OPPORTUNITIES FOR CO-OPERATIVE HEALTH PROVISION IN RURAL, REMOTE AND NORTHERN ABORIGINAL COMMUNITIES

WRITTEN BY:

SHANNON ROHAN

GOVERNMENT AFFAIRS & PUBLIC POLICY
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EXECUTIVE SUMMARY

The Canadian Co-operative Association (CCA) is a national umbrella organization representing co-operatives and credit unions with the mission to promote the growth and development of the co-operative sector for the economic and social betterment of communities and people in Canada and internationally. CCA is owned and democratically controlled by its membership including 23 regional and national co-operative organizations that represent the entire spectrum of economic and social activity including finance, insurance, agriculture, retail, housing, daycare and health.

In June 1999, CCA—in collaboration with Le Conseil Canadien de la Coopération (CCC), the Co-operatives Secretariat, the Assembly of First Nations and the Department of Indian and Northern Affairs Canada—participated in a research initiative to explore the use of the co-operative model within Aboriginal communities. In March 2001, the seminal report Aboriginal Co-operatives in Canada: Current Situation and Potential for Growth was published making important strides in identifying the specific contributions that co-operatives make to community economic development in Aboriginal communities. In addition, the report located some of the key obstacles that exist in further developing the co-operative sector and laid out a series of recommendations about the potential of growth for co-operatives in Aboriginal communities to meet their identified economic and social needs.1

At the same time, CCA has been active in examining the opportunities that exist for expanding co-operative health care provision in Canada. Health care in Canada has historically been a key priority area for the federal government. Health care took particular prominence, however, in 2001 with the release of the Romanow and Kirby reports. Both of these reports sought to determine the steps that needed to be taken in order to ensure the sustainability of Canada’s health care system. The emergence of health care to the forefront of the governments’ social policy agenda resonated with the values of Canadian citizens, including with CCA members. The co-operative model has been a part of the Canadian health care system since the 1940’s and has been successful in meeting a wide variety of health needs including those of marginalized groups who are underserved by traditional models of health care delivery. In light of these successes, CCA has been active in promoting the co-operative model in health care as one way for both government and Canadians to meet their health care needs.

Emerging from these areas—co-operatives in Aboriginal communities and co-operative health care—came an impetus within CCA to explore the complementarity between these two domains. Subsequently, CCA initiated a research process with the aim to look at the applicability of the co-operative model to health care in rural, remote and northern Aboriginal communities. The discussion paper that follows is the outcome of this research and is intended to act as a platform from which further dialogue can take place among relevant stakeholders on the potential of the co-op model for health care provision in rural, remote and northern Aboriginal communities and the opportunity for future collaboration and action.

Understanding the Context

- Aboriginal peoples living in rural, remote and northern communities do not have equitable access to the full range of health services enjoyed by Canadians living in the south. Geographic and political obstacles coupled with human resource constraints perpetuate these gaps in health care and make service provision in this context particularly challenging.

- The service delivery obstacles that emerge in rural, remote and northern Aboriginal communities have resulted in significant disparities between the health status of Aboriginal peoples living in the north and that of the general Canadian population.

- The socioeconomic environment of rural, remote and northern Aboriginal communities has consequences for the health of community members. High levels of poverty, poor housing, chronic unemployment, lower educational attainment, cultural suppression and exposure to environmental contaminants have a significant influence on the health status of Aboriginal peoples and must be considered when assessing health care needs.

- The inaccessibility of health care services identified in the rural, remote and northern Aboriginal community context emerges not only from a lack of physical access but also as a result of the nature, quality and appropriateness of the health programs that exist. In this sense, the qualitative characteristics of health care services as well as the delivery mechanisms, the decision-making structures and the basis of ownership in terms of who is defining the health needs of the community and thus shaping health services must also be considered when trying to improve accessibility.

A New Vision for Health Service Delivery

- The specific context—historical, cultural, political, social, economic and geographical—of northern Aboriginal communities ensures that a “business-as-usual” approach will not suffice in overcoming the health care challenges that have been identified. Therefore, a new approach to health care provision in rural, remote and northern Aboriginal communities is necessary in order to improve the health outcomes of Aboriginal populations.

- Five characteristics were identified in the research as being integral to a new approach to health care delivery. These characteristics are: 1) the provision of culturally-sensitive and appropriate health care services; 2) a shift towards preventive health and health promotion services; 3) the need to build on Aboriginal capacities and strengths; and 4) an emphasis on local control and authority over health care services.

Linkages with the Co-operative Model

- The governance structure of the co-operative model ensures member control over the decision-making process and therefore over the design of health care. By keeping decision-making structures within the community, the type and nature of services is more apt to reflect the priorities established by the communities themselves. This enables more
culturally relevant and appropriate services (See Appendix 1 for the Statement of the Co-operative Identity).

- Many co-operative models of health care are characterized by preventive health and health promotion services as well as in their employment of multidisciplinary health teams on a salary basis. These characteristics ensure the provision of interdisciplinary care which is conducive to aboriginal conceptions of health as holistic and incorporating mental, spiritual, emotional and physical elements of health.

