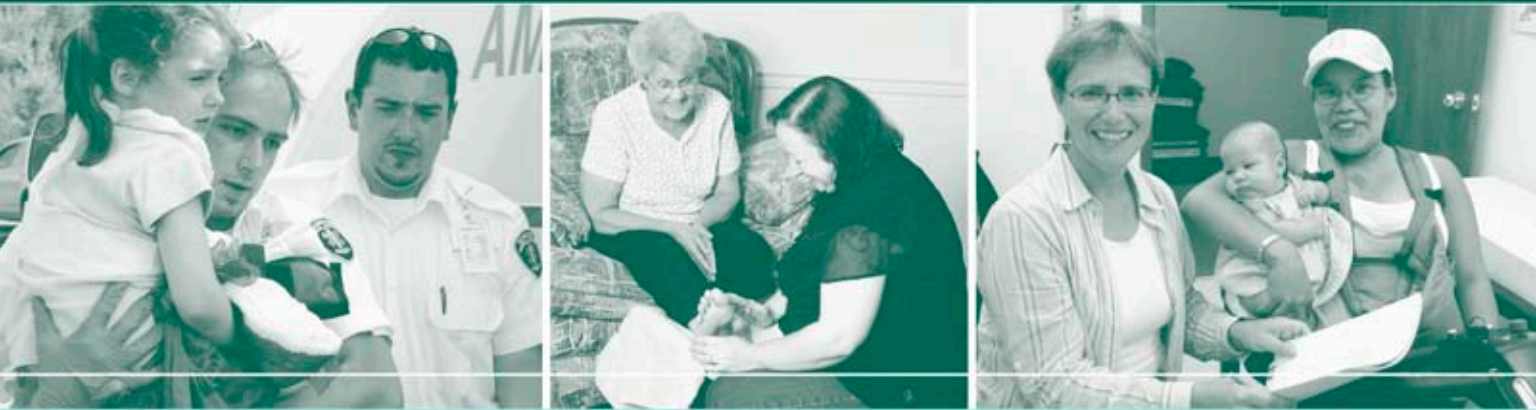


# Co-operating for health



a discussion about building  
union and community support  
for health care co-operatives

This book is part of the Hospital Employees' Union project, "Building Union Support for Community Health Care Co-operatives." The project is funded by the Co-operative Development Initiative of the Co-operative Secretariat, Government of Canada.

FIRST PRINTING 2006

Contents may not be commercially reproduced but other reproduction is allowed. Please credit.

PROJECT CO-ORDINATOR Marcy Cohen

WRITER Nancy Pollak

CONSULTANTS Melanie Conn, Jan Taylor

EDITOR Nadene Rehnby [www.handsonpublications.com](http://www.handsonpublications.com)

DESIGNER Working Design [www.workingdesign.net](http://www.workingdesign.net)

PRINTER Marine Printers

Thanks to Francois Aubrey and Lorna Knudson for assistance with the research.

Photos for this publication were provided by the Nelson Daily News, the Saskatoon Health Co-operative, Phillippe Serafino from CETAM, and the Multicultural Brokers Cooperative. Photographs of Care Connections were taken by Mona Kayello.

For copies of this book, please contact

Marcy Cohen, HEU Research Director

[mcohen@heu.org](mailto:mcohen@heu.org)

HEU Provincial Office

5000 North Fraser Way

Burnaby, British Columbia

Canada V5J 5M3

[www.heu.org](http://www.heu.org)

# Contents

<b>CHAPTER 1</b>	<b>Why co-operatives – and why now? .....</b>	<b>6</b>
<b>CHAPTER 2</b>	<b>Looking back .....</b>	<b>9</b>
<b>PROFILE</b>	<b>Community First Health Co-operative   Nelson, B.C.....</b>	<b>12</b>
<b>CHAPTER 3</b>	<b>The co-operative today: Untapped potential .....</b>	<b>15</b>
	The social economy .....	16
	Social co-operatives .....	17
	Non-profit status, yet entrepreneurial spirit.....	18
	Public funding and support: Essential ingredients .....	19
<b>PROFILE</b>	<b>Multicultural Health Brokers   Edmonton, Alberta.....</b>	<b>21</b>
<b>CHAPTER 4</b>	<b>Co-operatives in a nutshell.....</b>	<b>25</b>
	What is a co-operative?.....	25
	What do co-ops do?.....	25
	What are the membership types of co-ops?.....	26
	What is distinctive about a co-op? .....	27
	How are co-ops run? .....	28
	What is the status of workers in a co-op? .....	28
	Can co-ops be unionized?.....	29
	How do co-ops differ from ordinary businesses?.....	29
	What is the legal status of co-ops? .....	30
	What are the “co-operative principles”? .....	31

