HEALTH COOPERATIVES: A MODEL FOR CONSUMERISM IN MEDICAL CARE

by

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The health cooperative movement is examined as a successful model of consumer participation and control of health care services.

Cooperative medicine grew out of earlier cooperative movements originating in the mid-nineteenth century. The principles of the cooperative movement include consumer control and the elimination of the profit motive. The principles of cooperative medicine, well developed over forty years ago, include prepayment, group practice, preventive medicine, open enrollment, and lay control by the subscribers.

These early health maintenance organizations have provided comprehensive health services under control of a lay board elected from the membership. Prepaid group practice is examined as a system of delivering quality medical care at a significant saving in dollars. The structure of the Health Cooperative of Puget Sound is examined as a successful way of organizing consumer control and participation. The effect of consumer control is then examined.

Health cooperatives are a feasible solution to the need for comprehensive services with emphasis on preventive care. Furthermore, cooperatives offer a successful structure for consumer participation and control which is an important factor in the development of high quality accessible health services. There is still a need to foster stronger lay participation and thereby increase the effectiveness and scope of preventive services and health education. Combinations of cooperatives may have the potential of developing effective community preventive health programs.

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DEDICATION

Dedicated to the Consumers

"Who are everybody and who may yet learn to unite to supply their needs, and ultimately to create a cooperative democracy through which to control and administer for their mutual service the useful functions now performed by profit-business and by the political state."

from Cooperative Democracy

by James Peter Warbasse, 1936
FORWARD

My interest in the delivery of health services began in 1970 while volunteering at the Columbia Point Health Center in Boston. The Office of Economic Opportunity sponsored Neighborhood Health Center was one of the first attempts to deliver comprehensive community based health services to a medically underserved and needy population. The large gap between the health care needs of a low-income housing project community and available medical resources is sharp and clear at Columbia Point. Furthermore, the limitations of a strictly medical approach to answering those needs has now been demonstrated.

In order to develop my interest in the field of health, I became involved in an MIT fieldwork project in Somerville, Massachusetts to examine the health needs of a working class community and help residents to organize a system of services answering their needs. Over the three and a half years I have worked there I have met and talked with many residents about their health needs. The following are some examples of the problems and needs I found; many are common in communities throughout the United States.

Mrs. S. has an income high enough to keep her off welfare. She also has gall bladder stones and needs an operation. She cannot afford one and so takes
pills to fight off the pain.

Mrs. C. has a child of her own and takes care of two others during the weekdays. Her time is limited and she has no family physician. After several weeks of feeling sick and coughing, and after two trips to a large hospital out-patient department she was diagnosed with "walking Pneumonia."

Miss. S. is a young women working in Boston. She has no access to a private physician and hence had to rely on a large hospital OPD outside Somerville for her gynecological care. Her appointment proved to be worthless and humiliating; the physician was rude, disrespectful, and refused to answer her questions concerning her health and body.

Mrs. G. was expecting her first child and felt well covered financially with her health insurance program. She had adequate prenatal care and delivered a healthy girl. However, five days later she was rushed to the hospital because of hemorrhaging. She unexpectedly received an $800 bill which was not covered by her insurance.

Mrs. D. has two young boys. However, in Somerville there is no longer a pediatrician to serve the general public. So she travels several miles to Stoneham to see a pediatrician. When she gets there
he is so busy that she cannot ask him all the questions she has about childcare.

Mrs. F. is a young mother of two. However, since moving to Somerville four years ago she still has not located a local physician she has confidence in and as a result has had no personal health check-up in that time.

- Mrs. S. is elderly and has trouble getting around. She needs to visit the physician frequently for several major ailments. However, each visit means a ride with her son to a physician located outside of Somerville. A health center facility is located one block away but is not available for her to use.

Together these examples point out many of the inadequacies of our current organization of health services. Such inadequacies seem to fall in three groups: access, quality, and cost.

Access to health care is limited to many population groups. Without adequate resources and a home in the right neighborhood one is forced to travel great lengths for either private physicians or hospital OPD services.

If one does seek out medical care, the quality of services poses a second problem. Private practice physicians often take on so many patients that the time they can spend with each is limited. Furthermore, they must concentrate on
providing acute medical care rather than preventive health care. Those private physicians still practicing in a community such as Somerville are often old and lack training in current therapeutics. As they retire they are not replaced by younger physicians, thus forcing more people to go elsewhere. For those people relying on hospital out-patient departments, health care lacks continuity, becomes impersonal, and fragmented. Focus can only be placed on acute needs as opposed to preventive health which relies on a strong continuing patient-physician relationship.

The cost of medical services is a third problem that strikes many communities like Somerville. Many residents are in the low-middle income range and hence carry limited health insurance. For routine non-hospitalized care the costs are prohibitive. Hence, illnesses must wait until they are severe before being treated. Continuous routine and preventive ambulatory care is put off in order to attend to more immediate needs.

My work in Somerville also pointed out the relation of non-medical factors to a person's health. Lead poisoning becomes a health problem because of a housing and/or environmental problem. Medical care is generally an after the fact intervention. From the point of view of prevention, one must talk about housing and education.

Income is another factor that has a major effect on
health. With a proper income one's family is properly fed, clothed, housed, and educated. These are clearly the prerequisites for good health.

In all the recent publicity about a health care crisis one voice has consistently been left out. That is the voice of the consumer. And who can better speak about the inadequacies of our system of health care than those whose needs are not answered.

Through both my direct work with health care consumers and my association with Dr. Robert C. Buxbaum, I have developed a strong awareness of the need for consumers to develop their own programs to answer their own needs. If services are truly responsive to needs, as they should be, then consumers must be involved in developing and controlling those services. Furthermore, if preventive health is to be the foundation of any health care system, then consumers must be made a part of that system.

Through discussions with Dr. Buxbaum at MIT and research for Mr. Paul Danaceau in the U.S. Senate, I became interested in health maintenance organizations, particularly those with consumer boards. My early impression was that they provided high quality medical services at a lower cost. After some further research I decided to study the health cooperative movement because it was one of the earliest proponents of the HMO system of health care organization, and was based on
the principles of lay participation and control with emphasis on preventive medicine. Furthermore, the foundation of its principles in the cooperative movement, makes it part of a potential reorganization of the community to truly serve man's best interest.
I. INTRODUCTION

Is there really a crisis in medical care; and if so, what is the crisis? Over the last several years many books and articles have been published about the health crisis in America.\(^1\) Several other books have been published claiming that there is no real crisis.\(^2\) Perhaps the word crisis has been misused largely in the hope of drawing attention to particular problems and justifying particular solutions. However, one would be hard pressed to deny that problems exist in the American system of health care. The problems can be divided into cost, quality and access, and control.

The cost of medical care and the total amount of resources spent on medical care have risen dramatically in the last fifteen years. Some of the cost rises are explainable by inflation present throughout the economy, more realistic salaries for professional and non-professional employees, and the change in the type and focus of medical care today. Medicine today is oriented toward high technology based in hospitals, chronic diseases, and new techniques for prolonging and improving the life of people with severe or unusual diseases or abnormalities. The provision of health care must rely more and more on health teams consisting of specialists in various techniques and fields of study. Many of these trends will certainly continue in the future.
However, as Faltermeyer writes, "the real propellant forcing up costs is the archaic manner in which most medical care is arranged and paid for in the United States."³ Payment is on the basis of individual services rendered. You give more services- you get paid more. There is no way of restraining the ordering of many laboratory tests and X-rays. Payment and services are separated and for many physicians this can mean anything goes if at all applicable. According to Bailey, an economist, health services in America are sold as a good and hence reflect the expressed demand rather than determined need. "This is the way our health service system is largely organized today- on the basis of providing those services that can be sold in a free market setting. But note that this is a limited bundle of services. It may not begin to cover the spectrum of services that should be made available."⁴

Faltermeyer further stated, "the growth of 'third party' payment of medical bills through Blue Cross, Blue Shield, and group insurance policies has provided another inflationary thrust."⁵ Reimbursement by the "third Parties" is on a payment after the fact basis. The physician orders the test, performs the surgery, etc; the insurance pays. Therefore, the physician knows he will be paid by the insurance company and it won't really hurt the patient.

Furthermore, insurance benefits do not cover all services and often times services are delivered in less appro-
appropriate ways in order to guarantee insurance reimbursement.

As Walter J. McNerney, president of the Blue Cross Assn. says, "Use tends to follow prepayment." It is not unusual for new, better, and cheaper ways of delivering health care to be scrapped because "third parties" won't cover the services. In effect, the payment mechanism determines the services rendered and the form in which those services are rendered.

Access to quality health services is becoming a bigger problem for more and more of the population. Many consumers in Somerville express the lack of and need for primary care which according to Kerr White is, "ambulatory care, treatment of the common acute diseases and management of the common chronic disorders, as well as preventive measures, counseling and an understanding of psychiatric and social problems." According to Jonas, "These sentiments of individual health care consumers, which are repeated in virtually every current report or article on health care, confirm the conclusions of the major professional reports on primary care which have appeared in the past 5 years. They are the Mills Report, the Coggeshall Report, the report of the National Commission on Community Health Services, and the Report of the Ad Hoc Committee on Education for Family Practice of the Council on Medical Education. The Pellegrino Committee summarized its conclusions succinctly: 'They express the common opinion that in our present system of medical care there is a serious
deficiency in the provision of comprehensive, personal and family health services.' To put it in the vernacular, 'primary care just ain't there.'"  

The quality of health care is compromised when utilization of emergency room and hospital out-patient services is used as a substitute for primary care in the community. Such hospital based services are not geared to provide personal, continuing, and preventive medical care; instead they act as a "tap" for patient admissions. As a result people's medical needs are not met. Acute needs may be dealt with but long term efforts at health maintenance are not possible.

Statistics on prenatal care and infant mortality are an example of how primary care needs are not met resulting in inferior health status. An analysis of prenatal care and infant death in New York City concluded, "among the offspring of white native-born women with social risk and adequate care, the mortality rate was one half as high as among infants of mothers of the same ethnic and risk groups with inadequate care. Similarly, twice as many infants of Puerto Rican mothers at no risk with inadequate care weighed 2,500 grams or less at birth compared to infants of no-risk Puerto Rican mothers with adequate care." Furthermore, those groups in greatest need generally received the fewest services. "There is a gross misallocation of services by ethnic group and care when the risks of the women are taken into account. Among mothers
with inadequate care, 70 percent were classified at social, medical, or combined social-medical risks, while among women with adequate care more than 60 percent were classified as without risk."^{10}

The problem of quality is also reflected in the cultural gap between providers and low-income consumers. Providers tend to be middle and upper class. Their own perceptions of the poor reflect their own cultural views. Many cannot understand the problems and constraints of the poor, instead the poor are seen as simply uneducated and uninterested in their health. To the consumer this gap is reflected in the care he receives. He does not understand the provider, and does not want to return to a "hostile" institution for follow-up care. Instead of health services being seen as answering his needs in a fashion he understands and is comfortable with, the health institution is seen as a symbol of the middle and upper class run for and by professionals. According to Strauss, in order to try to bridge this gap, "lower class people must themselves be enlisted in the campaign to give them better care."^{11}

For many people the health care system is not viewed as a system but as a fragmented jungle of unconnected services. In few instances are there efforts to coordinate, under the responsibility of one provider, all the services a family needs. As a result many problems either do not get treated at
all because it is someone else's problem to deal with or overlapping responsibility leads to waste, uncoordination, and inaction. Furthermore, the lack of a person responsible for an individual's health care places the responsibility for getting treatment exclusively on the patient—thus leading to delayed action or no action if the problem is never perceived.

