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J P Firman
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Prologue: One of society's responses to its growing elderly population has been the creation of a complex array of health and social service programs to serve them. At the same time, there have been major changes in government programs which serve the elderly, such as Medicare’s new prospective payment system and the movement to transform Medicare through marker principles. These changes have led many of Medicare’s elderly consumers to become confused; this confusion has been complicated by the enactment of the Gramm-Rudman-Hollings budget-balancing legislation.

Whether Medicare continues down the road of price competition or Congress opts ultimately for a model that blends the principles of regulation and the market, James Firman argues in this article that having informed, educated consumers is essential to the success of any fundamental health care reform. Firman is chief executive officer of the United Seniors Consumer Cooperative and has worked as a program director at the National Council of Aging and as a senior program officer at The Robert Wood Johnson Foundation. In this essay, Firman promotes the idea of developing Medicare consumer cooperatives. As Firman envisions it, such cooperatives would be designed to help senior citizens better bargain for, select, and pay for needed medical services. The cooperatives, which would be independently managed and financed, would provide elderly members information, financial counseling, and the power of group bargaining. Firman is not only committed to the idea, but will soon embark on implementation of the first cooperative, an organization that will serve older people in the nation’s capital. Firman holds a master’s degree in business and a doctorate in education from Columbia University.
Most proposals for improving health care arrangements for older Americans advocate greater reliance on the marketplace or more direct economic regulation. However, the potential of both strategies is limited unless older persons are able to become better informed and more rational consumers. This article explores the difficulties older persons encounter in negotiating the current health care system. It suggests, as a complement to other strategies, a way of enabling older consumers to be a more effective third force in the health care marketplace.

Concerns Of Older Health Care Consumers

Current and emerging health care arrangements are a source of great anxiety for millions of older persons who are concerned about the appropriateness, cost, and quality of available care. Surveys confirm that perceived health is the strongest single influence on an older person’s feelings of well-being and that there is a strong relationship between health and economic security among older persons.1 Despite Medicare and Medicaid, out-of-pocket expenditures for the elderly in 1984 are about the same percentage of total income that they were before 1965. Although access to at least a minimal level of general medical care has been realized, major gaps in coverage still exist for catastrophic illness and long-term care.2 The quality of available care also remains a major concern, particularly for low-income elderly.

The marketplace is becoming increasingly complex and difficult to negotiate. The unabated growth of technologies, the emergence of new health care arrangements, and the multiplicity of insurance and direct pay options present consumers with a confusing array of choices. It is virtually impossible for many older people to assess intelligently all available options. Consequently many, if not most, are making suboptimal choices.

The health care marketplace for older persons is actually an agglomeration of several separate but related industries each characterized by its own mix of private and public financing. Major sectors include hospital care, physician services, nursing homes, drugs and medical supplies, home health care, dental services, eyeglasses and appliances, podiatry, and medical quackery.3 Despite the panoply of public programs, private financing accounted for more than 40 percent of the nation’s total health care bill for the elderly in 1981.

Over the next fifty years, it is likely that most sectors of the health care industry will continue to grow robustly, and the marketplace will probably be characterized by growing oversupplies of providers, continued development of new services and products, and heightened competition for the dollars of older consumers. Who will look out for the best inter-

The views expressed in this article are those of the author and not necessarily those of the United Seniors Consumer Cooperative.
ests of older folks in this rapidly changing and increasingly volatile health care marketplace?

A Medicare Consumer Cooperative

Most current proposals for reforming health care for the elderly advocate greater reliance on either regulatory or marketplace strategies. Although often at odds with each other, proponents of both approaches are likely to agree on the need for and value of a more informed and educated group of citizen/consumers. Consumers capable of deciding intelligently among alternatives and making judgments regarding both quality and price are essential ingredients of an effective market strategy. Better organized and informed consumers could also make possible the more effective use of regulations to control abuse and promote compliance with industry or governmental standards.