- The governance structure facilitated through the co-operative model provides a forum where Aboriginal people can develop their own solutions to the health care needs that emerge in their communities. Such an arena ensures that local capacities and strengths can be explored and utilized so as to improve health care delivery.

- Co-operative organizations are democratically controlled and owned by members ensuring local authority over its operation. As a result, co-operatives enable communities to have a degree of self-determination that is less subject to outside forces and more responsive to the needs of the community as they conceptualize them (CCA-BC, 2003).

**Challenges**

- There is a lack of awareness and knowledge of co-operatives by health professionals, Aboriginal leaders, communities and policy makers at the provincial, territorial and federal level.

- The geographical and political context as well as the financial and human resource constraints that emerge in rural, remote and northern Aboriginal communities presents difficult barriers to the provision of health services including to the application of the co-operative model.

- In the context of rural, remote and northern communities with small populations, there is significant challenges in ensuring strong interest and involvement by members and the need to avoid burnout of Aboriginal leadership (Ketilson and MacPherson, 2001; Minister’s Advisory Committee, 2002b).

**Recommendations**

- At this stage, the co-operative sector, with initial leadership from CCA, should engage relevant stakeholders in dialogue around the potential that the co-op model holds in delivering more effective and responsive health care in rural, remote and northern Aboriginal communities. The intent of this dialogue should be to look for potential opportunities to collaborate and move the research forward to possible applications of the co-op model in rural, remote and northern Aboriginal communities.

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2 The British Columbia Co-operative Association (CCA-BC) is a regional affiliate of CCA. It is a member supported, non-profit co-op representing the co-op and credit union movement in BC. They have done extensive work in health care co-operative development in BC and therefore have significant expertise in this area.
• An Advisory Committee should be established with representation from key stakeholders including Assembly of First Nations, Inuit Tapariit Kanatami, National Aboriginal Health Organization, Arctic Co-operatives Limited as well as health co-op practitioners and co-op developers to devise a strategy and recommend an implementation process to foster the development of health co-operatives in rural, remote and northern Aboriginal communities. As resources are limited, the first step of such a committee should be to identify cost-sharing measures between the various stakeholders in order to facilitate this process. It would also be necessary for the committee to look at additional funding sources. At the outset, the committee should look to the research and innovation funding available through the Co-operatives Secretariat’s Co-operative Development Initiative.

• It is recommended that community forums are held to introduce the co-operative model and explore its application in light of the communities’ identification of their own health needs. It would also be valuable for those interested in looking at co-operative health to visit some of the co-operatives operating in the health field as it is here that first hand experience and expertise can be shared.

• In addition, consistent dialogue and feedback should be solicited with relevant government departments including Health Canada, Indian and Northern Affairs Canada as well as provincial and territorial ministries.
BACKGROUND

The health outcomes of Canadians are among the best in the world. The Canadian health care system is often credited for these achievements and upheld as an exemplary model of publicly financed health care. Medicare is a central element of Canadian identity and encompasses the values of equity, fairness and solidarity that characterize a universal health care system delivered on the basis of need as a right of citizenship rather than as a privilege extended to a fortunate few. The benefits of the Canadian health care system, however, are not enjoyed equally by all citizens in Canada. Many individuals and communities do not have equitable access to the full range of disease prevention, health protection and specialist services nor to primary, home and community care taken for granted by other Canadians.

These gaps in health care are particularly prominent in rural, remote and northern Aboriginal communities. The obstacles that perpetuate these gaps include a geography characterized by a sparse and widely dispersed population coupled with a climate that makes transportation and accessibility extremely difficult and even impossible during parts of the year. In addition, rural, remote and northern communities face particular human resource constraints in terms of attracting and retaining health care professionals. In 2000, only 17 percent of family physicians, 4 percent of specialists and 18 percent of registered nurses practiced in rural, remote and northern communities where up to 30 percent of Canadians lived (Ministerial Advisory Council on Rural Health, 2003).

In the context of Aboriginal communities, even when services are being delivered, health care professionals are often not familiar with the specific health care needs of Aboriginal peoples or to the traditional health practices that are used in Aboriginal communities. The shortage of Aboriginal health care professionals who can amalgamate indigenous knowledge with formal training is further indicative of the human resource constraints that are endemic to the health care systems in the north. With a lack of universities in the north in general, coupled with a lack of universities in the south offering programs that engage with the specific health issues and perspectives of northern Aboriginal communities, the prospects of overcoming this obstacle in the short- to medium-term is particularly daunting.

It is also important to recognize the distinct political obstacles that emerge around health care provision in Aboriginal communities. Complex jurisdictional arrangements between federal, provincial and local level governments has led to fragmented funding and programming that further exacerbates the gaps in services in northern communities. Moreover, the devolution of administrative functions for health from federal to regional and local level governments has happened at varying degrees in different communities making the jurisdictional arrangements unique in each context.