<b>CHAPTER 5</b>	<b>Co-ops and health care: A healthy match.....</b>	<b>33</b>
	Innovators and advocates.....	35
	Good work, steady work, committed work .....	36
<b>PROFILE</b>	<b>Saskatoon Community Clinic   Saskatoon, SK .....</b>	<b>37</b>
<b>CHAPTER 6</b>	<b>Come together now: The co-op-union dance .....</b>	<b>42</b>
	Social solidarity.....	43
	Workplace democracy .....	44
	Do co-ops contribute to the erosion of unionized public services?.....	45
	Collaborations... ..	46
	...and friction .....	47
	Building on the best of both worlds .....	51
<b>PROFILE</b>	<b>La Coopérative des techniciens ambulanciers de la Montérégie (CETAM)   Quebec .....</b>	<b>52</b>
<b>CHAPTER 7</b>	<b>The co-op challenge: Not for the faint hearted.....</b>	<b>57</b>
	Starting out.....	57
	Generating a sense of ownership .....	58
<b>PROFILE</b>	<b>Care Connection Co-operative   Mission, B.C .....</b>	<b>62</b>
<b>CHAPTER 8</b>	<b>Building support: Getting the government on side.....</b>	<b>67</b>
	Policies and practices that make a difference.....	68
<b>IN CLOSING</b>	<b>Getting unions on side .....</b>	<b>70</b>
	Resources.....	72
	Sources.....	73

## About this book

This book is intended to stimulate a conversation between unions and co-operatives. The topic? How can the two social movements – each dedicated to mutual aid and committed to community action – collaborate in the realm of health care services?

Many union activists are uncertain about co-ops, and many co-operators are wary of unions. Yet there are still a variety of ways in which they can work well together and build on the best of both movements. This book is testimony to the possibilities: it offers positive examples of union/co-op health care organizations that are effective and stable.

The need for collaboration is acute. The Canadian social safety net is being torn open by privatization and contracting out. In this market-driven environment, union jobs are disappearing and local needs are overlooked. Co-operatives have emerged as a community-controlled, non-profit alternative to the corporate model. Community-based health co-ops can use government funding to deliver programs that reflect the needs of real people and respect the principles of workplace democracy. Indeed, both unions and co-ops share the ideals of participatory decision-making and concern for community.

Our hope is that readers who are active in either (or both) movements will find practical and thought-provoking information in these pages.

# Why co-operatives – and why now?



Co-operatives enjoy a high profile in some parts of Canadian society. Many of us are members of co-ops. We might do our banking at a credit union, live in a housing co-op, or shop at the local co-op store. VanCity Credit Union is a celebrated example of co-op success, as is Mountain Equipment Co-op. Some of us are active in cultural co-operatives, such as radio stations and arts organizations. We often do business with co-ops whether we know it or not.

But co-ops are not as evident in health care and social services. This is changing. The social co-op movement is growing in Canada. Social co-ops provide community-based health and social services, as well as employment opportunities for people with disabilities, new immigrants, and other marginalized people. The growth of social co-ops is due to creative efforts by Canadian activists, inspiring developments in other countries, and raw necessity.

In Canada today, the term “health care restructuring” is often a euphemism for privatization and contracting out. Health support jobs are disappearing from the public sector. In B.C. alone, 8,500 support service jobs in hospitals and care facilities were privatized between 2003 and 2004. Privatization is often promoted as a cost saving to the public purse, yet the savings are highly questionable. In fact, privatization often involves major losses. Two of the most significant are:

- the eradication of relatively well-paid and secure jobs; and
- the reduction of public control over health care services

Co-operatives can play a role in reversing these losses, both for workers and for community-focused care.

But co-ops are not just a response to crisis. They are also an attractive option for communities seeking to fill their unmet health needs. Ambulance services, primary care clinics, programs for vulnerable groups, home support – co-ops can provide all these types of care and are already doing so in parts of Canada.

Moreover, co-operatives can fill these needs while reinforcing the primacy of public health care, ensuring local decision-making, and democratizing the workplace. They represent a form of non-profit delivery rooted in community and democratic control.