Proposed here is one approach for empowering older citizen/consumers of health care: a Medicare consumer cooperative. The cooperative organization would be designed to help older persons better bargain for, choose, and pay for needed medical and social care. The prototype organization would be independent and consumer financed, serving its members through the provision of discrete services. A brief description of and rationale for some of its major services are given below.

Group bargaining and cooperative purchasing services. Unlike adults in the labor force, most older individuals who are retired negotiate in the marketplace of providers as individuals rather than through groups. While unions and employees organize and represent workers in the purchase of health care insurance (usually at substantial discounts), older persons negotiate individually, with little economic leverage. This condition is particularly ironic considering that the elderly comprise the largest single health care consumer group by virtue of their participation in Medicare.

A Medicare consumer cooperative could gain for individuals the benefits of group purchasing: to receive substantial discounts and/or expanded service benefits. This group bargaining and cooperative purchasing approach may be applicable to every sector of the health care economy including hospitals, physicians, nursing homes, home health agencies, prescription drugs, hearing aids, and eyeglasses.

Group purchasing not only generates significant benefits to members, but also to cooperating providers who have the opportunity to increase their volume and reduce their marketing costs. For example, in the Medicare health maintenance organization (HMO) industry, marketing costs are projected to run as high as 40 percent of gross revenues. Group purchasing arrangements may encourage a shifting of resources from advertising to expanded services and benefits.

The Metropolitan Senior Federation of Minneapolis/St. Paul is cur-
rently the leading example in the United States of a local organization of older persons that has been able to produce substantial benefits to members through group bargaining and cooperative purchasing arrangements. Formed in 1972 as a loose alliance of existing senior citizens groups, the Metropolitan Senior Federation has negotiated significant price discounts from a wide variety of health care providers. For example, the federation reports that it has negotiated discounts for its members of 20-30 percent on the purchase of dental services, hearing and eye care, chiropractic, and other services. The organization has also demonstrated the ability to work with providers to make available new services and products, including the nation’s first catastrophic insurance plan. In 1985, the organization had approximately 40,000 members who pay annual dues of $7 each.

On the national scene, the American Association of Retired Persons and the National Council of Senior Citizens offer supplemental insurance policies and mail-order drug services. But these organizations have not exercised their full potential for organizing members on a local basis nor for bargaining for improved services and discounts in the multiplicity of other sectors which account for most out-of-pocket expenditures by older persons.

**Consumer health information services.** Informed decision making is critical to successful functioning of competitive markets. A major difficulty faced by older individuals is that it is currently impossible to easily understand and assess the range of alternatives available in most health care marketplaces. Information on providers (for example, their credentials, the services offered, their fee structures, and their hours of service) is just not available. Consequently, the choice of providers, often made under stressful circumstances, is usually made haphazardly or serendipitously. Uninformed decision making often leads to suboptimal choices and hardly promotes effective competition.

In addition to objective information, consumers might derive substantial benefit from subjective consumer ratings on many aspects of care which can be considered to be legitimately in the domain of consumers. For example, in the case of physicians, such factors might include how well the physician explains diagnoses and treatment plans to the patient, how concerned the physician seems to be with the patient’s total well-being, how much time the physician spends with the patient, how accessible the physician is to telephone queries outside of office hours, and how considerate the physician’s staff and office arrangements are for the needs of older patients.

Other major areas where older persons need better information to help them make choices are supplemental insurance, alternative health plans, and long-term care options. Decisions in each of these areas involve significant cost and can have major impact on the quality of care and qual-
ity of life for the people involved. Supplemental health insurance for the elderly (an $8 billion industry in 1984) is a sector of the health economy distinguished by confusing options, extensive and expensive direct mail and media advertising, and a remarkably high level of consumer ignorance about differences between various types of insurance and features of current coverage. It appears to be both desirable and economically feasible to develop a supplemental insurance evaluation service that would be personalized (able to respond to specific questions of individuals about their particular circumstances), objective (providing balanced and complete analyses of specific policies), current (able to keep up to date with changes in insurance policy offerings), independent (having no vested financial interest in any specific insurance product), and inexpensive (capable of being provided on a high-volume, low-unit cost basis).