As the American system of health care has evolved control has accumulated and been consolidated in the hands of the professional physicians. As a result, health care has been narrowed to those services rendered by physicians. Health care means medical care and acute care. There is little or no emphasis on preventive care. Preventive care means dealing with non-disease issues in the community of everyday existence. Physicians have reduced health care to acute, after the fact intervention based in hospitals and based on technology and pharmacology. A perfect example is the case of heart disease—the number one killer of adults in the United States. Because of the professional's control or dominance of health care, heart disease is largely dealt with by physicians and expensive technology—specialized surgery and specialized intensive care emergency services. The preventive approach is not used because physicians are not trained or inclined toward it. Community efforts at education, better nutrition, exercise, and weight loss are minimal.

The lack of preventive care is further reinforced in
medical schools and by the insurance companies. Future physicians are trained through work with severely ill patients in the hospital. Ambulatory care and health maintenance is not emphasized—instead the student is taught what to do after, not before, illness strikes.

Insurance companies only reflect and strengthen this bias. Hospitalization is covered while ambulatory care is left for the consumer to pay. This bias is a direct result of the original intent of the early Blue Cross insurance programs. Blue Cross developed in the 1930's, not to insure health, but to insure the continued existence of hospitals that were in financial distress during the Depression. Furthermore, Anderson writes, "for voluntary hospitals and physicians alike the establishment of hospital and medical prepayment plans made manifest their desire to maintain control over their own destinies, as it were, as respective providers of service."

The link between professional dominance of health care and the ultimate narrow focus of services is examined by Freidson. "In the case of medicine, a strategic facet of its authority is its delineation of pathology, the definitions of health and illness that guide the application of knowledge to human ills. The physician is the ultimate expert on what is health and what illness and on how to attain the former and cure the latter...Most work is limited to that which conforms to the special perspective and substantive style of the pro-
fession- a perspective that emphasizes the individual over the social environment, the treatment of rare and interesting over common and uninteresting disorders, the cure rather than the prevention of illness, and preventive medicine rather than what might be called 'preventive welfare'- social services and resources that improve the diet, housing, way of life, and motivation of the people without their having to undertake clinical consultation with a practitioner. In short, I suggest that by virtue of its position in the public esteem and in its own division of labor, the dominant profession of the field of health exerts a special and biased influence on planning and financing services of the general field within which it is located....The consequence for the client is an array of differentially supported services that may not be adequate for his needs and interests."14 Furthermore, Freidson points out that the trend is toward greater professional control. "Given the highly visible miracles medicine has worked over the past century, the public has even been inclined to ask the profession to deal with problems that are not of the biophysical character for which success was gained from past efforts. What were once recognized as economic, religious, and personal problems have been redefined as illness and have therefore become medical problems."15 Freidson points out that as a result resources get shifted toward medical solutions though the most appropriate intervention may lie elsewhere.
The focus of health care is far more limited than might be suggested by the World Health Organization's view that, "Good health is a positive concept which involves general protection of the individual against sickness and the promotion of a general state of well-being."\(^{16}\)

Having identified some of the basic problems in American medicine, who is calling for change? Cries for change, what to change and why, depend upon one's role in the current system. Alford has noted that despite many analyses of the health crisis by Commissions and committees over the past 40 years, little improvement has occurred in problems concerning cost and access. In trying to understand this "dynamics without change" Alford looks at health service delivery as a pluralistic system of diverse interest groups.\(^{17}\) The professional monopolists, doctors and researchers, seek control over the way in which their services are provided. The corporate rationalizers—hospital administrators, public agency heads, medical school administrators, seek control over the organization of health services and in that way would hold some of the power previously held by the professionals.

Alford found that virtually all the government and civic bodies investigating the "health crisis" were composed of "corporate rationalizers" or "bureaucratic reformers." Cries for change have largely been the result of efforts on the part of the bureaucrats to wrest away some power from the profes-
sionals. As a result, basic changes fail to occur. The system continues with professionals maintaining hold of their control and the bureaucratic rationalizers developing larger organizational structures.

Change therefore has been the result of pressures from various provider interests to enhance their own position. A third group that Alford mentions, the "equal health advocates representing various consumer groups, has lacked any power in the system and hence has been ineffective in bringing about change.

The Medicare legislation of the 1960's is an example of how change comes about. Rather than being a movement on the part of elderly and other citizens to insure the expensive costs of medical care for senior citizens, Medicare was pushed by a coalition of government officials interested in developing national health insurance and hospital administrators interested in guaranteeing the receipt of payment for their services.18

The voice that has consistently been overlooked; the voice that has lacked a place in our system of health care is that of the consumer. There is no advocate for consumer needs. How is this important interest group to be heard in the dynamics of change in health care delivery? Perhaps, this lack of input is reflected in the fact that so little has changed since the 1932 Committee on the Costs of Medical Care spelled out many of the same problems that exist today.19
According to Freidson, "the delivery of medical care cannot be controlled by the profession, that its autonomy and its dominance must be tempered by administrative or bureau-creatic mechanisms that stress accountability for effective and humane services and must be in some way made responsive to the lay client himself."\(^{20}\)

Health cooperatives bring to medical care both a different structure for financing and delivering medical services and a different philosophy of organization. Cooperatives represent a movement by consumers to control the goods and services they receive in order to provide for their needs and to lower costs. The health cooperative movement is an outgrowth of the broader economically based cooperative movement and as such is based on the principles of cooperation. By placing consumer interests foremost and developing a different financing principle, health cooperatives have developed a structure for a real consumer based health movement based on prevention and equal access.

As stated by Jerry Voorhis, "The cooperative health movement...depends upon the basic decision of a group of people to act together, to cooperate, in order to guard the whole group from the economic disasters of costly illness and to improve their health standards at the same time. Out of that basic decision there comes the opportunity of these cooperative groups to decide for themselves all sorts of
related questions. Questions like these: How much shall we pay for drugs and prescriptions; shall we provide dental services for ourselves; what group of doctors do we believe can serve us best and with most interest; what should be done to make certain that those doctors can practice the best of medicine under the best of conditions and with the best economically practical rewards; what can be done about health problems of aging people; what must we charge ourselves per month in order to assure ourselves of the health care we need and still keep our plan economically solvent? Shall we build our own hospital, make arrangements to use community hospitals, or require our members to carry Blue Cross insurance? Cooperative health plans make it possible for groups of people to decide for themselves a lot of vital questions about their family health. This is good for the people and good for their health.21

This thesis will now examine the principles of cooperation and health cooperatives, the structure of health cooperatives and their delivery of health services, and conclude with an examination of the health cooperative movement today and its future.
II. THE COOPERATIVE MOVEMENT

"A cooperative society is a voluntary association in which the people organize democratically to supply their needs through mutual action, and in which the motive of production and distribution is services not profit. In the cooperative movement the ultimate tendency is toward the creation of a social structure capable of supplanting both profit-making industry and the compulsory political state."

Cooperative Democracy
James Peter Warbasse

The cooperative movement had its roots in those efforts by people to pool resources and work together to answer similar needs. Many of the earliest cooperative enterprises were organized to improve peoples' "buying power." These cooperatives were concerned with improving the distribution of retail goods and food by elimination the profit of the retailer and where possible also improving the quality of the goods. The basic philosophy of the cooperative movement is to replace the profit motive by the service motive. The consumers join together and control the distribution or provision of a good or service for their own benefit. Such businesses are run on a non-profit basis and provide the consumer those things he feels he needs. The cooperative idea dates back ages and some
would argue is an inherent characteristic of man. However, the cooperative movement itself developed as a result of the industrial revolution. As goods became mass produced and food grown in large quantities, a merchant class developed profiting on the distribution of these goods to the growing working classes. Many of the early distribution cooperatives formed among the working poor in an attempt to "stretch" their dollars (or pennies!) The movement gained solid footing when a set of principles was developed to guide cooperative enterprises.

In 1844 in Rochdale, England after a year of planning and $140 in starting capital, twenty-eight working class families established a cooperative store in which to purchase without profit to anyone basic food staples. At the time they put down three basic operating principles which are at the heart of the cooperative idea and have ever since been the basis of cooperative societies the world over.

The Rochdale principles are:

1. Each member of a cooperative society shall have one vote and no more.
2. Capital invested in the society, if it receive interest, shall be paid not more than a fixed percentage which shall be not more than the minimum prevalent rate of interest.
3. If a surplus-saving ("profit") is made out of the
difference between the net cost and the net selling price of goods or services sold, it shall be returned to the members in proportion to their patronage or purchases. This money that is given back to the members is called savings-return, dividend, or rebate. The surplus-saving is what is left after the expenses of the business, including interest on capital, are paid and after funds have been set aside for reserve and other purposes. Among these latter purposes may be any welfare undertakings for the general good of the members or of the society. 23

The first principle deals with control of the cooperative. Each person has only one vote. Thus control is in the hands of every member equally. No one person has more control than another.

The second principle insures against using the enterprise as a capitalist investment. Joining a cooperative and investing in it is not for the purpose of profit gained through speculation. In fact, some cooperatives pay no interest on members' capital.

The third principle eliminates profit from the enterprise. The difference between the cost of a good and its selling price is returned to the consumers.

These principles are the foundation of the cooperative
philosophy—consumer control and the elimination of the profit motive by the service motive.

In addition, to those principles cited by the Rochdale weavers, several others exist that apply to cooperative enterprises.

4. There shall be unlimited membership. No reason shall exclude a person from membership except that his purpose might be to injure the society.

5. A cooperative society shall be composed of individuals who voluntarily join.

6. Business shall be done for cash.

7. A certain percentage of the surplus-savings shall be used for educational purposes in the field of cooperation.

8. There shall be political and religious neutrality.

9. Beginning with distribution or the rendering of service to the members, the society shall aim to expand its business, to unite with other societies, to produce the things which the members need, and finally to secure access to raw materials.24

As cooperatives have developed in a more structured fashion, the following methods of operation have developed:

a. Each member is expected to patronize the society in any commercial enterprise in which it engages.
b. Each member shall bind himself to the society by the investment of some of his capital or substance, if capital is needed.

c. Persons, who have not capital to pay for initial stock, may be permitted to join the society, and may allow the savings-returns accruing from their patronage to be applied to the payment for their share-capital.

d. At each inventory, depreciation shall be charged off against the property of the society.

e. Federation of societies shall prevent economic competition and hostility, avoid overlapping of jurisdiction, and make possible mutual assistance among societies; for nonfederated societies, while they may be cooperative, are not cooperating, and are not a part of the cooperative movement, national or international.

f. The ultimate aim shall be to supply such needs of the members as a social organization can supply, especially to attain to the control of production, to encourage membership, to promote other societies, to create national organizations in every country, and to effect a union of the societies of the world into an international organization having the same common purpose.
Through these principles and methods of operation, cooperative enterprise has proven to be a radical alternative to both capitalist enterprise and state controlled industry. In the words of former Executive Director of the Cooperative League of the United States, Jerry Voorhis, "They (cooperatives) gear all their production and distribution of goods and services to what their patrons need- and say they need. Other businesses gear their production to what consumers can be persuaded to take after the business has decided what it wants to produce and at what price."26

Cooperatives represent a truly consumer controlled and consumer oriented enterprise. Furthermore, the cooperative movement represents an alternative social system to that of capitalism and state socialism.