These obstacles and the subsequent gaps in service provision have resulted in significant disparities between the health status of Aboriginal people and that of the general Canadian population. According to the National Aboriginal Health Organization (NAHO) Aboriginal communities are facing “rapid change and daunting symptoms of imbalance such as community and family violence, suicide, high levels of infectious and chronic disease and tragic levels of childhood deaths, youth injuries and adult disabilities” (2003: 4).
Data from Aboriginal communities show disconcerting trends in health outcomes from infancy through to adolescence, adulthood, and old age. The gap in life expectancy between Aboriginal people and the general Canadian population, for instance, varies from 6 to 14 years. Health Canada found that infant mortality rates among Aboriginals were up to 3.5 times higher than the national rate. The neonatal\(^3\) mortality rate was up to 2 times higher, while the post-neonatal\(^4\) mortality rate was almost 5 times higher in the Aboriginal population than in the general Canadian population (Health Canada, 1999).

Alcohol, substance, and solvent abuse has also presented particular challenges to the health systems of Aboriginal communities. For example, Aboriginal youth are 2 to 6 times at higher risk for every alcohol-related problem than their non-Aboriginal counterparts in the Canadian population (Health Canada, 1999). Tobacco use is also much higher in Aboriginal communities. 69 per cent of Inuit youth, for example, smoke by the time they are teenagers (Archibald and Grey, 2000). High levels of substance abuse are associated with other health problems such as higher incidences of Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE) among Aboriginal children. In addition, substance abuse can magnify conditions such as depression, family violence, and suicide—all of which have risen to alarming levels in many Aboriginal communities.

Diabetes is also a serious health concern for Aboriginal peoples who are facing prevalence rates that are among the highest in the world. Health Canada estimates that in all age categories the prevalence rate is anywhere from 3 to 5 times higher than that of the Canadian population (Health Canada, 1999). While prevalence rates are generally lower in northern Aboriginal communities, particularly among Inuit peoples, recent regional data indicate that this too is changing as traditional diets and lifestyles are gradually being eroded (Health Canada, 2000).

Addressing the inequitable access to health care services that persists in rural, remote, and northern Aboriginal communities is integral to improving the health status of Aboriginal people. However, Aboriginal organizations emphasize that the discrepancy in health outcomes among northern Aboriginal populations can not be attributed entirely to the problems of accessibility. High levels of poverty, poor housing, chronic unemployment, lower educational attainment, cultural suppression, and exposure to environmental contaminants have a significant influence on the health status of Aboriginal people (NAHO, 2003). These non-medical determinants of health both perpetuate and are perpetuated by the poor health status that exists in Aboriginal communities and must be considered when assessing health care needs.

Moreover, the qualitative characteristics of health care services in Aboriginal communities must also be considered. Resolving the inaccessibility of health care services in northern Aboriginal communities must not only look at enhancing physical access but also recognize that the nature, quality, and appropriateness of health programs is as significant to improving access to health care.

Aboriginal organizations have also noted that in order to achieve a health care system that works for the community, Aboriginal peoples must be empowered to identify and address their own

\(^3\) Neonatal begins when the infant is born and through the first month after birth.

\(^4\) Post-neonatal begins when the infant reaches one month of age and lasts until they are one year old.
needs and shape their own solutions. The Inuit Tapiriit Kanatami (ITK) claims that “until Inuit
dvalues, approaches and perspectives are incorporated into health and social services, it is difficult
to imagine the system enhancing the mental health and well being of Inuit individuals and
communities” (Archibald and Grey, 2000: 33) In this sense, an analysis of health care provision
in Aboriginal communities must look—not only at the types of services being delivered—but
also at the delivery mechanisms, the decision-making structures and the basis of ownership in
terms of who is defining the health needs of the community and thus determining the shape that
health service provision should take.

In light of the overt disparities in the health status of Aboriginal peoples in the North, as
compared to those in the general Canadian population, the federal government has begun to
recognize the need for action. In the final report on The Future of Health Care in Canada,
Commissioner Roy Romanow emphasized the need for a “new approach to Aboriginal health—
one that tackles the root causes of health problems for Aboriginal peoples, and cuts across
traditional administrative and jurisdictional barriers and focuses squarely on improving the
health of Aboriginal communities” (Romanow, 2002: 212). Key characteristics that have been
identified by the government include incorporating a holistic approach to health care with a focus
on prevention and primary care models that reflect the specific cultural, social, economic and
political circumstances of different Aboriginal groups.

The Report of the Royal Commission on Aboriginal Peoples (1996) also identified the need for a
human resource strategy that could incorporate traditional knowledge and training of Aboriginal
people to transform Aboriginal health and social services to more effectively meet community
needs. The Ministerial Advisory Committee on Rural Health (2003) reported that “culturally
sensitive and relevant programs and health services are prerequisites for improving the health
and well-being of First Nations, Inuit and Métis people.”

**RATIONALE**

The specific context—cultural, political, social, economic and geographical—of northern
Aboriginal communities ensures that a “business-as-usual” approach will not suffice in
overcoming the health care challenges that confront these communities. Providing more of the
same—more money, more services, more programs—will not achieve the desired outcomes in
terms of the improved health status of Aboriginal peoples (Government of Canada, 1996).