Emerging marketplace offerings of alternative health plans (for example, Medicare HMOs, social HMOs, and independent practice associations or IPAs) portend the need for consumer information services in this area as well. Because high volume is viewed as one of the keys to successful development of these prepaid health plans, it is likely that the marketplace will be characterized by aggressive marketing efforts. In the future, there is likely to be significant demand for consumer services which help older people to discern differences in price, coverage, and quality of alternative health plans and which assist them in choosing the plan which best suits their needs. An effective service may also encourage providers to compete on the basis of quality, price, and coverage, and to divert expenditures from advertising to patient care.

Another area for which there appears to be a great need for improved consumer information services is for long-term care options. To the extent that counseling and case management services currently exist in this country, they tend to focus primarily on choosing a nursing home or arranging for alternative in-home services. However, the true range of choices available for persons in need of long-term care should also include a wide range of housing alternatives (including boarding care, residential care, continuity care retirement communities, and shared living arrangements) as well as a growing range of financial options including analyses of the possible eligibility for public and private programs, the potential of utilizing home equity conversion as a means of supplementing cash income, and long-term care insurance. Whereas it is probably not cost-effective to develop these information services for a small client population, a large membership base of older people may well be able to justify the investment of resources necessary to develop and make available a long-term care options service to its membership.

Older consumers also need better information on health promotion and disease prevention. The nature of their disabilities should be explained in ways supportive of making sound decisions about the types of
providers they should see and the kinds of medical and social services they should have. Older persons could also benefit from peer counseling services to help them in obtaining the information they need to choose appropriate providers. Also not generally available to, nor understood by, Medicare beneficiaries are second-opinion surgery services, which could help individuals feel more confident in making major decisions involving significant costs to themselves, their families, and society. All of these information services, designed to help consumers make better choices, could be provided through a consumer cooperative.

**Financial services.** Older persons have several financial concerns which are not being adequately addressed. One mundane but serious concern of most older consumers is the fact that a Medicare bill is virtually unintelligible. Most older individuals are unable to understand the bills, and if they do happen to detect an apparent discrepancy, they are usually unable to advocate effectively for themselves with their third-party fiscal intermediary.

Financial counseling services designed specifically for the elderly are also needed. The current orientation of most financial planning models is on asset accumulation, but the actual financial planning needs of most older persons are for asset preservation or for gradual decumulation. Designing and delivering these tailored financial counseling services, perhaps through peer counselors, is another logical and needed service of a Medicare consumer cooperative.

Another increasingly common problem among older persons is the lack of adequate access to the credit markets. Millions of older individuals are house rich, cash poor, and unable to meet medical or social care expenses. Despite the fact that older homeowners have more than $700 billion tied up in home equity, retired homeowners are usually unable to borrow money from banks which look at income as a primary investment criteria. Enabling older homeowners to borrow money without having to sell their homes could provide needed help to millions, particularly those with health impairments. For example, a recent study estimates that if home equity conversion plans were available, two-thirds of all elderly homeowners could afford an adequate long-term care insurance policy and more than three-fifths of “high-risk” single elderly could afford comprehensive home care for the rest of their lives.5

A consumer cooperative could play an instrumental role in enabling members to gain access to needed credit in a manner that would guarantee members lifetime tenancy in their homes. There are a variety of consumer and investor concerns that remain to be overcome before home equity conversion plans are more widely available but none appear to be insurmountable.6 Enabling more members to pay for needed services would also enhance the ability of individuals as well as the collective membership to bargain for and pay for needed care.
Cooperative work programs. Consumer cooperatives may also prove to be excellent vehicles for promoting exchanges of labor among older persons. Many retirees have both the time and inclination to be of service, but have a difficult time finding paid employment and are reluctant to work without any compensation. Through a cooperative, older persons may be able to provide services to others (for example, chores, friendly visiting, home-delivered meals, and peer counseling) and in return earn credits which can be redeemed for similar or other services at some future date. A major barrier to the development of cooperative work programs has been the lack of an ongoing source of funding for the administrative costs of such a program. In a consumer cooperative, a portion of membership revenues could be allocated for this purpose.