Based on its growing history there are a number of important points to be made for cooperation along with certain criticisms. Furthermore, the history of unsuccessful cooperative ventures provides us with valuable knowledge concerning the development of successful cooperatives.

First, a cooperative will only succeed if it provides a service or good that its members really need. Coops can only answer real needs. If its foods and/or services are not needed then a cooperative will rightfully go out of business. If its goods and/or services are no longer needed, then, again, it will cease to exist. What better criteria can there be for
an enterprise's existence. Cooperatives do not develop "hardening of the arteries," thus, ceasing to answer people's new needs but continuing to longer on as many agencies seem to do. Instead, they either change and revitalize themselves or die.

An important lesson learned by most cooperatives is that idealism does not run a business. Cooperatives are legitimate businesses many of whom deal in millions of dollars. Cooperatives must be run with sound management. The two largest reasons for failures in cooperatives are poor management and errors in finance. One must understand that the consumers control the business or operation and necessarily hire capable management to run the business. One of the major criticisms of cooperatives is that the members would tinker with the daily operation of the enterprise. This criticism is false. Cooperatives could not succeed and grow if they were not run on sound managerial principles with strong administration.

Education is vital to cooperation. People have grown up in a society (in America) based on capitalist enterprise and profit. The cooperative idea is different. People have to be taught about the meaning of cooperation, how it functions, and how and why it can heal them. People must be made aware of the accomplishments of cooperatives.

A second aspect of education and cooperatives is at the heart of the cooperative movement. Through cooperation and
the control of enterprise people educate themselves about the goods and/or services they purchase. In order for a cooperative to be controlled successfully the members must teach themselves about its operation. When changes take place the consumers must be well educated in order to make the proper decisions.

A result of this self-education is that the consumer becomes an intelligent buyer no longer at the mercy of the retailer. If members of a food cooperative want more nutritious food—-they learn about nutrition and purchase foods accordingly for their members. The membership may learn that sugar products are harmful to teeth and hence ask that such products not be ordered. Housing coops may educate their members to the safety features of well constructed homes and order materials and instruct contractors accordingly. Members of a retail cooperative may learn about the importance of non-flammable clothing for children, toddlers, and infants and order clothing accordingly.

Thus, cooperatives, if they are to be most successful, involve the education of their membership about their cooperative and its goods and/or services. Members have the right and responsibility to ask questions about the goods and services they receive!

An important feature of cooperation, that is often overlooked or underemphasized, is that the development of a
cooperative enterprise "trains people to take the initiative in organizing, to assume the responsibility in administering and directing, and to create experts from their own ranks to carry on enterprises in their own interests." 28

Cooperatives help to build self-respect by allowing people to share in the ownership and control of the production and distribution of their own goods and/or services. People learn the value of their own efforts to improve their condition. Basically, cooperatives are an effort on the part of a group of people to improve their lot by their own resources and energies. The success of a cooperative enterprise proves to people that they can affect their own lives for the better. A successful cooperative venture in one field will lead to further efforts against other problems or needs.

Perhaps the major weakness of cooperatives is their tendency to be dominated by a few members. In most cases, the development and decision making is carried on by a small number of members without the participation or even interest of the majority. Broad participation can be an important factor in maintaining a cooperative's vitality and relevance. However, efforts to maintain a "grassroots" participation contradict several strong forces in a successful cooperative. First, growth is an important factor in maintaining a cooperative. History shows that those cooperatives that remained small and content with a limited service and membership eventually
Therefore, growth helps increase a cooperative's success on the one hand, but bigness tends to limit the individual's own participation, thus limiting many of the indirect benefits of participation. Secondly, as a cooperative succeeds many of the memberships' original needs and reasons for organizing are solved. Thereafter, participation will drop unless for some reason the cooperative errs and no longer satisfies those needs.

Non-participation is an inherent weakness of cooperatives simply because cooperatives are made up of people and the majority of all people tend to be indifferent to changing the systems that serve them. Cooperatives as social systems in themselves, reflect many of the problems and phenomenon of the larger social systems. As Warbasse points out, "The imperfections which exist in all human beings do not disappear when they join a cooperative society. The aggressive, self-seeking, efficient, and egotistic individuals come to the fore and take control as in all affairs. Often the control of cooperative societies gravitates into the hands of a few officials. Sometimes these are the paid employees. In some cases this bureaucracy is used for the pecuniary advantage of the bureaucrats. Many societies are literally controlled by the manager, who conducts the affairs as though he held the voting proxies and power of attorney for all the members. This occurs in small and weak societies as well as in large organi-
However, it is important to realize that the power still resides with all the individual members. In times of crisis they will exercise that power. When cooperatives are doing their job, the members feel content to allow a few interested people run the show.

Cooperation is inherently a classless movement. It brings together all people with a similar need. Cooperatives exist among all economic strata and all economic strata belong to any major cooperative. The idea of eliminating profit and thereby reducing cost is not limited to any one class of people. In concluding his book *What Is Cooperation* Dr. James Peter Warbasse, first President of the Cooperative League of the USA wrote, "Here we see a movement made up of all manner of men, people with all sorts of connections and every variety of circumstances of birth and station. It is more radical, perhaps, than the theories of organization which are commonly called 'radical.' It is not waiting, like a vulture, for the death of any economic system, nor does it propose to fatten upon the funeral meats of any class. It is purely creative. It is constructive because it begins by doing a fundamental thing and moving on into the provinces both of profit-business and of the political State. There are other movements which would take the place of one or the other of these, but cooperation carried to its conclusion, would take the place of both.
It is conservative because it aims at the destruction of nothing that serves well. It quietly and without ostentation builds something which can succeed only if it is better and more satisfactory than the existing things. This is the reason why cooperation has appealed to people of all classes, who wish well for humanity, and who are willing to put their hands to a constructive task."31

The cooperative movement in the United States had its early roots in small experiments by isolated groups trying to better organize and utilize their resources. While many of the earliest cooperative efforts took place in urban areas the first major cooperatives and for many years the only sizeable cooperative movement took place in rural areas- in the form of agricultural cooperatives.

Joseph Knapp in his history of the American Cooperative Movement explains why. "Prior to the Civil War, cooperative undertaking received a strong impetus from factory workers and townsfolk- including consumer groups. But the growth of industrial corporations from the 1880's on diverted this worker interest into trade unionism. In agriculture, cooperatives provided a method of economic organization uniquely adapted to the needs of farmers, for the agricultural industry was organ comprised of millions of individual small business units that could best be coordinated for productive efficiency by means of the cooperative form of organization. Through cooperative
associations farmers found they could obtain for themselves the operating advantages available to large-scale commercial concerns."

Agricultural cooperatives continued to grow through the first quarter of the twentieth century and have maintained a strong position ever since.

The post World War One era saw a great expansion of cooperative enterprises into non-agricultural businesses and services and a spread of the movement throughout the nation including urban areas. Large strides were made in forming rural electrical cooperatives, credit unions and housing cooperatives in urban areas, and consumer cooperative stores.

Furthermore, this era saw the development of regional cooperative federations such as the California Fruit Growers Exchange and national organizations such as the Cooperative League of the USA.

The Great Depression and the New Deal Era had a great effect on the cooperative movement. As a result of the Depression and widespread unemployment, many people turned to cooperative self-help organizations in order to survive the economic woes. Many people, especially in populated areas began to learn about the potential of cooperation. Furthermore, the New Deal of the Roosevelt Administration saw a significant effort by the government to support the cooperative movement. The government not only helped develop some cooper-
ative efforts with financial support but decided to use existing cooperatives as a vehicle for new social programs.

The history of American cooperatives has been one of learning from past mistakes. As a significant way of doing business, cooperatives had a lot to learn, and many were slow to learn. However, over the years the keys to successful organization and management were learned and today large cooperative enterprises exist in nearly all areas of consumer interest.

The Canadian cooperative movement has had a similar history to that in the United States. The Province of Saskatchewan, however, is an example of the potential of the cooperative movement. In that Province a widespread acceptance of the cooperative ideals led to early and strong political organization resulting in strong government support of cooperative enterprises. This support was strengthened by the establishment of a Ministry for Cooperatives! The strong cooperative movement laid the basis for the later rapid development of health cooperative societies when doctors went on strike in the early 1960s.33

Cooperative Medicine

As health care came to be recognized as a basic need for man, groups, particularly in Europe, organized to provide it for themselves. In the United States one of the earliest proponents of a concept of cooperative medicine was Dr. James
Peter Warbasse, a leader in the cooperative movement, who believed, "The practice of medicine will be on a sound basis only when the doctor is paid a salary or has his living guaranteed, when his chief duty is prevention of disease, and when the ownership and control of medical institutions, as distinguished from the professional practice of medicine, is in the hands of the consumers—the patients and prospective patients."  

At the President of the Cooperative League of the USA and as a renowned surgeon himself, Dr. Warbasse began to preach about both a new system of organizing health services and also a new role for the physician. Together with Dr. Michael Shadid, the founder of America's first cooperative hospital, they developed and spread the principles of cooperative medicine. Cooperative medicine is based upon the following four principles:

1. prepayment
2. group practice
3. preventive medicine
4. consumer cooperative control

The financing of cooperative health care is through a prepayment mechanism. Members of the cooperative each pay a fixed fee on a regular basis (generally monthly). In this way, families no longer pay for health care only when they are ill. Families pay during both sickness and health and need not fear
paying enormous bills during a costly illness. The insurance principle allows families to budget for all their health needs. Members can receive any health services they need and need not stay away because of cost. The patient no longer must identify himself as sick (usually on the basis of pain) but seeks regular care and health check-ups. Prepayment thus encourages early and preventive treatment before illness occurs or grows worse.

Prepayment also provides the organization with a fixed budget to provide health services. Physicians are hired on a salaried basis—thus removing any profit motive from the practice of medicine. Any net income to the organization is used to either reduce premiums or increase services.

Cooperative medicine is more than insurance because it provides the means of delivering health services. Services are delivered by a group of physicians, including both primary care and specialty care doctors. Physicians pool both their own knowledge and equipment—something unavailable to the doctor practicing alone.

Preventive medicine is a major principle of cooperative medicine. It is clear that it is easier and better to prevent illness than to wait until it develops and then treat it. Yet current medicine is geared to treatment. Hospitals treat disease. Medical students learn only about disease and study only patients that are ill in the hospital. Cooperative medi-
cine, however, concerns itself with maintaining health and
developing the means to deal with community issues which lead
to illness. Health education is an important part of coopera-
tive medicine. People learn to take better care of themselves
and understand the processes of health and illness, thereby
taking a more active role in their own health maintenance.