Members of the Hospital Employees' Union have expressed interest in forming co-ops as an alternative to privatization. An example is Care Connection Co-operative in Mission, B.C. (profiled in Chapter xx). Activists in rural areas such as Nelson and Port Alberni are turning to co-ops as a means of retaining local health and social services through community ownership and control.

The political pressure to cut public programs and privatize public service jobs is not letting up. Corporate interests continue to call for “smaller government” and demand lower taxes, which inevitably result in a loss of public programs. The marketplace ideology that champions for-profit delivery of health and social services is still loudly proclaimed. And governments and health

The political pressure to cut public programs and to privatize public service jobs is not letting up. Corporate interests continue to call for ‘smaller government.’

authorities are still free to make sweeping changes to health care delivery, with little regard for local preferences or local needs.

Working people will continue to advocate for Canada's public schools, hospitals, social programs, and income security programs. Unionized jobs in the public sector must be maintained. And in these times, the social co-operative has emerged as a progressive way to deliver community-run services and create jobs that are rewarding, equitable, and socially useful.

**The social co-op model is:**

- **a means of mobilizing local citizens on issues of social and health care services;**
- **an alternative to privatization, after government services have been discontinued;**
- **a model for increasing control over services for both care providers and care recipients;**
- **a model for containing costs while improving the quality and responsiveness of services; and**
- **a strategy for aligning the interests of care providers with the interests of care recipients by linking job quality with service quality.**

**ADAPTED FROM THE B.C. CO-OPERATIVE ASSOCIATION**



# 2

## Looking back



“Co-operatives were created by people who needed an alternative to investor-based corporations to meet their needs. Consumers were getting chalk in their flour, rock in the coal, and paying for a pound of goods that weighed only 12 ounces...

Workers created co-operatives because they were being cheated out of a fair share of the value of their work or because investors would not invest their money or hire them. Rather than ignore their problems or look to others to save them, they solved their problem by creating democratic businesses that they could trust to meet their needs.”

TOM WEBB, IN *CANADIAN COOPERATIVES IN THE YEAR 2000*

Historically, people have formed co-operatives for two fundamental reasons: as a practical response to their social and economic needs, and as an ideological response to capitalism. The motivation to create a co-op is almost identical to the motivation for joining a union. Working people seek:

- to overcome their economic powerlessness, dependency, and insecurity; and
- to develop their collective strength and cohesion

The co-operative impulse is nothing new in Canada. Indeed, a study of our co-op history invites the reaction, “Why haven’t we heard this stuff before?” The tradition is a buried stream, neglected in most historical accounts and

ignored in mainstream media today. The idea that private greed is the natural stimulus of economic activity – and the best approach to nation building – has overshadowed other philosophical strains in Canadian society. Yet robust traditions of collaboration and solidarity can be found in our labour, co-operative, and social justice movements.

Canadians often see Europe as the font of co-operative inspiration. The European experience runs deep, beginning with unemployed English weavers who launched the first formal co-op in the 1840s – the Rochdale Society of Equitable Pioneers – and hammered out the first set of co-op principles. Today the Mondragon co-operative network in the Basque region of Spain is an economic powerhouse, employing tens of thousands of workers and generating annual sales in the billions of dollars. The Italian state of Emilia Romagna is a working model of co-op innovation, with a system of co-operatives that encompasses every dimension of economic and social activity.

But Canadians have home-grown traditions too. Nova Scotia and Prince Edward Island have strong co-operative roots. Quebec and Saskatchewan pioneered several co-op models, a fact that reflects the unique cultural character of both provinces. Quebec is far ahead of the rest of Canada in developing a provincial infrastructure to support co-ops. The province also has a strong co-op ambulance sector and some new primary care co-operatives. Not surprisingly, Quebec has a fascinating co-operative

The idea that private greed is the natural stimulus of economic activity has overshadowed other philosophical strains in Canadian society.



history, beginning in 1900 with the *Caisse populaire* movement of Alphonse Desjardins. In Quebec, the labour and co-op movements have often made common cause.

Saskatchewan has a distinctive tradition of rural co-operation and was the birthplace of public health insurance (Medicare). In the 1960s, these two tendencies lead to the formation of co-op health care clinics in Saskatchewan cities, many of which continue to thrive.