Potential Benefits Of Consumer Cooperatives

Perhaps the greatest attraction of a Medicare consumer cooperative is that it may be a means of simultaneously improving market forces and promoting equal access to health care services. One way that a consumer cooperative could improve market forces is by promoting competition on the basis of quality of care, price, coverage, convenience, and interpersonal aspects of services rendered. Because such relevant information is generally not available to consumers as they make decisions, these factors are currently less significant than they ought to be in a free-market system.

Group purchasing services can also improve market conditions by enabling economies of scale and by utilizing such mechanisms to negotiate for better service arrangements.

A third way that a consumer cooperative could improve market forces is by reducing the cost to consumers of making choices. There is a growing body of literature suggesting that consumers perceive the cost of researching alternatives to be quite high, and this is a major barrier to changing providers. In an ideal marketplace, information would be readily available and the cost to consumers of making changes would be minimal. A consumer cooperative can both reduce the cost to individuals of learning about alternative providers and can facilitate the decision-making process through personalized information and consultation services.

In addition to holding promise for improving the efficiency of the health care marketplace, a consumer cooperative can promote equal access to improved services for people of varying socioeconomic levels. One strategy for achieving this objective is to negotiate progressive billing arrangements for health care services. A good example of this arrangement is a plan developed by the Allied Council of Senior Citizens in Milwaukee, Wisconsin and Mount Sinai Medical Center. Under this arrangement, the hospital agreed to accept Medicare assignment for all individuals and couples with incomes below $25,000 and waive copayments and deduct-
ibles for persons with incomes less than $14,000. This model for group bargaining arrangements (or variations thereof) may improve access to medical services for low-income persons. Many physicians, hospitals, and other providers who may be reluctant to accept Medicare assignments for all patients are likely to find it reasonable and fair to agree to these more progressive billing and fee structures. The ability of low-income people to negotiate for either price breaks or improved service arrangements is likely to be significantly enhanced if the group representing them also includes substantial numbers of middle- and upper-income consumers. Thus, if a consumer cooperative makes a firm commitment to progressive reimbursement arrangements, it may be able to do considerably more for low-income members than they could do by themselves.

Consumer cooperatives may be of substantial benefit to low-income consumers in several other ways. As noted earlier, a cooperative may be an ideal organization for promoting the delivery of cost-effective services currently uncovered by Medicare and Medicaid. In addition, the development of a cooperative home health program, job registries, or barter service arrangements may enable older people to obtain needed non-professional services in return for exchanges of labor, thus increasing access to these services.

A Medicare consumer cooperative offers several potential benefits to provider groups. An organization of informed and interested consumers provides a means of increasing volume and reducing marketing cost. This could be done in a way to improve benefits and/or reduce prices for consumers and permit significant savings for providers. A consumer cooperative with an effective marketing research arm could also help providers to design and bring on-line services which are more responsive to the needs and preferences of elderly consumers. Finally, the development of consumer credit and other financing services could enable more consumers to pay for services offered by various providers and thus reduce bad debts and accounts receivable.