One of the major efforts of cooperation is to fight
poverty which itself is a major cause of disease. The physi-
cian in a medical cooperative is a community physician inter-
ested in improving the quality of an individual's life, a
family's life, and a community's life. Dr. Warbasse invi-
sioned a new science of preventive medicine combining social
science with medicine into a "science of cooperative
hygiene." 36

At the First National Cooperative Health Conference,
held in 1946 at Two Harbors, Minnesota, Dr. Warbasse pro-
claimed, "The new task is to carry it (medicine) beyond doc-
tors, laboratories, bedsides, and hospitals, and take it out
among the people, and make it their instrument, in their
control, for their good." 37

The fourth principle of cooperative medicine is consu-
mer control. Medical cooperatives are organized under the
Rochdale principles of cooperation thereby insuring that the
medical services rendered will be in the prime interest of the
consumer and will answer his needs. According to Dr. Warbasse,
"To bring the doctor closer to the patient, and to make him function most effectively in the interest of the patient, requires that he should be constantly in the employ of the patient." Furthermore, the resources and property come under the control of the consumers.

It has long been argued by coop advocates that cooperative medicine offers the best solution to two extremes in medical care organization- private fee-for-service in which doctors control for their own benefit and socialized medicine under the control of the state. Today medical cooperatives still offer the same alternative voiced by Dr. John Lawrence at the 1946 Conference. "It is significant that in these days when thinking people are debating the problem of how to provide health care either by continuing the old methods based on 'fee for service' or via government agencies under government control, this Conference report presents the idea of voluntary cooperative association as a method of providing such care and further develops the basis for a relationship between these cooperative plans and any proposed National Health Plan." Three of the earliest successful health cooperatives are in Elk City, Oklahoma, Washington, D.C., and Seattle, Washington. Dr. Michael Shadid is generally given credit for developing the first successful health cooperative- the Cooperative Health Association of Elk City, Oklahoma. In 1929, Dr. Shadid presented community leaders with a plan to build a
community hospital by pooling resources and then providing health services at a reduced rate. The cooperative movement was already strong in this farming region and the idea caught on. After several years of difficult organizing, planning, and fighting medical society opposition, the Farmers Union Cooperative Hospital was built and has since served a several county population on a prepaid, group practice basis. 40

The Group Health Association of Washington, D.C. was founded in 1937 by employees in the Federal Home Owners Loan Corporation. The early history of the plan was characterized by a long bitter battle between the District of Columbia Medical Society and Group Health. In 1943 the Supreme Court ruled in favor of Group Health which has since grown and served the families of both Federal and non-federal employees through prepaid group practice. 41

The Group Health Cooperative of Puget Sound developed through the joint efforts of several local and regional farming and consumer cooperatives. In 1947 two hundred families pooled together $100 each, purchased a small health clinic, and founded the Cooperative. The Coop has since grown to now serve 200,000 members with two hospitals and eight health centers. 42

Only a few other major health coops exist today. There are health cooperatives in Two Harbors and Minneapolis-Saint Paul, Minnesota, and Deer Park, Washington. Another health
cooperative is organized but not yet delivering services in the Madison, Wisconsin area. Rural health cooperatives are more numerous but much smaller in size.
III. HEALTH COOPERATIVES

Health cooperatives deliver services through a prepaid group practice system. A governing board of consumers, elected according to the Rochdale principles of cooperation, distinguishes health cooperatives from other prepaid group practices.

Prepaid group practice is a system of delivering health services through a group of physicians paid by fixed regular fees charged to enrollees. The late Dr. E. Richard Weinerman defined group practice as follows:

"The requirements of a 'true general medical group' were established as follows:

1. A systematic association of at least three full-time physicians;
2. More than one specialty of medicine represented;
3. Joint use of office facilities and auxiliary personnel;
4. Formal organization for administration and financing;
5. Pooling of income and sharing of common overhead expenses, with net payments to physicians made according to a prearranged plan."

Prepayment is a mechanism for financing health services. Instead of paying for individual services rendered the consumer pays a fixed premium (usually on a monthly basis) to a
health delivery organization. In return for that fixed fee, the consumer is entitled to all health services he or she needs regardless of their extent or cost. Most plans, while excluding dental care, some psychiatric care and out-patient drugs, do provide a full range of ambulatory care and hospitalization. Prepayment combines the insurance principle (spreading over an entire population the risk of incurring high costs) with the guaranteed provision of health services by a specific practitioner or group of practitioners.

Prepaid group practice combines prepayment of medical services with delivery of those services by a medical group. Several large prepaid group practices have been in existence for several decades. The largest and most well known are the Kaiser-Permanente plans (generally on the West Coast) and the Health Insurance Plan (HIP) of Greater New York. The Group Health Cooperative of Puget Sound and Group Health Association in Washington, D.C., both organized as cooperatives are also among the larger prepaid group practices. The performance of these plans, both under cooperative and non-cooperative management will be examined in order to draw conclusions about their suitability as systems of organizing health care delivery. The structure, effectiveness, and influence of consumer control will then be examined to determine the uniqueness of health cooperatives as a system of controlling and developing prepaid group practices.
Prepaid group practice's major success has been to provide more comprehensive services for lower cost to the patient. At a time of spiraling costs, the Kaiser Foundation Health Plan, largest and most successful to date, claims a 20-30% reduction in medical costs for members for comparable services in the fee-for-service system. In 1973 the Group Health Cooperative of Puget Sound was providing a package of comprehensive benefits to its members for less than 2/3 the comparable cost nationally. Estimates show that between 1960 and 1968 per capita medical costs rose 59% for Kaiser Health Plan enrollees compared to 97% in the United States as a whole. In 1969 the American Hospital Association reported a 17.3% increase in total operating expenses for the nation's community hospitals. For Kaiser Hospitals the increase was 9% in Northern California and 14% in Southern California.

The reasons for these cost savings stem directly and indirectly from the organization, financing, and provision of services through prepayment and group practice.

Prepayment affects the organization of care in several important ways. First, the provider works on a fixed budget. Because the organization has a limit with which it must provide all the services required, emphasis is placed on providing care for the lowest cost. Physicians become cost conscious and better management control is necessary. Furthermore, physicians are paid on a capitation basis. Physician
income is not dependent upon the amount of services they provide but simply upon the number of enrollees for whose health care they are responsible. Therefore, there is no longer an incentive for physicians to overtreat and to overprescribe.

The major cost savings of prepaid group practice result from lower hospitalization rates. With hospitalization accounting for the largest percentage of medical costs and, by far, the major area of spiraling cost, reduction can provide major savings. A chart appearing in The Harvard Law Review compares hospitalization for group practice and Blue Cross-Blue Shield plans. It is clear that prepaid group practice plans are able to significantly cut down on expensive hospitalization.

<table>
<thead>
<tr>
<th></th>
<th>Blue Cross-Blue Shield</th>
<th>Group Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>D.C., Va., Md.</td>
<td>830</td>
<td>430</td>
</tr>
<tr>
<td>N.Y.</td>
<td>800</td>
<td>570</td>
</tr>
<tr>
<td>Calif.</td>
<td>715</td>
<td>395</td>
</tr>
<tr>
<td>Ore.</td>
<td>930</td>
<td>290</td>
</tr>
<tr>
<td>Wash.</td>
<td>760</td>
<td>335</td>
</tr>
<tr>
<td>Hawaii</td>
<td>1,000</td>
<td>515</td>
</tr>
</tbody>
</table>

There are two major reasons for these lower hospitalization rates. Prepayment provides an incentive for the physician to provide as many services as possible outside of the
hospital and reduce when possible the need for and length of
hospitalization.

Prepaid group practices provide most of their services
on an out-patient basis. Compared to fee-for-service a study
has shown that while national community hospitals show a
ratio of out-patient visits to hospital admissions of 30:1,
Kaiser-Permanente has a ratio of 45:1.49 By covering the
costs to the patient of out-patient ambulatory care, there is
no incentive to hospitalize the patient in order to receive
third party payment for services that could be more easily and
inexpensively performed on an out-patient basis.

Incentives and emphasis shifts to controlling hospital
utilization and cutting down on all unnecessary utilization.
Not only does this save on costs to the organization working
on a fixed budget, but it is often more convenient for the
patient who does not lose important time while unnecessarily
in a hospital bed.

Prepayment reverses the incentives for unnecessary
surgery. Studies over a six year period at Kaiser Hospitals
on the West Coast have shown that under fee-for-service all
procedures ran 135% higher, tonsillectomies and adenoidect-
tomies ran 200% higher, appendectomies 50% higher, chole-
cystectomies 90% higher, and female surgery, including mas-
tectomy, dilatation and curettage, and hysterectomy, 77%
higher than in prepaid group practice hospitals.50
Prepaid group practices also emphasize early discharge from the hospital after an operation or illness. Lower lengths of stay further reduce hospital utilization.

Working with a fixed population, prepaid group practices are able to plan effectively and, therefore, build hospitals to meet demand rather than build and then provide the demand. Thus, major savings for hospital-based plans results from the lower number of beds required per enrollee and greater hospital occupancy rates.

On the West Coast Kaiser Hospitals are able to operate with only 1.6 hospital beds per 1,000 members compared to the California state average of 3.7. Much of the savings not ordinarily thought of are the hospitals that prepaid groups need not build. A study showed that in order to provide the comparable amount of hospital services in 1966 as private physicians had ordered, an initial capital investment of 14,000,000 would have been required.

In 1969 Kaiser Hospital occupancy rates varied from an average of 77 to 88 percent. Certain prepaid group practice hospitals in Southern California even reported occupancy rates exceeding 100%. While such high rates of occupancy do add to efficiency and reduce costs, excessive concern with full occupancy can lead to both patient inconvenience and pressure to delay certain operations due to excessive occupancy.

Within the various types of prepaid group practices,
major savings result from ownership of one's own hospital facilities. The same control over services that exists in ambulatory care facilities extends to the hospital services of such hospital-based plans as the Group Health Cooperative of Puget Sound. Non-hospital based plans cannot exercise the same control over hospital services as they do for ambulatory care. They are forced to pay hospitals the same cost-plus charge as any other patient. Furthermore, it is difficult to integrate both ambulatory and in-patient care when the two are completely separate.

Group Health Association of Washington, D.C., a non-hospital based cooperative prepaid group practice founded in 1937, is forced to charge premiums that are about 1/3 higher than those of hospital-based plans. Similarly, the Health Insurance Plan of Greater New York estimates that it can attain only 1/4 the savings in hospital bed-days as comparable hospital-based prepayment plans.

Prepaid group practice, however, has not been able to control the national trend in rising patient-daily hospital costs. Hospital savings result primarily from lower hospitalization and not greater efficiency in the hospital. Prepayment plans have been equally plagued by rising wages of ancillary personnel and rising costs of equipment. Hospital savings result from that which occurs before hospitalization rather than improving that which occurs inside the hospital.
Savings also occur through the introduction of new facilities more appropriate and less expensive than hospitals. Kaiser was able to further reduce hospital utilization by over 10% with the introduction of long-term care facilities.56

Savings are also claimed for the fact that medicine is practiced in groups. What economies result from maintaining physicians in one central location? Off hand, one would suspect that group medicine is far more efficient. However, indications are that the group practice of medicine has only a minor effect on the savings of prepaid plans. What group practice does do is to provide the physician with all the equipment he may need in his practice. The physician is no longer required to hospitalize a patient in order to have him near the equipment he may need for further treatment or diagnosis. The Federal Manpower Commission wrote, "Kaiser undoubtably achieves economies in investment, purchasing, and administration, (but) these areas account for only a small fraction of the total cost of providing comprehensive medical care."57

Financing procedures are simplified both for the individual physician and the health plan by requiring members to pay only a fixed monthly fee (except for some minimal co-payments for certain services) rather than on a fee-for-service basis.