Clearly Canadians have experience in creating and running successful health care co-operatives, even though the sector is still very small. A study by the federal Co-operatives Secretariat found that 57 new health care co-ops were formed between 1997 and 2001, yielding a total of 101 health co-ops across the country in 2001 (Craddock). With the exception of New Brunswick and the northern territories, all provinces have at least a few health co-ops in operation today.

## Nelsonites commit to community control

Nelson is a dynamic community in the West Kootenay region of British Columbia. It is also the birthplace of the Community First Health Co-operative, created to stem the loss of local services and community control.

Like much of rural B.C., the Nelson area suffered a series of blows to its health care services beginning in the 1990s. The actions of the province and health authorities – restructuring, amalgamations, and cuts – were rarely in step with the real needs of the community.

But Nelson was distinct. In previous decades, the Nelson and District Home Support Services Society (HSS) had purchased two buildings with their own money. The society used their buildings to run over two dozen publicly funded programs for seniors, people with disabilities, teen mothers, children, and mental health consumers.

In the early 1990s the drive to amalgamate services and seize assets from non-profit societies caught up with the non-profit board. The HSS reluctantly turned over their buildings to the local health council. Eventually the buildings were appropriated by the Interior Health Authority. Nelson's aging extended care facility – Mount St. Frances, owned by a religious order – was also turned over.

Cuts to home support services hit Nelson hard. Some of the town's acute care services were also eliminated, and the health authority stopped funding services deemed unrelated to health. The authority's view of health was extremely narrow. For example, funding was cut to a peer-based program for seniors that facilitated their access to community services.



“We were determined and enthusiastic about having ownership of our facilities.”

JOAN REICHARDT, LONG-TIME ACTIVIST AND RETIRED HEALTH ADMINISTRATOR

Nelsonites reacted forcefully to the confiscation of their community assets and cuts to their services. In 2002 they formed the Nelson Area Society for Health, a non-profit group that went to work on several fronts. The Save Our Services committee launched a vigorous protest against further cuts to hospital and community services, and the Community First Health Co-operative was formed to address long-term solutions.

“Community First Health Co-op has a strong membership base of ordinary community people, including many seniors,” says Joan Reichardt, a long-time activist and retired health administrator. “We also have many members with expertise and skills in finances and health care services. And we were determined and enthusiastic about having ownership of our facilities.”

The co-op’s first endeavour was to secure the contract for Nelson’s new extended care facility (“the Mount” was old and due for replacement). The co-op put together a solid, community-focused bid and was horrified when the health authority awarded the contract to a commercial operator. To add insult to injury, the operator had a well-documented record of non-compliance at its private-pay hospital in Nelson.

“It was the worst possible case,” says Reichardt. “One of our concerns was that the quality of care by the for-profit sector does not meet our standards. They have too few staff, and the training is poor. Our philosophy as a co-operative is be concerned about fairness and ethics and community. We don’t want to see women forced into low-paying jobs.”

Community First Health Co-op has two projects underway in 2006. One is a plan to convert a former university building (now vacant) into supportive housing for seniors. The co-op received exploratory funding for this from the Canada Mortgage and Housing Corporation. But other authorities are not yet stepping up to the plate “despite the huge need,” says Reichardt. She



suspects they are reluctant to extend funding to the co-op because, after all, “they cannot control us.”

With guidance from their local MLA, the co-op also purchased a former government building in downtown Nelson. Their hope is to create a nexus of primary health care services – a modern-day version of a co-operative clinic. Reichardt was witness to the birth of the Saskatoon Community Clinic in 1961 – she and her husband were charter members – and she has a deep appreciation for the strength of community-controlled services.

Nelson is a bad-news, good-news story. The bad news is the failure, to date, of provincial and regional health officials to recognize the advantages of local co-operative energies and skills. Nelson is proof of the need to raise the profile of the co-op model through education, policy changes, and advocacy over the long term. The good news is the creative tenacity of the local co-op movement. Community Health First has many irons in the fire and at least one project underway. The Nelsonites behind it are committed to community control, and they recognize the value of stable, well-paid jobs. Their determination and vision are durable.

# 3

## The co-operative today: Untapped potential

Since the 1990s Canadian governments at all levels have moved to reduce their role in social and health care services. Increasingly, public provision of these services is threatened by commodification and privatization. In this environment the co-op model presents a progressive option: social and health care services that are locally controlled, participatory, and beneficial to consumers and workers alike.