Consumer cooperatives could also aid government in controlling health care costs and improving the quality of services. Group purchasing arrangements can directly lead to reduced costs, and information services are likely to lead to more appropriate utilization of available resources and technologies. Consumer credit services enhance the ability of those older individuals, who so desire, to pay for care or insurance for themselves, and an active consumer organization could make the enforcement of regulatory procedures more possible. The benefits to the Medicare Trust Fund of consumer cooperatives may eventually justify expansion of current coverage to include membership fees.
Financial And Market Feasibility

The feasibility of a Medicare consumer cooperative has not yet been demonstrated. However, preliminary financial and market analyses suggest its potential for success. A membership of 30,000 or more in an urban area, would enable the provision of the package of group bargaining and consumer health information services described above at an estimated cost of $30 per person per year. This fee would be equal to less than 1 percent of annual average per capita expenditures for the elderly in 1982. Achieving this breakeven volume of 30,000 members over a three- or four-year period would require, for example, enrolling approximately 9 percent of the people over age sixty in the Washington, D.C. standard metropolitan statistical area (SMSA).

When examining the potential feasibility of a consumer cooperative, skeptics might question the ability of consumer groups and provider groups to work together successfully. If provider groups and senior citizens organizations are often at odds with each other on the national scene (for example, over pocketbook issues like mandatory assignment), why is it reasonable to think that they will be able to cooperate on the local level? One reason is that on the national level the arena is primarily political, whereas the basis for cooperation on the local level is primarily economic. Secondly, it seems to me that the collective ethos of professional organizations and trade associations (which dominates discussions on the national level) tends to be quite different than the behavior of individual providers. For example, whereas most professional provider organizations oppose advertising, tend to discourage competition on the basis of price, and often support anticompetitive referral practices, many individual providers view themselves as entrepreneurs and have no compunctions about competing for consumer demand.

A third difference is that the issues at stake at the national level are usually framed in win-lose terms. For example, the debate over mandatory Medicare assignment is usually cast in terms of saving consumers money at the expense of physicians or enriching physicians at the expense of consumers. On the other hand, group bargaining arrangements, are premised on win-win outcomes: by reducing out-of-pocket costs to consumers, cooperating providers will be able to increase their volume, revenues, and profits. Win-lose propositions are the basis of adversarial relationships, but win-win outcomes are the stuff on which collaboration and cooperation can be based.

Perspectives On Consumer Cooperatives

Cooperatives hold a rather unusual place in American political and economic thought: they appeal to conservatives and capitalists as well as
liberals and socialists. As Paul Starr notes: “Although cooperatives express some of the fundamental concerns of socialism for equality and collective actions in economic life, they make no direct challenge to the capitalist order.”

Despite their broad philosophical appeal, the development of cooperatives in the U.S. health care marketplace has been quite limited. The leading examples of medical cooperatives in the United States have been consumer-owned provider organizations. The first medical cooperative, the Ross-Loos Clinic, was founded in 1921 in Elk City, Oklahoma. Federal employees formed the Group Health Association in Washington, D.C. in 1937, and workers formed the Group Health Association of Puget Sound in 1947. Each was formed to provide services in a manner not otherwise available to their members. In 1980, there were no more than twenty known health care cooperatives in the United States. Significantly, each of these organizations were consumer-owned providers of direct health care services and consumer information services. They had an estimated membership of 740,000 and an annual volume of about $750 millions.

One reason for the scarcity of consumer cooperatives has been the organized opposition by local medical societies afraid of competing provider groups. Another barrier has been the substantial amount of capital necessary to establish a prepaid provider organization and the difficulties of raising such sums from individuals. Because it would not be a provider of direct health services, the prototypical organization proposed here would require only a fraction of the capital needed to purchase or build hospital and clinic facilities.

Consumer cooperatives are somewhat more abundant in the financial services industry. More than 26 million Americans belonged to credit unions in 1983, although their total assets represent less than 5 percent of the assets of all banks. The impetus for the formation of credit unions (that is, the need for members to gain better access to credit markets) is the same problem faced today by millions of retired homeowners.