The rationale for this research then, is that a new approach to health care provision in rural,
remote and northern Aboriginal communities is necessary in order to improve access to health
care services and to improve the health outcomes of Aboriginal peoples. This new approach
must be grounded in the cultural, political and geographical realities of Aboriginal communities
so that the health care models created are more accessible, culturally appropriate and reflective
of indigenous perspectives.

The following characteristics have emerged as integral to any new approach to health care
delivery in rural, remote and northern Aboriginal communities:

i. The provision of culturally-sensitive and appropriate health care services;

ii. A shift in focus toward preventive health and health promotion services;
iii. The need to build on Aboriginal capacities and strengths;
iv. An emphasis on local control and authority over health care services.

**Culturally Sensitive and Appropriate Health Care Services:**

As one of the determinants of health, culture is particularly important in shaping the way people interact with the health care system. In order for health care services to have a positive impact on the health of Aboriginal peoples, they must be responsive and relevant to the patient and communities that they serve. This requires not only an awareness of, but an intimate understanding and respect for, the cultural context in which health care is being delivered. This is particularly significant to health care delivery in Aboriginal communities where good health is conceptualized as a balance between body, mind, emotions and spirit. Health care provision that incorporates a singular biomedical approach will inevitably fail to meet the full range of health needs of Aboriginal people. Providing culturally-relevant care that encompasses Aboriginal perspectives and philosophies will therefore be more apt to achieve better health outcomes in these communities.

**Preventive Health and Health Promotion Services:**

It is widely recognized within the field of health that investing in health promotion and prevention is a more effective way of delivering health care and is more conducive to improving the health status of individuals and communities. Despite this acknowledgement, however, the majority of health spending in Canada continues to be devoted to treatment and curative care. There are many barriers within the health system in general that hinder a transformation from treatment-driven to preventive oriented health care. One of these barriers is that the outcomes of investing in health prevention and health promotion will not be observed immediately. The long-term nature of the returns to investment in health prevention strategies acts as a barrier to further resources being devoted to these types of programs. In rural, remote and northern communities additional barriers are present that hinder the transformation of health care from treatment-driven to more preventive models. These barriers include insufficient resources—financial, physical and human—to devote to more preventive services ensuring the maintenance of a health care system operating in crisis mode.

The isolation of many northern communities limits access to health services at the community level resulting in regular emergency medical evacuations to southern hospitals. Medical conditions that could have been detected in the early stages often go undiagnosed where health facilities and health professionals are either non-existent, insufficient or overworked. The outcomes of this for the community are poor health and high levels of stress when emergency evacuations occur. The health care system, on the other hand, must allocate limited resources to emergency evacuations rather than investing in programs and facilities within the community.

Although these barriers exist, the benefits of providing preventive health and health promotion services in rural, remote and northern communities is substantial. In high cost regions like the north where high salaries and the costs of transporting people and supplies puts unusual pressure on budgets, the benefits of investing in prevention and promotion, are significant even if these can only be realized over the long-term (ITK, 1999). In order to move towards more preventive-
centered health provision, innovative solutions to the barriers that rural, remote and northern communities face are necessary.

This innovation needs to be directed to developing human resources within the community through community-based training and innovative forms of education. These human resource strategies need to be supported by technological innovations that can connect remote and isolated communities with a range of health care professionals in the south on a consistent and sustained basis. Technologies such as telemedicine and videoconferencing offer great potential in terms of facilitating a continuum of care. Developing solutions with communities by building local capacities in human resources and technological infrastructure will allow health care systems to be better equipped to shift to a more preventive focus.

**ABORIGINAL CAPACITIES AND STRENGTHS:**

George Erasmus of the Aboriginal Healing Foundation emphasizes the need to move from a preoccupation with “crying needs” towards an emphasis on “vigorous capacity” when thinking about Aboriginal communities. New programs must build on the strengths that exist in Aboriginal communities rather than being preoccupied with problems and needs. For example, one area where studies have found that Inuit surpass Canadian norms is in the area of social support and social cohesion (Archibald and Grey, 2000). This support reflects the strong family and community ties that exist among Inuit peoples and are vital community assets that innovative health services must build upon and support.

In addition, building on the extensive indigenous knowledge that exists and designing health programs that incorporate traditional medicine practices will more likely result in more effective health care services. By highlighting such “vigorous capacities” the self-esteem of individuals and communities can also be revitalized. For example, in a health initiative that sought to utilize the skills of Inuit midwives the benefits went much further than improving access to maternal health services. As one Inuit midwife describes, “In the beginning, our women used to ask their questions to the white people, not to us. Now women ask us the questions, and they trust us. It means our self-esteem, not only personal, but as a community is coming back. We are trusting our own people again and providing great care to our women, in our own cultural way” (Archibald and Grey, 2000: 43).

**LOCAL CONTROL AND AUTHORITY OVER HEALTH CARE SERVICES:**

It is well-known that populations that have more direct control over their own lives, and the resources for meaningful participation in decision-making processes, tend to have better health outcomes than those who have little control. (NAHO, 2003: 10).