People create co-ops to meet their unsatisfied needs. But equally important is their commitment to co-operative values: faith in local community, trust in self-help and self-governance, and a wish to equalize the burdens and benefits of citizenship. Co-ops are part of an alternative zone that lies between the state and the commercial marketplace (sometimes called “the third sector”). This alternative sector includes non-profit societies and other types of voluntary organizations. The non-profit co-op represents a different way of delivering social and health services: community-based rather than state-run, yet still *funded* by government.

Associated with this sector are ideas about the social economy and social care.

**“The co-operative model offers a tremendous opportunity to engage citizens in responding to local needs through community-owned organizations.”**

**BRETT FAIRBAIRN**

## The social economy

The social economy is the diverse array of activities, organizations, and informal processes by which communities take care of human needs. Breaking isolation, alleviating poverty, strengthening grassroots connections, and integrating the needs of body, mind and spirit – these are the goals of the social economy.

In contrast to the commercial economy, with its narrow pursuit of profits for owners and shareholders, the social economy hinges on *reciprocity*. Italian economist Stefano Zamagni uses this term to describe how co-operators create and exchange goods and services for their mutual benefit, based on long-term relationships (Restakis 2004). To Zamagni, reciprocity involves the circulation of human qualities such as “gratitude, consideration, empathy, liking, fairness and a sense of community.” His ideas are reflections on the co-operative culture of Emilia Romagna in northern Italy (see page xx).

Players in the social economy are attracted to principles of democratic and local control. In other words, rather than an economy built on competition and materialism, the social economy aims to satisfy people’s “need to belong and fulfil themselves . . . . Rather than fighting for life, we unite for life” (Béland).

People who choose the co-op route have multiple bottom lines. Their goals include local development and environmental wholeness, not just economic survival. They understand the benefits of grassroots rather than top-down solutions. They see the energy that is released by genuine democratic processes in the community and within workplaces.



## Social co-operatives

A social co-operative delivers health care, counselling, education, childcare, recreation, and rehabilitation, often to a particular group but always with the wider goal of benefiting the whole community.

Social co-ops aim to meet the needs of their participants by empowering them. They emphasize mutual support rather than top-down or paternalistic interventions. They marshal the skills and capacities of abandoned or neglected resources (whether human or material). Social co-ops often forge partnerships among community groups, faith groups, governments, public agencies, and other local bodies. Their membership can include care recipients, family members, workers, and other interested parties.

Social co-ops have tangible activities. They are productive in a conventional sense yet their deeper significance lies in subtle benefits to members and community alike. Participants can feel a growth in their confidence, physical

### **Social co-operatives come in two basic types:**

- **Social service co-ops deliver health, educational, and social services to members or the community at large. Sometimes a co-operative will be formed to replace a privatized or cancelled government service. Other times a co-op will step forward to offer a critical service that has been lacking. Social service co-ops are usually, but not always, non-profit. Their membership can include consumers/clients, care providers, or both.**
- **Social care co-ops provide opportunities and services to members, who usually face barriers as vulnerable or marginalized people. These co-ops offer services relating to employment, personal support, skill building, and community development. Their membership can include care recipients, their relatives, and/or care providers.**



health, and emotional well-being. Isolation is broken, hope is nurtured. These subtle personal benefits also translate into less pressure on traditional social and health services.

Social co-ops are a relatively new idea in Canada. But they are thriving elsewhere. In the northern Italian city of Bologna, the majority of social services are delivered through co-ops. Indeed, the Italian state of Emilia Romagna is the birthplace of social co-operatives (see page xx). Importantly, most of these care providers are unionized. The first social co-ops in Emilia Romagna were created in the 1980s by parents and workers to provide services for people with disabilities. As researcher John Restakis notes, these Italian co-ops were not a response to privatization of public services, but a proactive strategy to fill a void: "... social co-operatives rose autonomously, largely from voluntary organizations, to compensate for the inadequacies of the Italian welfare state, and as an expression of the renewed vitality of civil society." (Restakis 2004)

## Non-profit status, yet entrepreneurial spirit

In Canada, the preferred social co-op model is a non-profit organization supported by public funding. The co-op might rely wholly on government contracts or partially sustain itself via a *social enterprise*, which creates jobs and generates income by selling goods or services. It is not uncommon for social co-ops to have a mixture of public and private revenue sources.