Another saving, both economical and in light of the current manpower shortage, is the productivity of prepaid
group practice physicians. Prepaid group practice has been able to provide office and hospital care with fewer physicians for comparable populations. In a recent publication on the Kaiser Health Plan, Greer Williams cites a table comparing the ratios of physicians per 100,000 population of Kaiser Health Plan and their respective state populations. In each case Kaiser has been able to provide services with at least 1/3 fewer physicians.  

<table>
<thead>
<tr>
<th>Region</th>
<th>State Ratio</th>
<th>K-P Ratio</th>
<th>% Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern California</td>
<td>161</td>
<td>102</td>
<td>-36</td>
</tr>
<tr>
<td>Southern California</td>
<td>161</td>
<td>90</td>
<td>-43</td>
</tr>
<tr>
<td>Hawaii</td>
<td>133</td>
<td>83</td>
<td>-38</td>
</tr>
<tr>
<td>Oregon</td>
<td>128</td>
<td>67</td>
<td>-48</td>
</tr>
</tbody>
</table>

In economic terms, the greater productivity of physicians can lead to savings as great as 50%. The Report of the Health Manpower Commission estimated that in California Kaiser physician expenses per member were 50% of the state-wide figure.  

Part of the increased physician productivity is a direct result of the way in which medicine is practiced in group facilities. Exactly how much of a saving group practice is responsible for is not clear. However, surveys and studies all seem to indicate that groups, whether prepaid or not, do tend to function more efficiently as measured by increased patient visits and greater volume of business.
Organization into groups provides physicians with services and personnel that increase physician productivity. The addition of nurses, nurse practitioners, ancillary professional and para-professional personnel, laboratories, and administrative personnel free the physician and allow him to concentrate more of his time on the practice of medicine.

Some of prepaid group practice's lower physician and allied health personnel need may be a result of shifting care from the hospital, where more manpower intensive care is provided, to office and out-patient care.

Greater efficiencies in manpower utilization, undoubtedly, do occur in group practices. However, how significant these savings are is still questionable. In the area of new and innovative manpower utilization, it appears that prepaid group practice has not made many significant changes.

All in all, prepaid group practice's major savings are a result of lower hospitalization rather than major changes in physician efficiency or traditional staffing patterns.

Dr. Alex Gerber, himself a physician practicing in a group, writes, "Even the mighty Kaiser system, with all its advantages of huge scale, admits freely that savings on that account are relatively minor. Kaiser's lower total cost results almost entirely from fewer hospital admissions and fewer patient days as compared to surrounding areas generally." Gerber goes on to add, "A more valid comparison would be be-
tween Kaiser and fee-for-service groups that maintain equally high standards. My experience leads me to believe that such a study would show that Kaiser has no cost advantage important enough to overcome the disadvantage of its less personal and often inconvenient care."62

In fact, such a study was done of two health plans in New York City. Although the data for the study is from the year 1958, the authors, Paul M. Densen, Sam Shapiro, Ellen W. Jones, and Irving Baldinger, did produce some significant findings. They compared hospital utilization rates for the Health Insurance Plan of Greater New York, a prepaid group practice, and an alternate Union fee-for-service health insurance payment plan. The union plan maintained a "very active program of control of expenditures." The study concludes, "Annual hospital admission rates for the two groups of enrollees under comparison were almost identical...In summary, the current study raises the interesting possibility that a highly disciplined fee-for-service program...may have and important influence on hospitalization...This factor may be responsible for bringing the hospital rate down to at least the comparatively low level consistently shown in the past for HIP-covered groups."63

The ultimate responsibility for cost savings lies in strong management-physician control and cost-consciousness on the part of the physician. The physician is the single most
important person in determining utilization, both type and location. Quoting from the Report of the Manpower Commission, "The majority of savings achieved by Kaiser result primarily from effective control over the nature of medical care that is provided and over the place where care is given."  

"Kaiser has been able to achieve substantial savings because it has been able to get individual physicians to control the costs of providing medical care. The Kaiser physicians operate in a setting which makes them constantly aware of the costs associated with providing medical services and which exerts pressure on them to avoid waste."  

While many of the statistics tend to show that Kaiser and other plans are able to perform tremendous efficiencies, one must ask to what degree are they a result of members seeking care outside of the system and to what extent are they a result of services not rendered by the plan. Excluded from most plans either in part or in whole are dental services, psychiatric care, and some special nursing services estimated to account for close to 1/3 of a family's total medical expenses.  

With savings resulting from the reduction of major costs such as hospital care, prepaid group practices can offer a wider range of benefits than standard insurance plans. In particular these savings are used to provide comprehensive ambulatory services thereby providing the consumer with a com-
prehensive set of services (both in-patient and out-patient) for a comparable (although generally higher) premium. Only by maintaining such large savings in hospital care can prepaid groups provide such a wide range of services and remain a marketable plan.

What about the quality of care that patients receive in prepaid group practice plans? Is the consumer's return for a monthly fee comparable in quality to the care he can receive elsewhere? The issue of quality is always a difficult one to assess.

Quality from the provider's point of view often means better technology for diagnosis and treatment, physician competence, and a better environment or structure of organization under which one can practice "good" medicine.

From the consumer's point of view quality generally means personal interest in the patient, convenience and availability, and physician competence. However, competence is a very difficult component for the lay person to appraise. Patients, lacking any concrete mechanisms by which to judge, often assume that most physicians are medically competent and consequently place most emphasis on personal interest, availability, and medical technology (tests, equipment, back-up facilities) as a measure of competence and quality. One can begin by examining certain basic structural features as to their possible effect on quality.
The structure of prepaid group practice has several inherent aspects that potentially improve the quality of care delivered. First, the delivery of care lends itself to better medicine for the patient. In a multi-specialty group specialists are available when they are needed. The physician need not deal in those areas in which he lacks expertise. Specialists are available for informal consultations and back up facilities are available if necessary. More careful and accurate diagnosis can be accomplished through use of the more extensive facilities available in group practice locations.

For the patient, group practice provides a single entry point in seeking medical care. The patient need not go to several locations to have a certain illness diagnosed and/or treated.

Another factor associated with quality medicine is the continuing education of physicians. After all, with medical education increasing more rapidly every year, and new techniques of treatment and diagnosis developing constantly, the continuing education of physicians seems vital to their continued good practice. For two reasons, group medicine has been able to perform quite well in this regard. First, continuous contact with fellow physicians in the practice of medicine keeps doctors abreast of the latest developments and techniques in medicine. Secondly, group practice can afford to set aside times each week for physician post-graduate education. Kaiser sets aside a half day each week for physicians
Selection of physicians for the group can play an important role in providing quality. Groups are inherently careful in their original selection. The success of any group can be severely hampered by even one "bad egg." After a physician enters a plan, the same review continues, if not always on a formal basis, certainly on an informal one. Doctors are always working in the same facility, sometimes treat the same patients, and write diagnoses and reports in the same medical record. It is important to the group that all parts function smoothly, efficiently, and properly. If one physician is wasteful, it affects the whole group. If one physician is not competent it can be very harmful to the other doctors' practices.

At the Group Health Cooperative of Puget Sound new physicians have a two year probation period during which the staff evaluates them for "suitability to group practice, professional ability, patient rapport, and potential for leadership." After this period they are either recommended for full staff membership or asked to leave. Over an eight year period four of sixty entering physicians were found unacceptable. Four others left on their own after the probationary period.

Group practice plans also make use of the unit medical record. The unit medical record's advantages work in two ways. First, the patient's complete medical history is avail-
able wherever he may be seeking care, and he needn't bother to fill out histories for each physician he sees. Secondly, the physician has a further incentive to be careful because he knows that other physicians with whom he works will be reviewing his own work as it appears on the medical record.

Prepayment can improve quality both by insuring the availability of a comprehensive set of services and by eliminating any incentives for unnecessary procedures, especially surgery. Prepayment eliminates any worry or hesitation on the part of the member to seek early care for any disorder. Knowing in advance that all services are paid for, the enrollee faces no financial barrier for seeking care.

From the physicians' perspective, eliminating the "money question" allows him to provide services regardless of the member's ability to pay. The physician is now free to provide the appropriate service at the appropriate location. The doctor is no longer influenced by the opportunity to receive an increased fee for more services. Capitation payments, based on the number of patients, not services delivered, eliminates any incentives for unnecessary treatments. Only under those cases in which surgery is warranted by accurate and careful diagnosis is the patient hospitalized. Also, during surgery, the patient need not worry that more procedures than those medically called for will be performed.

Many prepaid group practices have been experimenting
with new forms of manpower utilization. Kaiser has programs involving nurses in uncomplicated prenatal care and some care during labor, pediatric nurses to handle well-baby care, registered nurses handling primary care in satellite clinics, and expansion of the use of orthopedic aides, pathology technicians, and operating room technicians. Prepaid group practices are better suited to innovate in the area of paraprofessional usage because they are less constrained by license and practice laws than hospitals and solo practice.

Group practice physicians appreciate the fact that they have at hand all necessary personnel and equipment that may provide the best health care. Specialists are available when their expertise is called for. Furthermore, group practice frees the physician from time consuming administrative and routine duties. He is no longer required to be manager of an office or director of any personnel.

Many physicians feel that for them the best selling point of prepaid group practice is the elimination of the financial aspects of medical treatment. No longer need the physician involve himself in sending bills and charging separate fees for individual services. Others appreciate the more regular hours of work leaving more time for family affairs.

With these structural advantages potentially improving the quality of medical care rendered through prepaid group practice, are there any structural disadvantages that may lead
to poor medicine, especially in the eyes of the consumer?

Prepaid group practice's very foundation of cost control and efficiency can, if carried too far, cut into quality and lead to severe consumer dissatisfaction. Emphasis on cost control in prepaid group practice can be a two-edged sword. While saving money on the one hand, critics claim that devotion to efficiency sometimes reaches too far and becomes underutilization where services are, in fact, deemed necessary.

The Citizens Board of Inquiry Into Health Services for Americans visited the Kaiser-Portland facilities and their report dealt heavily on the issue of over-economizing and mechanisms for making the consumer's voice heard. The Report states, "Costs may also be saved by diminishing the value of the services rendered by reducing the quality or the quantity of services actually delivered to members. Thus, some critics contend that Kaiser members are not hospitalized when they should be, that out-patient treatment is rushed and impersonal, and that the appointment system is set up to discourage usage."70

The appointment system does appear to be a major drawback in existing prepaid group practice plans. Appointments for nonacute care often have a six to eight week waiting time. Such long waits are no doubt a discouragement to any member seeking so called preventive care.

The physician-patient relationship changes under pre-
paid group practice. The organization of group practices gives the impression, at times accurately, of less personalized medicine. Rules and regulations affect usage of services. Non-physician personnel often perform tasks that private solo practitioners would perform themselves. Furthermore, receiving care in a single large institution adds to the feeling of impersonality. Group institutions also make greater use of technological advances and, hence, give the impression of dispensing more technical and scientific medicine.