In order for health care provision to be more effective in meeting the needs of rural, remote and northern Aboriginal communities a change must occur in the decision-making structures, the direction of accountability and the nature of ownership that characterize mainstream health care systems. As noted throughout this discussion, the current model of delivery has not met the full-range of health needs of rural, remote and northern Aboriginal communities and has resulted in inequities in access to health care as well as in the health status of Aboriginal peoples.
New approaches to health care are needed that are responsive to the communities needs. Such responsiveness implies that decision-making structures be built within the community rather than outside of the community. Increasing community responsibility for decision-making empowers individuals in terms of allowing them to take control over their own health care and to define their own health needs (Sinats, 2001). It also empowers the health care system to provide more effective care as local organizations and entities are best placed to understand and respond to the needs in their communities.

Donat Milortok, vice-president of the Kivalliq Inuit Association and Mayor of Repulse Bay emphasizes the important role that local control has in terms of health by claiming that:

> The community must be in the driver’s seat in determining what is helpful and what they need to assist them in their healing process. If real change is to occur in any one person’s life, they need to participate meaningfully in making that change, choosing what help they need and changing patterns which have contributed to the problem. The same is true of communities. Communities need to actively participate in their own healing process (As quoted in Archibald and Grey, 2000: 37).

Enhancing the decision-making capacity of individuals and communities with respect to health care ensures meaningful participation in both the conceptualization of community needs as well as in framing appropriate solutions.

**STATE OF THE PRACTICE**

Health care in the North is characterized by extremely limited access to a full range of health services by most northern residents. While almost all communities have a health facility of some kind—even in the most remote areas of the north—the majority of these do not have doctors on staff resulting in almost 80 per cent of health care being delivered by nurses. The result of this is that nurses bear heavy workloads, isolation and a lack of professional support leading to burnout and a subsequent high turnover rate medical staff. The outcomes of this are particularly problematic for both the users and the provider of health care.

For example, the long-standing practice of removing women from remote communities to southern hospitals for birthing results in many problems for the pregnant woman, her family and the community. Because there are no funds to subsidize travel for the father and other family members, women are often left to give birth in a foreign environment without the support of her family. In addition, women may be absent from their families for up to four weeks leaving other children and family members on their own. The result of such evacuations is heightened stress and isolation for both the woman and her family.

On the other hand, the provincial or territorial government, as the provider of health care, faces problems in terms of devoting scarce health care resources to transportation costs. One out of every eight dollars in Nunavut’s health care budget goes to jet fuel. One-fifth of its $147-million health care budget is spent on transportation (Younglai, 2003). Such spending on emergency evacuations and transportation takes limited resources away from health programs and facilities operating in northern communities.
While it is clear that Aboriginal communities in the north are facing critical gaps in health care, there is evidence of resurgence within many Aboriginal communities—both in the north and the south—in the areas of health, healing and community wellness. Initiatives such as the Rankin Inlet Birthing Centre and the Inuulitsivik Maternity; the Eskasoni Primary Care Project; the Kahnawake Community Services Program; the Igloolik Early Intervention Project; the Wabano Centre for Aboriginal Health; and the Traditional Medicine Program in Akwesasne are all examples of innovative initiatives that have emerged. Lessons learned from these various models should be documented and applied to programs in rural, remote and northern Aboriginal communities.

**BOX 1: THE INUULITISIVIK MATERNITY – INNOVATION IN MATERNAL HEALTH**

The Inuulitsivik Maternity opened in 1986 in Puvungnituk, Québec and is highly regarded for its success in integrating traditional Inuit approaches to health within the mainstream medical system. The Centre was started by a local Inuit women’s group with the purpose of enabling women to give birth closer to home. The centre employs a registered midwife and works in cooperation with a local health centre and family physician. Local women have been trained as community midwives and a committee has been established to assess each pregnant woman to determine whether she can safely give birth at the centre. The Inuulitsivik Maternity has been upheld as an important innovation that has brought control over birth and health care for mothers and infants back to the community.

In 1999, the Québec government legalized midwifery as an autonomous profession allowing the Inuulitsivik Maternity to operate within provincial legislation. This has been a positive development in that it ensures that the five midwives working at the Inuulitsivik Maternity Centre are recognized under the Québec Order of Midwives. The legislation, however, only recognizes one academic program in midwifery training at the University of Québec at Trois-Rivières. The ramifications of this is that Aboriginal midwives currently in training at Inuulitsivik are unable to apply for a midwifery license allowing them to practice legitimately under this legislation. The failure to include the community-based training that takes place at the Inuulitsivik Centre excludes Aboriginal midwives from benefiting from the new legislation. This is indicative of the constraints that Aboriginal communities are facing and the obstacles that persist—despite legislative changes—for Aboriginal peoples seeking to improve health care within their communities.

**CO-OPERATIVES IN HEALTH CARE**

The co-operative model has been a part of the health care sector in Canada since the early 1940’s and has been particularly prominent in the provinces of Québec and Saskatchewan (Sinats, 2001). Health co-operatives, like all co-ops, are owned and democratically controlled by the users of the goods and services provided. Users can be consumers of health care, employees
such as nurses and doctors, or producers of the goods and services used in the health sector. Four types of co-operatives have delivered health care services to different communities across Canada. These include: users’ co-operatives, producers’ co-operatives, workers’ co-operatives and multi-stakeholder or solidarity co-operatives (See Appendix 1 for a more detailed description of these types of co-operatives).