Three of the organizations profiled in this publication – the CETAM ambulance co-op in Quebec, the Saskatoon Community Clinic, and the Edmonton-based Multicultural Health Care Brokers – are non-profit, government-funded co-ops. The Care Connection Co-operative in Mission, B.C. is a non-profit entity that relies on private-pay clients and government contracts, while seeking stable funding from the health authority.

Social co-ops often combine entrepreneurial thinking with community-based values. This entrepreneurial spirit, which can seem foreign to unionists, is directed toward collective security and mutual responsibility, not individual gain. Members of a social co-op ask, “What’s in it for us?” rather than “What’s in it for me?” They consider the economic angle of their situation by asking, “How can we use our human resources and material assets to meet our collective needs?”

## Public funding and support: Essential ingredients

Social co-ops require and deserve public support. For example, housing co-ops use seed money from their members and then negotiate a mortgage with the Canada Mortgage and Housing Corporation. A co-op of people with developmental disabilities might generate wages by selling a service, yet will require funding for administrative salaries, mentoring, and member services. A worker co-op of home support attendants might seek a contractual arrangement with a health authority, Veterans Affairs, or the Insurance Corporation of B.C.

In this way, social co-operatives straddle the border between public provision and social economy: they blend government funding with grassroots initiative.

Members of a social co-op ask, “What’s in it for us?” rather than “What’s in it for me?” They consider the economic angle of their situation by asking, “How can we use our human resources and material assets to meet our collective needs?”

**“Some co-ops have more ‘heart’ – they embody more trust, depth, caring, love, vision, integrity, passion, commitment and respect. These co-ops generally attract more support in all forms.”**

**SUTHERLAND  
AND BEACHEY**

Public support can be seen as an investment in community well-being. Many social co-ops provide stability and opportunities to isolated and vulnerable people, who would otherwise be forced to fall back on mainstream emergency health and social services. Public support for social care co-operatives makes sense, economically and ethically.

An in-depth Canadian study of social co-ops for people with mental illness and developmental disabilities noted the systemic benefits of government support:

*Social co-ops tend to significantly improve the quality of life for their members, which translates into reduced costs of hospitalization, crisis intervention, medical expenses, policing, etc. One cost benefit study showed that on average, mental health survivors participating in consumer-run businesses used \$13,000 less in social services /year than a comparable population. (Sutherland)*

Unfortunately, governments usually overlook the co-op option as an alternative form of service delivery. They are happy to deal with private care providers and non-profit societies, but slow to appreciate co-ops as service providers *and* community builders. This, despite solid evidence from Saskatchewan, Quebec, and elsewhere about the efficiency and advantages of co-operative social care.

The problem is not simple lack of awareness. Authorities tend to view co-ops as fringe: too small and too autonomous. These exact qualities – local and self-governed – are perhaps why authorities are reluctant to engage with co-ops. Co-ops are collectively owned and operated. As independent organizations, they cannot be controlled by government the way non-profit societies can be.

## Bridging, advocating, and serving across cultures

The Multicultural Health Brokers (MCHB) is a non-profit, worker co-operative in Edmonton, Alberta. The 16 women members, all from visible minority backgrounds, provide health-related services to immigrant and refugee families, especially in the areas of pregnancy, childrearing, and community development.

The co-op is a pioneer in the field of multicultural health brokering. Health brokers are trained community workers who mediate between marginalized ethnic Canadians and mainstream health providers. They take a community development approach that honours diverse cultural practices about sickness and health, and seeks to build both individual and community strength.

Incorporated in 1998, the MCHB serves new Canadians from China, South Asia, Arabic- and Spanish-speaking countries, Vietnam, Kurdistan, the Philippines, Somalia, and the former Yugoslavia.

The co-op grew out of a demonstration project funded by Health Canada in the mid-1990s. The brokers were trained to work closely with pregnant immigrant women, who faced the daunting prospect of giving birth in a new city and within an unfamiliar health care system. The MCHB engaged with the women on many levels: visiting in their homes, speaking a shared language, providing interpretation services, and connecting them to health providers and support groups. During all such encounters, the brokers aimed to cultivate relationships of mutual respect and trust.



The MCHB's interactions with the Edmonton moms produced many tangible benefits:

- increased breast-feeding rates among participating mothers;
- increased immunization rates for their infants;
- development of pre-natal classes in various languages; and
- growing understanding among mainstream health providers of different cultural issues.