Patients generally feel that they are receiving better technical care, however, at the expense of a more personal patient-physician relationship. Better medical care is felt to be a result of greater use of diagnostic, technical, and consultative resources. 71

In order to maintain a strong patient-physician relationship health cooperatives place strong emphasis on family physicians as the cornerstone of health services. Each member family is given a wide choice of family physicians for their primary care. Specialists are only used when needed and the family physician still acts as the main care giver.

One would think that the least a plan would do, both from the consumer's point of view and that of the organization, is to set up an effective complaint mechanism. While the Citizen's Report described the Kaiser-Portland grievance procedure as largely a sham, 72 the Group Health Cooperative of
Puget Sound has always maintained an effective Member Services Committee for reviewing and processing of complaints. The best that can be said concerning the quality of care rendered through prepaid group practice is that its organization of services and financing have the potential to improve care. Organized peer review, continuing education, better patient control, and emphasis on the preventive aspects of health care can all be enhanced through prepaid group practice. However, hard data on the effect of prepaid group practice is still difficult to effectively evaluate. Certain studies in the City of New York, dealing with members of the Health Insurance Plan of Greater New York, showed that prepaid group practice was able to reduce perinatal mortality and prematurity rates of babies.

In general, prepaid group practice tends to improve the technical aspects at the possible expense of the personal aspects of health care.

Preventive care or health maintenance is a significant quality issue that prepaid group practice claims for itself. However, there is reason to question the extent to which it is "practiced rather than preached."

There are factors inherent in prepaid group practice plans that do encourage preventive care. Prepayment is in large part responsible for this. Members have no financial barriers to seeking early care. Furthermore, opportunities
are available for complete physical check-ups. Incentives, due to financing on a fixed income, fixed annual salaries, and even bonus funds, exist by which the physician benefits by keeping patients healthy.

However, the existing pressures on the limited staffs of prepaid group practices forces preventive medicine to play a secondary role to acute, crisis oriented care.

Dr. Gintzig, of the George Washington University Department of Health Care Administration, summed up the problem this way. "The basis of prepaid group practice is structured on prevention. However, beyond the organizational aspects that promote preventive care, the exercise of preventive medicine is minimal. Preventive medicine, due primarily to its high cost, is becoming the least important aspect of prepaid group practice. And people do not want to spend money on preventive medicine. Not only has the physician always been taught to cure and not prevent, but the patient has always been taught to go to the doctor when he is sick, and that's all."75

Health education has always been thought of as the foundation of preventive health. Dr. George Rosen stated, "In the last analysis the achievement of improved health depends on personal effort guided into the proper channels by knowledge presented in situations conducive to understanding and learning. The existence of an interested, receptive and in-
formed public is essential for any successful preventive program. From all this the need for health education follows ineluctably. Indeed, health education must be at the center of any effective preventive program."

However, prepaid group practices have been slow in developing strong health education programs. Health education programs should be particularly suited to prepaid group practices because of their "captured" membership. Meetings could be more easily organized and materials sent to members. However, as Gintzig states, these programs would inevitably cost money. In Schwartz's study of prepaid group practices he found, "Health education programs were clearly not a prominent feature of either cooperative or private physician groups." Schwartz did site the exception of the Group Health Cooperative of Puget Sound which publishes a bi-monthly health education magazine for its members and holds regular regional health education lectures and discussion groups.

Preventive care still appears to be less a reality than health plan representatives would lead one to believe. While there are incentives for greater preventive care they depend to a great deal on the initiation of the patient rather than the dispensing of preventive medicine on the part of the health plan physician.

It is a well documented fact that prepaid group practice has been able to hold the line on costs better than the
predominant system of medical care. However, prepaid group practice's ability to do so is largely a result of better control over hospital utilization rather than significant reformations. It has also been shown that comparable savings can result from conscientious fee-for-service groups. Many other aspects of cost increases, inflation, and wage increases are in many respects out of the control of current medical institutions.

In addition to reducing the cost of medical care prepaid group practice has accomplished two goals toward which any health policy should aim. First, prepaid group practice has rationalized the delivery of health care. Care is provided for a specific population in a specific location. The patient can receive almost all his medical care from one institution, and he knows that that institution is responsible for his medical care. No longer is the patient confronted with an unorganized "shopping cart" system, but instead, a rational delivery mechanism. Planning is a factor for the first time, and personnel and other resources are used in a more meaningful way.

Secondly, prepaid group practice provides the patient with security from unexpected health crises. If ever something unexpected should come up, the member knows that he or she will not get stuck with an enormous bill. A major attraction of prepaid group practice is the security it provides.
With the cost of care generally more expensive than insurance premiums, and a significant percentage of the members never seeking health care, security appears to be the most attractive feature.

Consumer Control

Consumer health cooperatives differ from other prepaid group practices because their governing board is elected from amongst the consumer membership. In general each family belonging to the cooperative has one vote in electing the members of the board of directors, themselves members of the cooperative. Not all prepayment enrollees are coop members. Coop membership generally entails an additional single membership fee. At the Group Health Cooperative of Puget Sound about forty percent of the enrollees are also members of the cooperative.\textsuperscript{78}

The topic of consumer control has been of increasing interest since the early 1960s. However, health cooperatives have always recognized the need for lay control. It must be clear that this control exists at the board level and is directed at corporate and policy issues. Medical decisions are always left exclusively to the medical staff. Hiring of personnel varies but usually consists of input both at the Medical Director level and the board level.

The Group Health Cooperative of Puget Sound, the largest health cooperative in the United States, is an excellent
example of the concept of consumer participation and control. By 1974 Group Health Cooperative was serving 200,000 people of which over 70,000 belonged to the Cooperative.79

The Board of Trustees is made up of 11 members—one elected from each of eight regional districts and three members elected at-large. Three or four members are elected each year for three year terms. Elections are held at the Annual Meeting of the Cooperative with the inclusion of mailed absentee ballots.

The Board of Trustees elect a Medical Director and a Hospital Superintendent. The Medical Director is in charge of the medical staff and makes all decisions affecting the hiring of staff. The Hospital Superintendent is in charge of administration and management of the facilities.

The Board conducts much of its research, discussions, and business through twelve subcommittees consisting of board members, physicians, and coop members (not on board). These twelve committees are arbitration, charitable fund, community affairs, district activities, facilities, fiscal and management, health care assessment, joint conference, member services and hospital, planning, research and patient rights, and deferred compensation. From time to time an additional committee, retirement benefits, is appointed by the board.

The member relations and hospital committee is in charge of dealing with consumer complaints. It has maintained
an impressive record and deals with both consumer complaints about services and/or staff and staff complaints about members. The committee receives about 500 to 700 calls a month—many of which are simply calls for information. However, generally 100 or more complaints are investigated each month with either proper referral, explanation, or appropriate action taken.

The joint conference committee, comprised of three board members and three staff members, is responsible for discussing and suggesting solutions to mutual problems.

The Group Health Cooperative encourages consumer participation through regional representation. The Seattle service area is divided into eight regions. In addition to electing a representative to the board, each region holds quarterly meetings for members to attend, be informed of policy discussions and to discuss and present their own views. Coop members have a right to discuss and give advisory votes on issues at the regional meeting. (All coop members can vote on issues at the Annual Meeting.) In addition, each regional meeting features a speaker on a topic of interest in health education. One typical quarter featured the following health education discussions: family planning, viruses, cancer checkups, back problems, hyperactivity, emotional problems of mature and older women, personality and disease, and a physician's experiences in a Mississippi health care program.
Occassionally the quarterly regional meetings focus directly on policy questions—such as extension of benefits in areas such as congenital defects, renal dialysis, family planning, and blood bank services.

All district meetings and the annual meeting are well publicized in the bi-monthly GHC magazine View. In addition, flyers describing the topics at the district meeting are sent to each home. View also fully describes all members running for election. In a recent article in View board member Mr. Eugene Lux urged that consumers participate in the Coop and attend its regional meetings. "Group health has experimented with the size and number of districts and committees throughout the past 25 years to reach an organizational structure in which the consumer Co-Op members can make his or her beliefs known and translated into action by the board. This is an on-going project and membership participation and interest in this process make the District organizations more relevant and responsive as new conditions present new challenges.

'But it all begins in the District meeting,' Lux said. 'If a member is dissatisfied with some part of Group Health he can, of course, make his feelings known to the Member Relations section. If he will bring his concerns and suggestions for improvement to his District meeting there is an even better chance that the group can help solve the problem and get direct action by the Board.'
"Lux pointed out that a number of misunderstandings can be cleared at District meetings. Management representatives often can take corrective action immediately.

"Lux said the 'good, plain practical sense' of members participating in District meetings has caused a number of improvements and extension of service by Group Health Cooperative to its enrollees."82

Jerome L. Schwartz made an extensive study of six health cooperatives.83 Schwartz focused his study on two aspects of consumer organized health care. First, to what extent do consumers participate in and influence health systems that they control. Second, by comparing health cooperatives with six physician organized prepaid group practices, what effect does consumer control really have on the type and quality of health services?

Schwartz found that participation by the general membership was low. This, however, is the case with almost all organizations and cooperatives as well. It had long been known by cooperators that member participation is generally limited to a minority of "participators." Schwartz found "most organizations have an oligarchical structure with an active minority and an inactive, apathetic majority."84 However, Schwartz also found that general membership participation was high at the start of these health plans. Consumers, lacking satisfactory services joined together and were active
participants in organizing services until they were satisfied with what they received. Membership participation and influence declines as staffs are hired and professional and technical services are required. As the size and complexity of the organization increases, member participation decreases to only a small minority.

In many of these plans the activity of the consumers is strongest at the board level. Weakest participation exists at the grassroots level. The most active participants tend to be from higher socio-economic levels. Schwartz found that there was greater activity among consumer boards with higher socio-economic status and higher education level.85

Schwartz found that, in general, administrators and physicians had the most influence in policy decisions. However, on boards with "professional" members, consumers had an important and on many issues major influence on decisions. "In general, administrators had the most important role in cooperative plans and physicians had the second most important role. However, in plans with professional or executive trustees, the board had a major voice in policy making."86

Physicians tended to be most influential in decisions covering medical staffing, quality of care, and other medical questions. Consumers, on the other hand, had strong influence on decisions concerning enrollment, eligibility, rates, coverage and scope of services, complaint procedures, and health
education.

This pattern of board influence is similar to other types of cooperatives. Those cooperatives with a professional and executive type board generally are more active and have a stronger influence over policies. Schwartz found that the three most active consumer boards were those three boards composed of members very much interested in other cooperative programs. The boards with the least "coop" influence were also the least active. "Over a period of time, three boards have become composed of professional and administrative people, many of whom are cooperative-oriented individuals. These boards are the ones which play an important part in policy making. The other three boards have trustees whose backgrounds are somewhat similar to those of the original trustees, except that the strong cooperative influence is no longer present." 87

Schwartz hypothesizes that consumer influence is limited because of the reliance of consumers on the administrator for information. In order to make proper decisions, consumer boards must have information and be familiar with the various aspects of a problem. Therefore, the administrator plays a vital role in facilitating the proper functions of the consumer board.

