations can be served more effectively; as well as the expanded role of specialized nurse practitioners in the provision of healthcare.

In an era when numerous actors from the spheres of politics and business strive after an increasing role for the private sector in the healthcare system, cooperatives have another task in common: to offer a viable and coherent alternative that integrates the goals of the State with the concerns of civil society (including unions). In both cases, the networks of Korea and Québec have militated for this recognition to varying degrees.

Finally, from a scientific point of view, universities and health co-ops of both nations could collaborate in the documentation and analysis of the impact of health promotion and disease prevention activities on health indicators, the effectiveness of various funding mechanisms, etc. This collaboration could include performance measurement in reference to the sustainable development goals (SDGs) of the United Nations.

69 Organized and directed by one of the authors of the current report.

70 For more information, see Girard, Jean-Pierre and John Restakis (2008) "To life! Japan's model of co-operative health care & what it means for Canada," Making Waves: Canada's Community Economic Development Magazine, Vol. 19, No. 1, pp. 5-8. http://communityrenewal.ca/sites/all/files/resource/MW190105.pdf

CONCLUSION

Healthcare expenditures represent the equivalent of 10% of global GDP. Healthcare has always been a fundamental concern of peoples the world over. In Québec, it represents the government's most significant expenditure item and, election after election, remains a key issue for voters. Nevertheless, unlike other sectors, such as education, in which the participation of members of the general public is encouraged and formalized, Québec's healthcare sector has practically expelled the average citizen from decision-making forums and given free rein to the biomedical and pharmaceutical lobbies that are the main beneficiaries of the financial spinoffs of public healthcare spending. The emergence of health cooperatives in Québec is in part a reaction to this phenomenon and to the lopsidedness in services that has ensued.

Québec's health cooperative movement differs significantly from other networks established in the last 30 years in that it has developed despite the absence of public policies conducive to its emergence. In fact, as this report shows, it spread despite substantial barriers to its development. Originally a response to a shortage of primary care services, these projects typically outgrew the basic framework of primary healthcare, gave rise to bigger aspirations, and became veritable laboratories of social innovation.

This clearly speaks to the strength of a united and mobilized civil society and the collective intelligence that accrues as a result.The experience of Québec's health cooperatives in recent decades also highlights the importance of processes of knowledge transfer and mechanisms for scaling up social economy. In many places, the dissemination and adaptation of this model have been deliberately and systemically accomplished through processes of co-construction that are fueled by mechanisms for the transferral of knowledge and innovation. CDRs are pioneers of this approach, especially the CDROL , which has applied it to more than a dozen projects within its jurisdiction. This way of "spinning off" projects has been key to the model's success, because its fundamentals can be continually replicated and enhanced, while the necessary adaptations to local conditions proceed.

In conclusion, in regard to the challenges facing public healthcare and health cooperative networks, the parallels between Korea and Québec are unmistakable and merit particular attention. In the interests of our respective populations, governments, and various healthcare network stakeholders, we hope that this report is a source of inspiration to future collaborations between Québec and Korea in this sector and that it opens the door to a long and fruitful collaboration, as has been the case in other sub-sectors of the social economy.

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