Health co-operatives have often arisen where there has been inadequate provision by public health services and where other institutions have been either unable or unwilling to meet the communities identified needs. For example, health care co-operatives emerged in Saskatchewan in 1962 following the medical crisis brought about by the implementation of the universal health care system and the subsequent doctors’ strike (Government of Canada, 1999). It was during this period of insecurity that the community collaborated and sought ways to address their own health care needs. The outcome of this was the establishment of a network of co-operative clinics that still exist today.

Similarly, the health care co-operatives in Québec proliferated in a context where universal health coverage was not being achieved and when the accessibility and extensiveness of the health system was being compromised (Girard, 2002). More recently, co-operatives have begun to emerge in British Columbia in response to a new alignment of service delivery by the provincial government that has threatened many rural communities with a retraction of health care services.

**Box 2: The Multicultural Health Brokers Co-op – Innovative Solutions to Unmet Needs**

The Multicultural Health Brokers Co-operative emerged in Edmonton in 1992 through the work of a group of women who saw a need within immigrant and refugee communities to break down the barriers they faced in attaining health care services. In order to accomplish this, they established a workers’ co-operative called the Multicultural Health Brokers Co-op, which provides culturally and linguistically relevant prenatal education, post-natal outreach, parenting support, family liaison and community development support to immigrant and refugee families.

The definition of the practice of health brokering is “bridging cultures towards equity of access to health” (MCHB, 2003). In order to ensure this practice, the MCHB are committed to three key principles. These include:

I. holistic and attentive to the social, cultural and economic determinants of health in order to support families and communities in addressing issues such as inequitable access to health and social services, lack of income and food security, isolation and early childhood development.

II. oriented to community capacity building and mobilization to locate opportunities to create supportive networks among families to address common struggles, or to engage community members and leaders in taking action on community issues.
In their 1990 study entitled “Co-op Sponsored Health Care Delivery Effectiveness,” Angus and Magna identify five basic principles that define and govern co-operative models in health care. These are:

1. community based organization and control;
2. spectrum of primary health, social and related services in one location;
3. multi-disciplinary teams to deliver medical services;
4. emphasis on prevention, health promotion, education services and ambulatory services;
5. remuneration of health care professionals by salary or capitation rather than the fee-for-service method (Angus and Magna, 1990).

These five principles enable co-operatively delivered health services to transmit important advantages to communities that seek to regain control over their health services. These advantages are particularly pertinent to those communities where access to health services is not sufficient and where health needs are not being adequately met.

**ESTABLISHING LINKS: CO-OPERATIVE HEALTH IN ABORIGINAL COMMUNITIES**

“At the core of every co-op’s history is an unmet need” (CCA-BC, 2003: 11). Co-operatives in various sectors—finance, housing, agriculture and health—have emerged where other institutions have been either deficient or non-existent. Because significant service gaps are apparent in rural, remote and northern Aboriginal communities and it is clear that a “business-as-usual” approach will not suffice in meeting the diversity of health needs that exist, the co-operative model is one delivery mechanism that may offer a viable alternative.

In addition, the co-operative model is seen to be “naturally compatible with Aboriginal values of collaborative and supportive community planning” (Ketilson and McPherson, 2001: 145). Collaboration and mutual aid are characteristics of co-operative behaviour that have resonated in Aboriginal societies long before the institutionalization of the co-operative model. In this sense, the success of co-operatives in northern communities is less about the imposition of an exogenous institutional form but rather “an outward manifestation of a deep understanding of the benefits of collaborative behaviour” (Ketilson and McPherson, 2001: 23).

The co-operative model has proven successful both in Canada and around the world in health care to meet a wide variety of health needs. They have done so by responding to the needs of the community and by providing a venue where member-owners are able to determine their own
goals and identify the most appropriate practices thereby empowering ordinary citizens with respect to health care. There are several characteristics of the co-operative model that are particularly amenable to the health care needs that have been identified in rural, remote and northern Aboriginal communities.

First, the need to design health services that are culturally sensitive and appropriate is conducive to the co-operative model and specifically to the governance structure employed where members determine the type and nature of the services offered. As discussed above, by keeping decision-making structures within the community—and thus ensuring accountability to the members of the co-op—the design of health care services is more apt to reflect the priorities established by the communities themselves. Therefore, both the identification of needs and the formation of solutions becomes a community-controlled and facilitated process. The outcome of this is health care that is responsive to the communities needs as they define them; therefore enabling more culturally relevant and appropriate services.