Furthermore, lay trustees can only devote a portion of their time to board activities. Their main activities are
elsewhere. Therefore, administrators and physicians will always be in influential positions.

Schwartz also examined the influence of consumers on the type and scope of services rendered. Schwartz summarized several major findings as follows: "Communication between consumers and staff members apparently results in specific improvements in health plan programming. Although direct participation of consumers in policy making was weak in some plans, health plan programs were stronger in cooperatives where consumer boards were active in making decisions." 88

Schwartz singled out four major areas in which consumer boards had an important effect in improving services. These areas were enrollment policies, grievence procedures, eligibility rules, and extra medical services.

Both physicians and consumer plans had group enrollment policies; but only two physician plans enrolled qualified individuals. All consumer plans enrolled all qualified individuals. This policy stems directly from the open enrollment principle of cooperatives ennunciated by the Rochdale pioneers. "The cooperatives aimed at offering the plan and its benefits to all eligible persons in the community, thus fulfilling their stated principle of 'open enrollment.' Although care was exercised by consumer plans in admitting applicants who enrolled individually and waivers were imposed for some conditions, families not otherwise eligible for prepaid group prac-
were given the opportunity to enroll in consumer plans." 89

Schwartz found that consumer sponsored plans developed good grievance procedures which physician plans generally lacked. "At their outset, consumer cooperatives formed member committees to attend to consumer grievances. This early attention to complaints has persisted, and cooperatives today emphasize grievance procedures. In contrast, only two of the physician plans had a well-defined complaint mechanism. The interviews clearly established that consumers paid attention to complaints." 90

Schwartz found that, "consistent with the cooperative principle of extending benefits to the entire community, consumer groups have adopted eligibility policies with as few enrollment barriers as possible." 91 Such liberalized policies allowed members to qualify for more benefits resulting in a higher utilization rate at some coops. As an example, several cooperatives covered maternity care for unmarried teenage dependents.

Finally, a major finding of Schwartz was that consumer participation resulted in a more extensive set of extra-medical benefits. While both consumer and physician plans offered comprehensive medical services, consumer plans offered a greater number of additional services. "In general, consumer plans provided more extra services than physician plans. For
example, refractions for eyeglasses were covered by five of the six cooperatives, and three dispensed glasses at a reduced rate. In contrast, only one physician plan provided comparable benefits, while two other plans offered refractions at a reduced rate.

"Five of six cooperatives had developed extra services in at least three areas, but only one of the six physician plans had more than two types of extra services. Certain consumer plans had services not matched by any of the physician plans; one fitted contact lenses, offered a dental program and podiatry services, and operated an adolescent clinic. Two offered home nursing benefits, and two other plans operated senior citizens' homes. One of these latter groups also had a separate nursing home.

"One consumer cooperative had an impressive array of extra services. This plan offered benefits in dental, psychiatric, podiatric and nutritional care, and in prescription drugs, eyeglasses and social work services. In addition, it was the only plan studied which had instituted a special adolescent clinic and regularly scheduled night clinics.

"Prescription drugs were fully covered by one consumer plan but three plans of each type offered some drug benefits. One physician and one consumer plan offered psychiatric services. It should be noted that one important service area, rehabilitation, was not receiving attention from any of the
Schwartz also found that it was through the direct participation of consumers on the boards of trustees that these extra benefits were added. Schwartz cites pharmacy coverage as one example of consumer influence. The largest cooperative established its own pharmacy when the plan began. Drugs were free and paid for through the monthly premiums. One physician plan also had its own pharmacy but closed it as prices began to rise. "The members of the cooperative, however, have refused through the years to give up drug coverage, choosing instead to absorb rising drug costs by voluntary increases in prepayment dues." 93

Schwartz found that, "The groups with the highest number of extra benefits generally had high premiums, although several groups with modest dues also offered extra services. It is logical to expect that extra costs are involved when benefits such as drugs or psychiatric services are offered because plan income must cover these costs, but consumers do want broader coverage and are willing to pay for it." 94

Schwartz made the following conclusions about consumer participation and influence:

"Cooperatives with more consumer activities also had boards more active in policy making. Furthermore, the extent of general membership participation was directly related to the influence of trustees in deciding policy matters."
"Encouraging consumers to participate in the plan appeared to have beneficial results. The efforts of one plan to stimulate consumer participation, through enrollee committees, studies and a series of regional meetings, resulted in strong membership support for the plan and a pool of enrollees from which informed trustees could be drawn for more active consumer participation.

"The consumer plans with more consumer board participation had better overall programs. Although no cooperatives had substantial health education programs or devoted much attention to assessing consumer satisfaction, the plans most active in these areas were those whose boards played an important role in policy making. Even in grievance procedures, an emphasis of all cooperatives, groups with strong board participation devoted the most attention to handling complaints. When consumers are able to voice their sentiments either through participation on a board or through direct contact with staff members, there is a tendency to extend the scope of benefits beyond the basic plan features, and the result is an interesting number of extra services in consumer plans. Thus, consumer participation, although not widespread or substantial at present, can influence health plan programs in a favorable direction. However, consumer sponsorship and board representation alone do not result in better programming, unless consumer board members are active participants in ini-
tiating changes and planning programs.

"A high degree of competence is needed to make many of the decisions in health plans. Boards composed of professional and managerial people were active and influential in policy making, and better health programming resulted. However, consumer trustees did not infringe on medical prerogatives and medical decisions were left to practitioners, because the planning and administration of prepaid group health services is complex and calls for expert opinion. The study showed that administrators and physicians have influential roles in consumer plan policy making.

"Communication between enrollees and staff also contributes to better health programming. Direct contact between enrollees and staff members, which consumer plans provide, enables consumers to voice their opinions of the benefits and programs. Since consumers, physicians and administrators might each emphasize different areas of the health plan, the overall program appears to be strengthened when all three groups are represented in policy making."95

A potential for cooperation, being realized in some smaller areas is in the field of community development. Cooperation offers the strengths of community organization, economy, and self-help. Health cooperatives can be either the focus or seed for greater community cooperation or an outgrowth of other community efforts. Most of the existing
health cooperatives were formed by members already running and leading other cooperatives.

Health cooperatives can be a prime focus for community development because of their stress on health maintenance. It has long been known that people's worst disease is poverty. With rising income and better living conditions a person's health status also improves. Therefore, an interest in health care must fundamentally be based on improving economic and living conditions.

The two towns of Two Harbors, Minnesota and Mendenhall, Mississippi are examples of this potential. Both these towns are poor working class communities. The close to 5,000 residents of Two Harbors receive their medical care through a health cooperative. In addition, they have developed their own cooperative grocery, hardware store, gas and fuel oil cooperative, credit union, and cooperative light and power cooperative.

Mendenhall is now developing in many the same ways Two Harbors did over twenty years ago. They currently have a cooperative store, some cooperative housing, and a soon to open cooperative health clinic.96

The potential certainly exists to develop community health and medicine through combinations of health, food, housing, and goods and service cooperatives—each interested in providing better and more economical goods and/or services.
along with educating the consumer. And all this is done through true community self-help.
IV. CONCLUSIONS - WHERE DO WE STAND?

Today large well-established health cooperatives exist in Washington, D.C., Seattle, Minneapolis-St. Paul, Two Harbors, Minnesota, and Deer Park, Washington. Smaller cooperatives exist in several rural areas.

The Group Health Cooperative of Puget Sound (Seattle) represents the largest and most successful of all health cooperatives. The system of health services in Seattle is easily among the finest in this nation. As of 1974 the Group Health Cooperative is serving 200,000 members on a budget exceeding 34 million dollars. The Cooperative has two hospitals with a third under construction. Primary care services are delivered in eight primary care centers with two more scheduled to open by early 1975. Group health provides its members comprehensive medical coverage including unlimited in-patient and out-patient care. Drugs are also provided at no extra charge. A separate dental cooperative maintains offices in a Group Health facility. GHC is currently constructing its own extended care facility to provide rehabilitative services to members.

Group Health Cooperative also maintains a strong health education program including regional meetings and discussions, and a bi-monthly magazine sent to all members.

Consumer participation is high at Group Health. Several recent board elections have been contested as the times
change and new needs are expressed by the members. Benefits continue to expand as consumers demand more comprehensive services. When a big issue comes up, consumers make their feelings known and can vote to decide the issue.

A recent example has been the issue of providing contraceptives for free by increasing the monthly premiums. Hot debate was carried on over the last several years and at a special meeting of all members, those attending voted to accept the board's recommendation to include contraceptive devices in the benefit package. This issue will be under reconsideration by the coop membership at the next annual meeting.

Participation by consumers was extended recently through several significant revisions of the By-Laws. Group enrollees (not members of the cooperative) which constitute approximately 60 percent of the membership are now allowed to participate at nearly all levels of the cooperative. Group enrollees can now belong to all board committees, hold office in regional organizations, and participate in discussion and debate at the annual and all special cooperative meetings. Coop members still reserve the sole right to be board members and vote at the annual meeting.

Puget Sound can provide all these services at 61% of the national per capita rate. Hospitalization costs are 1/3 the national per capita rate.

If the Health Cooperative of Puget Sound can clearly
provide such quality services with such economy one must ask why is it nearly the only one of its kind? There are several reasons why health cooperatives are few in number and why no new ones have started since the 1950s.

Prepaid group practice, both consumer and physician controlled, has not developed and grown at the rate many would have expected. Two of the major problems involved in forming a prepaid group practice are attracting a sufficient subscriber population and forming a physician group to provide services.

For many plans, finding and hiring physicians is the most difficult problem. First of all, not all doctors work well in groups. After all, many doctors decided on their profession because they wanted to be individuals working in a setting where one is left very much to his own. One realized that his work is under greater scrutiny than if he worked in a private office. Salary scales are also a factor. Prepaid group practices must pay comparable salaries in order to attract doctors. While generally salaries are a little better than the average in a community, good doctors are often capable of earning more money outside in the fee-for-service system. Most difficult to attract are the specialists in high demand.

Furthermore, though less so now, group practice, especially prepaid group practice, has held little status value.
Doctors practicing thusly have often been held in low esteem by their peers.

An even greater difficulty, primarily in those areas where prepaid group practice is not yet established, is enrolling an adequate patient population. The biggest barrier is educating people about an alternate way to receive health care. Along with that is the problem of then convincing people to change. Health care is one of the most difficult aspects to change in a person's life-style. Medicine involves one's very well-being and life. Personal relations with a physician, once established, are very difficult to break. Furthermore, prepaid group practice raises several questions in the minds of patients, some of which are based on more than mere illusions. The "socialized medicine" taboo has been a long and in many ways stubborn attitude to change.

The Group Health Cooperative of Puget Sound readily admits its first big mistake. Dr. Shadid advised them to have professional salesmen selling memberships. Others felt that the cooperative had so much to offer that this wasn't necessary. Shadid turned out to be right. The cooperative eventually hired a staff to promote the health plan.

Experiences elsewhere point out the need for intensive and very personal selling and education. The Health Insurance Plan of Greater New York (a prepaid group practice) found that memberships had to be gained on a very personal, one-to-one
basis with the prime ingredient being "tender loving care" on the part of the salesman. The Harvard Community Health Plan in Boston similarly was forced to hire a professional sales staff to promote its plan. People did not flock to their doors as had been expected.

