

## Nova Scotia cooperative provokes growing interest

Doug Payne

**D**r Cathy Felderhof has practised family medicine in New Glasgow, a rural area of Nova Scotia northeast of Halifax, for more than 20 years, following in the footsteps of her father, who started the practice more than a half century ago. But the practice is no longer hers. It became the province's first patient-owned cooperative—the North Nova Health Care Co-Operative—on November 1, 2004.

“Something had to give,” she told colleagues and the local media last summer. She was putting in 80-hour weeks seeing to a patient list of almost 4000, doing on-call rounds at the local hospital, providing 1 day a week of services to the aboriginal community in Pictou, and “spending 40% of my time on paperwork.”

A change had become “a matter of survival,” according to Dianne Kelderman, the head of the Nova Scotia Co-operative Council, who has been fielding most questions relating to North Nova as Dr Felderhof tries to ease herself out of the public eye after a summer of media attention and passionate, sometimes rancorous, debate.

Dr Felderhof's change of thinking about the structure of her practice started after discussions with Dr Ray Rupert, the founding president of Doctors Care Cooperative in Ontario, who put her in touch with the economic development arm for the cooperative sector in Nova Scotia. “The rest,” said Ms Kelderman, “is history.”

### Lifetime fee

There are more than 400 patients who are currently members of the cooperative, and full-scale membership campaigns were under way early in 2005. “When we originally had some public meetings and some brief communication with the patients,” said

Ms Kelderman, “we had about 2600 out of the little less than 4000 expressing interest, which is more than 50%.”

To join, a patient fills out a membership application and pays a one-time, lifetime fee of \$10 per person or \$25 per family.

Dr David Gass, director of primary care for the provincial Health Department, said the government had very little involvement. “This is a business decision from Dr Felderhof. The way primary care is set up in the province, physicians have responsibility for organizing their own facilities.” But, he added, “We think that health co-ops, in general, have promise as they've been outlined by the Co-Op Council. We are looking at innovative models, and we're interested in that one.”

There are now four staff members at North Nova, including a business manager who happens to be a nurse; the fifth employee is Dr Felderhof. A seven-person board (all patients) is headed by Anna Fraser, a local lawyer. There are also two ex officio members, one of whom is a medical doctor from Halifax who is a resource person for the Nova Scotia Co-operative Council; the other is one of the Council's directors.

“The board will set strategic direction and policy,” explained Ms Kelderman. “It will deal with things like the contract with Cathy; with recruitment of a second doctor—which they have plans in place for—with dealing with uninsured services, costs, and fees; with looking at the other needs in the community; and with the standards of care that they would like to adhere to.”

The board has already discussed how to handle the practice's large elderly patient base, examining the feasibility of satellite clinics in some other rural areas so that elderly people do not have to come in

for blood collection during the winter. They have also discussed the idea of half-day workshops on certain topics, like managing diabetes, where 10 patients would come and meet with Dr Felderhof rather than having each wait to see her for individual counseling.

“The big difference,” she added, is that “we are seeing patients take responsibility not only for their own health care but also for the provision of health care in their community.”

### Concerns remain

But concerns remain. Groups such as the Nova Scotia Citizens Health Care Network continue to regard cooperatives as the beginning of the end of universal health care. Debbie Kelly, the group’s chairperson, even went so far as to say, “It’s a pretty slimy way to get extra money. This is another way of trying to get our doors open to private health care in this country.”

“This is one of several disturbing developments,” she added, “including the loss of insured services, the deterioration of rural health services, the rise of for-profit health care services, and a wide range of user fees that are undermining public confidence in public health care. This so-called co-op is not just another payment model. It was instigated at the request of the physician to deal with some major concerns she had with her practice [and] represents an organizational entrenchment of extra-billing or charges to patients for so-called uninsured services, [something] Nova Scotians [achieved] 20 years ago [when they got rid of extra billing] in Bill 106, passed in 1984.”