Both the broad-based political appeal of consumer cooperatives and the difficulty of such organizations in gaining access to capital markets have been recognized by Congress. The National Consumer Cooperative Bank was formed under federal charter in 1978. The bank was authorized: “to provide for consumers a further means of minimizing the impact of inflation and economic depression by narrowing the price spread between costs to the producer and the consumer of needed goods, services, facilities, and commodities through the development and funding of specialized credit sources for, and technical assistance to, self-help not-for-profit cooperatives, and for other purposes.” The bank, dedicated to promoting the development of cooperatives, particularly those which serve low-income or elderly persons, may provide a needed impetus for
the development of such organizations in the United States.

Consumer cooperatives have fared better in the mixed economies of other nations. In Sweden, for example, a consumer cooperative was formed in 1905 to provide fire insurance for members. The resulting organization, Folksam, started to grow rapidly after World War II and soon developed into one of the largest Swedish insurance companies. By 1977, Folksam was responsible for 21 percent of the nation’s personal sickness and accident policies and 41 percent of all group sickness and accident policies. Almost half of all Swedes are members of at least one consumer cooperative. To a lesser extent, consumer cooperatives are also active in Israel, Switzerland, Denmark, and Norway. The economies of these countries are dominated by privately owned businesses, with a relatively high degree of government intervention, but a relatively low degree of government ownership. As the American economy (and particularly the health care marketplace for the elderly) begins to increasingly resemble the mixed economies of other nations, the need for, and value of, consumer approaches that thrive elsewhere become more apparent.

Is consumerism dead or is there a place for consumer initiatives in health care and other marketplaces of the future? Paul Bloom and Steven Greyser address this issue from a marketing perspective, with consumerism viewed as a product and the public as its potential customers. They conclude that, far from being dead, consumerism may be entering an important new stage of its product life cycle: “We foresee a quieter but still active consumer movement during the 1980s. We think the public will shift from its past role as largely cheering spectators to one of active participants. We envision participative consumerism as a major characteristic of this marketplace.”

Conclusions

Older citizen/consumers, individually and collectively, have a choice to make about the role they will play in shaping the health care marketplace of the future. They can continue to rely almost exclusively on political strategies aimed at reforming Medicare and/or Medicaid in the hope of making coverage more comprehensive and reducing out-of-pocket expenses. Unfortunately, the current political and economic climate makes the prospects of substantial legislative improvements in the near term rather dim. Furthermore, even if government were to assume more responsibility for paying for health care, there is little historical basis for assuming that this would lead to better resource allocation or cost control. Alternatively, older persons can rely on providers and an increasingly competitive environment to protect their interests, but the growth of corporate medicine and the increasing oversupply of physicians and other providers lead many to believe that this would be an equally un-
A third strategy, one that deserves greater attention, is participatory consumerism. The concept of a Medicare consumer cooperative designed to help the elderly and disabled to better bargain for, choose, and pay for health care appears to be technologically feasible and holds promise of being quite cost effective.

Participatory consumerism may be an idea whose time has come. During the past twenty years, older Americans have begun to exercise increased political power. During the next twenty years, older citizen/consumers are likely to begin to flex their economic muscles in an attempt to become a more effective force in the marketplace. If older consumers can organize themselves to become a more effective third force in the health care economy, both market and regulatory strategies are more likely to succeed.

NOTES


3. Medical quackery, the promotion of medical remedies known to be false or unproven for a profit, is one sector of the health care marketplace that is usually overlooked by policy analysts. Because older consumers spent an estimated $6 billion on quack cures in 1982, medical quackery may have accounted for as much as 7 percent of all national health expenditures for older persons in that year and 21 percent of their out-of-pocket expenditures. See: U.S. Congress, House Select Committee on Aging, Quackery: A $10 Billion Scandal, 98th Cong., 2nd sess., 1984.

4. Metropolitan Senior Federation, A Decade of Action The Metropolitan Senior Federation (St. Paul: The Metropolitan Senior Federation, 1983).