However, once a plan is established in an area and people begin to understand the meaning of prepaid group practice and cooperative structure (in the case of health coops) growth is not a problem. The Group Health Cooperative of Puget Sound has grown so quickly in recent years that new enrollement has been temporarily frozen until construction of new facilities catches up with demand.

The growth of private health insurance has been another important damper on prepaid group practice. In the United States the first significant private health insurance, particularly hospital insurance, developed during the Depression. Blue Cross hospital insurance plans developed in the 1930s in order to support a financially unstable hospital system. At the same time the idea of prepaid group practice was proposed as a better method of providing medical care. Blue Shield and private health insurance plans (independent indemnity plans) developed during the 1940s. Therefore, at the time that new prepaid group practices were being planned and developed (late 1940s) health insurance plans had become a significant option to the old system of strict fee-for-service. Therefore, a
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One of the two must important reasons health cooperatives have not spread in the United States is that Americans have such a small notion about the cooperative way. As Dr. Warbasse wrote as far back as 1927, "Perhaps the greatest drawback to even starting cooperative societies in the United States is the fact that the people are not socially minded. They prefer profit business to the service idea." \(^\text{104}\)

It is not at all surprising that four of the five large cooperatives are located in the "coop" belts— the states of Washington and Minnesota. In all four cases strong cooperative organizations preceeded the development of the health coop. Many small rural health coops exist in areas strong in the farming coop tradition. The Province of Saskatchewan, Canada with perhaps the strongest cooperative movement in North America also has an important health cooperative movement. Much of this "coop" tradition stems from the Germanic and Scandinavian immigrants settling in these areas.

If consumers were capable of organizing a cooperative health plan, in almost all cases they ran up against perhaps the most significant roadblock of all—organized medicine, in particular the American Medical Association and State Medical Societies.

Organized medicine vigorously opposed many of the first prepaid group practice plans in the United States— even those controlled by physicians. Organized medicine placed a great
deal of stress on physician control. Organized medicine was interested in maintaining quality and maintaining control of the organization of care. "Regardless of the nature of the sponsoring body, the AMA has laid great stress upon placing control in professional hands. Such control involves two aspects: over standards of medical care, and over terms of physician participation. Lay sponsoring bodies readily grant the former. But the power to set terms of physician participation means determination of the method of practice and the type and level of doctor remuneration. This, in effect, means control over the table of fees which the plan pays the physician and consequently the rates which the plan must charge the consumer."  

Satisfied with physician control in the early prepaid plans, organized medicine turned all its guns on those plans not controlled by physicians—many of which were health cooperatives. "Groups of consumers outside of industry have formed cooperatives or community sponsored non-profit corporations to provide prepaid medical services. These are open to the entire community, subject only to the limitations of available facilities. AMA opposition to these latter type (health plan) has been much more pronounced that to restricted membership plans."  

American Medical Association action first took the form of discrimination against physicians practicing in coop plans.
"For many years attempts to form medical service plans were opposed by organized medicine through direct disciplinary action against participating physicians. The medical practitioner has much to lose when membership in his medical society or the good will of fellow physicians are denied him. It was therefore inevitable that organized medicine would apply its strongest weapon in opposing early attempts to form medical service plans." 107

In Elk City, Oklahoma, Dr. Shadid was expelled from the Beckham County Medical Society when it purposefully dissolved and reformed without him. Doctors working at the Cooperative Hospital were denied membership in the County Medical Society and several attempts were made to revoke Dr. Shadid's licence to practice medicine. After several years of bitter battles doctors on his staff became members of the Medical Society. 108

Actions were also taken in Washington, D.C. when the Group Health Association, Inc. was formed in 1937. "The local medical society, however, objected to this lay-sponsored group and employed its coercive powers to destroy this competitive threat to private practitioners. The District Medical Society expelled or otherwise disciplined several of the doctors hired by Group Health, in some instances mere threats of such action led to resignation from the GHA staff. Moreover, the Society circulated a 'white list' of approved organizations and individuals, from which GHA was excluded, thereby making it impos-
sible for GHA doctors to obtain consultation with fellow physicians. Furthermore, Group Health had no hospital of its own but depended upon the availability and cooperation of local institutions. The AMA and the District Medical Society virtually crippled GHA by enlisting nearly all the hospitals in the District to deny GHA physicians staff privileges and bed space for their patients. ¹⁰⁹ Not until 1943 when the Justice Department successfully prosecuted the AMA for restraint of trade did GHA physicians have the right to practice proper medicine.

The Group Health Cooperative of Puget Sound was also forced into major litigation against the County Medical Society. "Local medical society intervention caused hospitals throughout the area to refuse GHC doctors staff privileges, and even emergency surgical facilities. The society's characterization of GHC's staff as 'unethical' resulted in its withholding or withdrawing membership from several physicians who consequently lost consultation privileges and certification by specialty boards requiring society membership. In 1949 Group Health doctors sued to enjoin the county medical society under a provision of the Washington State Constitution forbidding combinations or agreements to fix prices or limit production of any 'commodity.' In 1951, the Washington Supreme Court decided for the Cooperative and delivered a forceful condemnation of organized medicine's tactics in attempting to halt
91.

the development of private medical programs in the state."

As court rulings against such action appeared in several states, organized medicine was forced to turn to other tactics in order to halt the spread of health cooperatives. As Cecil Crews warned in 1947, "We are fundamentally still fighting organized medicine. The strategy of our opponents has shifted in most communities from frontal attacks and thinly disguised conspiracy to a face for vantage points in the provision of prepaid services. It will be well for us to remember that physicians exert a powerful influence on public opinion. Their influence is particularly lethal when exercised covertly." The Yale Law Journal in 1954 came to the same conclusion as Mr. Crews had seven years earlier.

"Despite determined medical society disciplinary action against staff members of disapproved prepayment groups, various forms of medical service plans have continued to grow steadily. Furthermore, the use of discriminatory tactics has been found illegal under both federal and state law. Consequently, organized medicine has softened the use of such techniques, and adopted subtler, but possibly more effective methods of meeting the threat of prepayment plans." To gain these vantage points medical societies turned to two new strategies—alternate medical plans and new restrictive state legislation. By combining these two strategies organized medicine has been able to establish many medi-
cal service plans under physician control.

In many states legislation was passed requiring physician control of such plans. As late as 1962 seventeen states forbade the formation of lay controlled medical service plans. One type of statute requires that a majority of directors be doctors or they may provide for state medical society approval of directors. Other statutes bar any prepayment plan from providing medical services unless it includes a majority of the licensed physicians in the area of service. The practical effect of such laws is to prevent lay sponsors or small medical groups from offering prepaid services.114

The Yale Law Journal further stated, "Medical society plans frequently offer less comprehensive coverage than the independent plans with which they compete. However, they have exploited their competitive advantages through 'medical public education' campaigns and word-of-mouth promotion by family physicians to effect an impressive growth of membership."115

Furthermore, "State societies, encouraged by the AMA, then took the lead in establishing insurance plans. At the same time, the AMA attempted to shape voluntary plans into an approved pattern."116

Thus many cooperatives that were able to organize consumer support and resources were eventually forced to dissolve because of strong AMA opposition. In 1951, Dr. Warbasse
wrote, "The AMA has been the chief obstacle against the development of cooperative health associations in the United States. As a result, there are too few of these organizations, and this country is moving toward the political socialization of medicine. Since the private competitive method of practice is fading out and state medicine is expanding the alternative to the latter is cooperative medicine. Should medical practice in the United States become completely socialized under the political Government, the people and the medical profession will have the America Medical Association to thank for that eventuality."\textsuperscript{117}

Health cooperatives today still have not yet reached the ideal of cooperative medicine. Too few consumers play a role in the activities of health cooperatives. Preventive care, especially health education, is still lacking in most health coops and their focus is still on medicine and not on the community.

The best cooperative plans have proven to be those with the most active membership. Furthermore, some of the personal benefits of cooperatives, such as greater self-esteem, control over one's services, and greater knowledge about one's health are not possible if consumers do not participate in coop activities. Cooperatives must reaffirm their beliefs in the importance of consumer participation and develop more mechanisms by which consumers can be reached and heard. The Group
Health Cooperative of Puget Sound has been successful in encouraging increased member participation and has continued to develop mechanisms to do so. Its high quality program reflects these efforts.

Health education is still lacking in most plans. Jerome Schwartz correctly concluded that in most cases coop claims stressing health education were false. Only one of the six cooperatives studied "held lectures or meetings on preventive care or on health subjects...Health education programs were clearly not a prominent feature of either cooperatives or private physician groups. Nevertheless one cooperative did sponsor several educational activities; interestingly enough, this plan was the one with the most influential consumer board board."118

As a result of the way health care is generally financed in this country, many of the most medically needy cannot afford the use of medical cooperatives. This was a long recognized limitation of current prepaid group practice and in 1937 Dr. Shadid wrote, "Cooperative medicine is not a panacea. One of its faults is that in its efforts to provide the best medical care, it places its services out of the reach of a great many people in the very low income groups and the unemployed. For these groups the only answer may be compulsory health insurance."119

Health cooperatives have also limited themselves large-
ly to the practice of medicine. We still must wait until
health cooperatives fulfill Dr. Warbasse's view that, "In the
end, any health organization will be inadequate and ineffi-
cient if the people look to the medical sciences alone to
solve their health problem. There must be secured, in addi-
tion to these, better economic conditions for the people-
better housing, food, recreations, and schooling; children
freed from labor; and industry made safe. Without these
conditions assured, public health measures will continue to be
palliative—patching up the wreckage of social and industrial
havoc. It is for this reason that the protection of health
would seem to be the peculiar province of the cooperative
society."\textsuperscript{120}
REFERENCES AND NOTES

Chapter I


6. Ibid.


8. Ibid.


10. Ibid.


13. Ibid.


15. Ibid.


Chapter II


25. Ibid.


30. Ibid.

31. Ibid.


34. J.P. Warbasse, Three Voyages, Cooperative League of the USA, 1956.

35. M. Shadid, Principles of Cooperative Medicine, Cooperative League of the USA, 1937.

37. Ibid.

38. Ibid.

39. Ibid.

40. M. Shadid, A Doctor for the People, Vanguard Press, 1944.


43. Interview- Mr. John Wasson, Group Health Association of America, Winter 1974.

Chapter III


50. Ibid.

51. Ibid.


55. Ibid.


62. Ibid.


64. Williams, Op. Cit.


73. Personal Communication - Mr. Paul Danaceau.


77. Ibid.


79. Ibid.


81. View, Fall 1971.

82. View, Summer 1972.


84. Ibid.

85. Ibid.

86. Ibid.

87. Ibid.

88. Ibid.

89. Ibid.

90. Ibid.

91. Ibid.

91. Ibid.

92. Ibid.

93. Ibid.

94. Ibid.

95. Ibid.

Chapter IV


98. Ibid.

99. Ibid.

100. Ibid.

101. Danaceau—Personal Communication


103. Dr. Robert C. Buxbaum—personal Communication.


106. Ibid.

107. Ibid.

108. Ibid.

109. Ibid.

110. Ibid.


115. Ibid.

116. Ibid.

117. J.P. Warbasse, Cooperative Medicine, Cooperative League of the USA, 1951.
