

Community Ownership of Health Care Assets

By Raymond Rupert

If New Glasgow in Nova Scotia, Brampton in Ontario, Port Alberni in British Columbia, or Rogersville in New Brunswick want a hockey arena, they raise the capital and seek matching funds to build it. (Brampton did, and now everyone knows it as the hometown of Wayne Gretzky.) Clearly, communities have the right to fund specialized assets.

Unfortunately, many communities don't appear to understand that the same right also applies to health care assets, or don't know how to go about exercising it, and instead expect central health system planners to provide the assets for them. So wrong!

Health care assets, of course, usually require more considered planning than others do, as well as knowledge workers such as doctors, nurses, and technicians to work in and with them. Provinces restrict who may own and operate certain health care assets such as MRI machines. Many others are under no such restriction, however, and no one is better able to define the need for them than the members of each community.

This is in keeping with the logic of complex systems. Local input is essential to optimize their operations. The passive community that waits upon distant health planners to decide which asset to fund (clinic, hospice, colour doppler, or CAT scan, for example) and where to locate it is unlikely to get its needs properly met.

Even the active community that defines local needs and communicates them to distant decision-makers may be disappointed, nevertheless. Health care is a zero-sum game. There is system-wide competition for assets and funding. Some communities get these assets and some do not. The communities with more economic power, bargaining power, relationship capital, and political will are more likely to win.

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A community that is not successful in the competition for assets and funding can pass the hat and raise the money locally. Communities do this every day. Private funds donated by community members form a large part of the capital employed by hospitals.

If the community funds the hospital to acquire assets, then the hospital owns the assets. If the hospital owns the assets, then the community has no direct input (except through the hospital board) into the use of or re-allocation of those assets. Hospital ownership is not synonymous with community ownership.

Another option is for the community itself to own and manage the health care assets by means of a co-operative. This

is a very old governance model. Dairy farmers, egg producers, and fish farmers employ co-operatives to share assets in order to meet their needs. The co-operative structure and the rules inherent in one-member, one-vote offer a democratic way for communities to own and operate health care assets, too.

Say the leaders of hypothetical Community A choose to fund and own a new health care asset. The community

has defined the need for a new hospice backed by a solid plan and a clear forecast of need. The capital budget is estimated at \$950,000 for construction and equipment. The community forms a co-operative with a co-op friendly lawyer who knows the ropes. The co-op has a board and the board arranges to raise the funds from the community.

That – the capital budget – was the easy part. The challenging part for Community A is now to source the hospice's operating budget. The capital budget is used to fund the acquisition of the asset. The operating budget pays for running it: the technicians' salaries, new parts, repair bills, power, and the like. Anyone who has ever purchased a shiny new computer and then had to hire a

geek to make it perform, knows how meaningless a capital budget is without an operating budget. The first has all the shine, but it's the second that delivers the gold.

The community could seek operational funding from the central health system planners, but they might not approve. Even if they are sympathetic to this expression of local need, they don't have a lot of discretionary capital. When it comes to public expenditure for community infrastructure, in 1961 Ottawa spent 33 cents of every dollar and the provinces another 30 cents. In

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2005 Ottawa was spending 13 cents and the provinces were paying 58 cents. Lower investment in infrastructure has led to a significant decline in the net capital stock in all community infrastructure: roads and bridges, but also health care infrastructure, including hospitals, clinics, information technology, imaging technology, and public health resources. By funding infrastructure from general revenues, there is not enough capital to meet the rapidly growing demand for health care services.

Granted, the central planners just might agree to supply an operating budget for the community's capital investment. That too has its implications.

To take one example, say Community B decided to fund a modern colour doppler (an ultrasound machine). The fundraising was successful; the machine was purchased. The Regional Health

Authority agreed to supply the operating budget. There was a ceremony and local leaders enjoyed a photo-opportunity with the board members of the hospice. Everyone was pleased.

Then it really hit the fan when the Health Authority decided to move the doppler from Community B to Community C without consulting the members of Community B. No one expected that. Community B had funded the capital budget for the doppler. The health system planners controlled the operating budget. Without that funding, the asset could not be operated. The

community was held hostage because of the control that the health system planners had over the operating funds.

Now what? In fact, members of Community B blocked the roads until the health authority backed off. If they had decided to raise the operating capital from the community, then the ownership of the asset would have been beyond dispute.

If the central health planners are such unpredictable partners, what then is Community A to do? What if it decided to levy a small monthly charge to members of the community who elect to contribute to the operating budget of the hospice? That seems a possibility, but the collection and distribution of these monies can be onerous if you expect several hundred people to submit monthly cheques. Modern billing systems will collect small monthly contributions

(preauthorized or conducted at an installer) electronically and distribute them to the hospice very economically. Such services can be obtained from a community credit union or from companies such as the Doctors Care Cooperative (www.dcc1.ca). DCC was set up by a group of doctors to do the electronic billing for doctors' offices. It worked with a health care co-operative in the Maritimes to collect modest monthly amounts from community members to pay for extended (i.e., uninsured by the province) health care services they received at their clinic.

To review:

- Communities have a right to own health care assets. Communities are best able to define local needs for health care assets.
- Communities have the option to fund the capital budgets for health care assets.
- Communities can own the health care assets through a shared-ownership entity such as a co-operative.
- Communities have the option to fund the operating budgets for health care assets.
- Communities can be active participants in improving the community-based health infrastructure.



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The following works on the Community Right to Own are recommended from the Department of Communities and Local Government of the Government of the United Kingdom (www.communities.gov.uk):

- Government of the United Kingdom. *Communities Taking Control: Final Report of the Cross-Sector Work Group on Community Management and Ownership of Assets*. London: Office of the Deputy Prime Minister, 2006.
- Government of the United Kingdom. *Community Assets: The benefits and costs of community management and ownership*. London: Civil Renewal Unit, Department of Communities and Local Government, 2006.