Second, the co-operative model has also been successful in terms of providing preventive health and health promotion services. This is possible using the co-operative model through its endorsement of a multidisciplinary health team as well as its emphasis on effective partnerships between the people who use health services and the people who offer them. Employing a variety of health care professionals on a salary basis—including physicians, nurse practitioners, nutritionists and midwives—not only supports programming around health promotion but it also builds partnerships between the users of health care and the providers, enabling the co-operative to fulfill a multitude of objectives rather than just one “bottom-line”. The Community Health Services Association Limited of Saskatoon, for example, considers its facilitation of interdisciplinary health care as one of its greatest successes made possible by an active and effective partnership between the people who use the services and the people who offer them (LaPointe, 2003). Such interdisciplinary care is also reflective of Aboriginal conceptions of health as holistic and incorporating mental, spiritual, emotional and physical elements of health care provision.

Third, the governance structure facilitated through the co-operative model “makes room so that Aboriginal people can develop their own solutions” to the health care needs that emerge in their communities (Ketilson and McPherson, 2001: 25). By facilitating community-based solutions, co-operatives build on local capacities and strengths by providing the arena where these capacities can be expressed. Whether these capacities lie in the knowledge of elders, in traditional healing practices or in the norms of mutual aid and social support – the co-op model provides an arena where such capacities can be explored, utilized and operationalized. By building on these capacities, co-operatives can also become “strong manifestations of community pride.” For example, by building on extensive traditional healing practices, a health co-operative will not only provide more appropriate health care that improves the health outcomes of its users but may also build the self-esteem of the community around traditional cultural practices while also creating new employment opportunities within the community for traditional healers or midwives, for instance.

Finally, the emphasis on local control and authority over health care services by both Aboriginal organizations as well as the federal government echoes one of the core principles of the co-operative model. That is the principle of democratic member control which emphasizes a
decision-making process controlled by members and an organization that is accountable to members. Because of this, co-ops are responsible neither to outside owners, nor to government but to their own members. As a result, co-operatives enable communities to have a degree of self-determination that is less subject to outside forces and more responsive to the needs of the community as they conceptualize them (CCA-BC, 2003). There are significant advantages to building consumers and communities into decision-making and governance structures in terms of accessing the valuable knowledge that exists within the community as well as building on the strengths and assets that the community possesses. Moreover, such member participation empowers individuals, families and communities to take control over and responsibility for their own health care needs.

Through these linkages, it appears that the co-operative approach fits well with the health care needs that have been identified in Aboriginal communities. Moreover, it is clear that the health care needs that exist in rural, remote and northern Aboriginal communities demand an innovative solution that ensures that health care is more accessible, appropriate, and responsive to the communities that they serve. The co-operative model provides an alternative delivery mechanism that has had great success in other contexts where gaps have surfaced in health care provision and is, therefore, worth further exploration in the northern Aboriginal community context.

**Barriers to the Co-operative Model**

Despite the apparent potential of the co-operative model to fill some of the service gaps that exist in health care in rural, remote and northern Aboriginal communities, obstacles remain and continue to pose significant challenges. The geographical and political context as well as the financial and human resource constraints that emerge in rural, remote and northern Aboriginal communities presents difficult barriers to the provision of health services in general including to the application of the co-operative model.

In this sense, in order for the co-operative model to overcome these barriers and meet the full range of health needs identified by communities, strategies must incorporate innovations such as telemedicine and videoconferencing as well as strategies to ensure sustainable human capital development within the community. Dynamic partnerships with a wide spectrum of stakeholders needs to flourish including with hospitals, medical schools, Aboriginal organizations, Health Canada, Aboriginal development corporations, nursing associations and many others so that a wide range of expertise can be accessed to deal with the unique challenges that health care provision encounters in rural, remote and northern Aboriginal communities. While the co-operative model on its own cannot overcome some of these barriers, it does provide the opportunity for dialogue at the grassroots level where community-based, sustainable solutions can be designed and where community control and ownership can manifest.

Perhaps a more immediate obstacle to the application of the co-operative model to health care provision in rural, remote and northern Aboriginal communities is the insufficient awareness and knowledge of the co-operative model by health professionals, Aboriginal leaders, communities, and policy makers at the provincial, territorial and federal level. This lack of awareness by the most important stakeholders in Aboriginal health ensures that the co-op model is not being explored as a viable alternative. In order to promote the possibility of co-operative health care in
rural, remote and northern Aboriginal communities, awareness of what health co-operatives are, how they fit with the current system and the advantages they offer to meet the unique health needs of different communities need to be communicated at various levels including to communities, Aboriginal organizations, band councils, relevant government departments and policy makers at every level of government.

RECOMMENDATIONS

In light of the linkages that have been identified between Aboriginal organization priorities in health, the governments’ commitment to finding viable alternatives to health care provision in Aboriginal communities and the potential benefits that the co-op model can impart, it is recommended that CCA partake in a more vigorous exposé of the co-op model to relevant stakeholders. Specifically, it is recommended that CCA bring together dynamic representatives from across the spectrum—most importantly from Aboriginal communities—to formally introduce the co-operative model and to facilitate dialogue around possible next steps for application in rural, remote and northern Aboriginal communities.

In order to introduce the co-operative model as a viable alternative to health care provision, it is imperative that community participation take place from the outset through community forums designed to introduce the co-op model and explore its potential application in light of the communities identification of their own health needs. One potential way to facilitate this process would be to submit an application for support from the Co-operative Development Initiative’s research and innovation funding.