Maureen MacDonald, Member of the Legislative Assembly, the provincial New Democratic Party’s (NDP’s) health critic, shares that concern. “We have always supported, indeed advocated, the development of community-based health care centres or co-ops as a preferred model for primary health care delivery. [But] we have concerns that what Dr Felderhof is

proposing does not conform to this model in several important ways. Perhaps most troublesome is that she is proposing to charge patients fees for nonphysician primary health care services from nurses, nurse practitioners, and other health care providers. Moreover, it is likely that the administrative costs associated with running a private physician’s practice are simply being offloaded on to the back of patients, who through a monthly fee schedule will now bear the costs of office overhead, technology, financial planning, and support functions.

“Unfortunately the government’s primary health care reform has been very slow in moving beyond a small number of pilot projects with nurse practitioners. This has created a policy and practice vacuum in primary health care that physicians like Dr Felderhof are able to fill.”

Ms Kelly agreed. “The Health Network does support the community health centre model in place in eight centres in the province represented by the Nova Scotia Federation of Community Health Centres and the Canadian Alliance of Community Health Centre Associations. There is an alternative to the regressive model now in place in New Glasgow, and that is a community health centre (as a cooperative or non-profit society) owned and operated by patients and community residents that does not allow the charging of fees of members for extra-billing by its physician or other health providers.”

### “Every doctor is private”

Ms Kelderman, not surprisingly, disagreed. “Cathy’s practice was a private practice. Every doctor practising in this province is private. So, in

fact, we’re attempting to do more of what the NDP has been espousing. I think most of the criticism came from a lack of information, and certainly misinformation. [Besides,] the list of uninsured services that may be charged for, and the charges for them, is decided by Doctors Nova Scotia [the province’s medical society], and it is a public document.”

Nor did the province's Dr Gass share the level of concern of the Health Network and the NDP. "Of course, we're concerned that those billings don't get in the way of having access to insured services, but everyone has agreed here, that that's not the purpose or the intent."

### Comparative analysis

Dr Gass characterized his department's position as one of "watchful waiting."

Indeed, others have clearly been watching as well. The Nova Scotia Co-operative Council recently incorporated another cooperative in Wolfville,

which, said Dr Kelderman, "is a little bit different, and we're really pleased that it's different, so we can do some comparative analysis. [It] is actually a worker multistakeholder cooperative for doctors and for nurses."

The Council has also held meetings with the Capital Health District in Halifax, where the mental health division is examining the possible benefits of a cooperative governance structure. The Council has also had some inquiries from New Brunswick.

"So it is starting to resonate," Dr Kelderman concluded. "It promises to be a busy year." ❁

Mr Payne is a freelance writer based in Charlottetown, PEI.

## Bulletin Board

### Absolute fracture risk recommended for reporting

In family practice, optimal reporting of bone mineral density (BMD) is especially important for postmenopausal women and older men. Until recently, diagnosis and management of osteoporosis focused on optimal reporting of BMD results. New Canadian guidelines propose that an individual 10-year absolute fracture risk, rather than BMD alone, be used for calculating risk categories. Recently developed by a multidisciplinary committee of the Osteoporosis Society of Canada, the "Canadian Recommendations for Bone Mineral Density (BMD) Reporting" was published in the *Canadian Association of Radiologists Journal (Can Assoc Radiol J 2005;56(3):178-88)*. Also included are clinical resources, such as a patient questionnaire and a BMD reporting format, to help physicians better assess risk of osteoporotic fracture.

### First-ever international kidney transplant

Illinois resident Bill Lundborg will receive the first-ever international kidney transplant from a Canadian donor, Trent Fenwick of Kelowna, British Columbia, whom he met through **MatchingDonors.com**. The website's main objective is to find potential live donors for people in need of organ transplants. Patients on transplant lists post their profiles on the website, and potential donors browse the site for a life they would like to help save. After reading Bill Lundborg's profile, Trent Fenwick wrote, "I have been given the gift of having healthy organs and I would like to help someone attain their full potential. ... This opportunity I have to help someone is truly a blessing for me." For more information, visit **www.MatchingDonors.com**.