In summary, the following are recommended activities that CCA should facilitate in order to pursue more vigorously the application of the co-op model to health care provision in rural, remote and northern Aboriginal communities.

- CCA should further engage those stakeholders who have been introduced to the research, have validated the preliminary research findings and have shown an interest in more detailed discussion with CCA around the co-op model.
- CCA’s added value lies in its ability to bring together relevant stakeholders—including health co-op practitioners, co-op developers, government officials and Aboriginal organizations—to look at the initial research that CCA has compiled and to use this research as a platform for exploring the possibilities that exist for the co-operative health care in rural, remote and northern Aboriginal communities.
- Participants that should be involved in this process include Arctic Co-operatives Limited and/or Arctic Co-operatives Development Fund, the National Aboriginal Health Organization, the Assembly of First Nations, the Inuit Tapariit Kanatami, Health Canada, Indian and Northern Affairs Canada, the Co-operatives Secretariat, co-op developers and health care co-op practitioners.
- CCA should be one of many partners committed to operationalizing co-operative health care in northern Aboriginal communities. However, it is vital that the drive in pursuing the co-operative model come from Aboriginal organizations, individuals and communities in response to their understanding of how the co-op model can work for them. CCA, then, should play a supportive role in this process.
APPENDIX 1 – STATEMENT OF THE CO-OPERATIVE IDENTITY

DEFINITION: A co-operative is an autonomous association of persons united voluntarily to meet their common economic, social and cultural needs and aspirations through a jointly-owned and democratically-controlled enterprise.

VALUES: Co-operatives are based on the values of self-help, self-responsibility, democracy, equality, equity and solidarity. In the tradition of their founders, co-operative members believe in the ethical values of honesty, openness, social responsibility and caring for others.

PRINCIPLES: The co-operative principles are guidelines by which co-operatives put their values into practice.

1ST PRINCIPLE: Voluntary and Open Membership: Co-ops are voluntary organizations open to all persons able to use their services and willing to accept the responsibilities of membership, without gender, social, racial, political or religious discrimination.

2ND PRINCIPLE: Democratic Member Control: Co-ops are democratic organizations controlled by their members, who actively participate in setting their policies and making decisions. Men and women serving as elected representatives are accountable to the membership. In primary co-operatives, members have equal voting rights (one member, one vote) and co-operatives at other levels are also organized in a democratic manner.

3RD PRINCIPLE: Member Economic Participation: Members contribute equitably to, and democratically control, the capital of their co-operative. At least part of that capital is usually the common property of the co-operative. Members usually receive limited compensation, if any, on capital subscribed as a condition of membership. Members allocate surpluses for any or all of the following purposes: developing their co-operative, possibly by setting up reserves, part of which at least would be indivisible; benefiting members in proportion to their transactions with the co-operative; and supporting other activities approved by the membership.

4TH PRINCIPLE: Autonomy and Independence: Co-operatives are autonomous, self-help organizations controlled by their members. If they enter into agreements with other organizations, including governments, or raise capital from external sources, they do so on terms that ensure democratic control by their members and maintain their co-operative autonomy.

5TH PRINCIPLE: Education, Training and Information: Co-operatives provide education and training for their members, elected representatives, managers and employees so they can contribute effectively to the development of their co-operatives. They inform the general public—particularly young people and opinion leaders—about the nature and benefits of co-operation.

6TH PRINCIPLE: Co-operation among Co-operatives: Co-operatives serve their members most effectively and strengthen the co-operative movement by working together through local, national, regional and international structures.

7TH PRINCIPLE: Concern for Community: Co-operatives work for the sustainable development of their communities through policies approved by their members.

(International Co-operative Alliance, 1995, Statement of the Co-operative Identity)
APPENDIX 2 – VARIATIONS IN THE CO-operative MODEL

CONSUMERS’ or Users’ CO-operative—
This type of co-op is made up of users who band together to meet their health care needs and obtain adequate services or products. The model is particularly suitable for remote communities or communities that have been left without some services because of changes in the existing health care system or groups of people with special needs in urban settings. This model is also used to consolidate hospitals and other organizations in order to obtain volume discounts on purchase

PRODUCERS’ CO-operative—
This type of co-op makes it possible to offer the best price for the goods and services it buys from its members. In the health care sector, for example, this type of co-op can be used by groups of professionals to take advantage of affordable administrative services and perhaps even allow them to submit joint business proposals while at the same time guaranteeing maximum autonomy for the members.

WORKERS CO-operative—
This type of co-op is used to enable people to create their own jobs and secure better working conditions (pay, quality of life in the workplace, etc.) for the workers in the co-op. This model has enabled many ambulance technicians, for example, to create their own democratic businesses that meet their very specific needs.

MULTI-STAKEHOLDER or SOLIDARITY CO-operatives—
The aim of this type of co-op is to simultaneously meet the needs of different groups of members, such as employees and users. This model could play a key role in creating home care co-operatives.

(Adapted from Government of Canada, 1999, Health Care Co-operatives Startup Guide)
REFERENCES