The MCHB co-op embodies a holistic, community-based approach to health services for people at risk. Their mandate is “to support immigrant and refugee individuals and families in attaining optimum health through health education, community development and advocacy support.” Implicit in their work is the knowledge that many immigrants and refugees face racism, isolation, and other barriers in Canadian society. The MCHB has a strong belief in *advocacy with* – supporting people to raise their own voices.

## WHAT DOES THE MCHB CO-OP DO?

**In Edmonton, the health brokers offer immigrant families:**

- **social, emotional, and networking support**
- **prenatal classes in several languages**
- **parenting groups across different cultures**
- **hospital tours for new immigrant moms**
- **support groups for isolated immigrant women**
- **translations of health information**
- **community development projects**
- **advocacy and policy development**

“I have been in Canada for 13 years and I didn’t know about prenatal classes,” said an MCHB client. “It’s a long road between the home and the health unit.”

Co-op members have a keen interest in community mobilization, coalition building, and institutional change. They offer services that are supportive yet non-controlling (MCHB). Their decision to incorporate as a non-profit co-operative reflects these values. As a worker-run organization, the MCHB is committed to:

- democratic governance (decision-making that is inclusive and based on people’s realities);
- responsiveness and accountability (practices that are participatory, reflective, holistic, and flexible); and
- equity and social justice (actions that build alliances, expose injustices, and address positive social change).

These internal values are clearly in tune with the co-op’s external goals of mutual support and social change. The MCHB exemplifies the strengths of a worker co-op: meaningful jobs, worker control, and sensitivity to community. The MCHB also acts as a counterbalance to the racism and poverty that many skilled immigrant women face in the Canadian workforce. This co-op does not just *serve* immigrant women, it also provides valuable employment, social connections, and a sense of personal power to the worker-members themselves.

The co-op has a simple organizational structure: The member-workers elect a board of directors, who in turn oversee the work of the executive directors and administrative staff. The actual brokering is done by project teams. The co-op is not unionized.

The MCHB’s economic base is rooted in partnerships with publicly funded bodies. They have contracts to provide services through the Perinatal Education and Outreach (Community Health Services – Capital Health), Family Support and Early Parenting (Ma’mowe Children Services), and

Primary Health Care (Northeast Community Centre) programs. The co-op is also active in coalitions including All Together Now (a multicultural coalition with Health Canada) and the Community-based Immigrant Mental Health project of the provincial health ministry.

They also face challenges similar to other small co-operatives. The MCHB is learning to balance the need to be entrepreneurial (i.e., securing contracts and creating new revenue sources) while remaining true to their social objectives. In their own words, they are figuring out how to manage “the tension ...[of] being hybrid.” They contend with the limited support for small, start-up co-operatives from the Alberta government. They interact with clients and agencies that are unfamiliar with the principles of worker co-ops and multicultural health brokering. And they deal with the constant need to nurture their own organization: activating the board of directors, developing administrative policies, preparing financial plans, and mustering their members into committees and other co-op functions.

Nevertheless, the MCHB provides a flourishing range of services. Since their inception, thousands of immigrant families have received their support. Over 10 per cent of Edmonton families with newborn babies are clients of the MCHB. They ease the relationships between immigrants and a variety of mainstream social and health care providers. Beyond health care, they connect families to parenting groups, literacy circles, and community kitchens. Parents, children, communities, service providers, and workers – all are on the receiving end of this co-operative model of social care.



# 4

## Co-operatives in a nutshell

### What is a co-operative?

A co-operative is a voluntary organization, owned and controlled by its members. It engages in activities that provide benefits to its members and community. A co-op combines the spirit of self help with the power of collective action: People working together to accomplish what they cannot do alone.

### What do co-ops do?

You name it, a co-op can do it. Co-ops can provide tangible services such as child care, housing, and home care. They can create, distribute, and sell products such as clothing, pastries, and furniture. They can deliver a full program of publicly funded primary health care. They can distribute grain and dairy products. They can offer financial services such as insurance and credit. They can operate programs for groups such as youth with disabilities or mental health consumers.

A co-op combines the spirit of self help  
with the power of collective action: People working  
together to accomplish what they cannot do alone.



## What are the membership types of co-ops?

Co-operatives are classified into different types depending on their membership:

- **CONSUMER CO-OP** (also called “**MEMBER CO-OP**”) A co-op that provides goods or services for its members’ personal use. Food co-operatives, retail co-operatives, credit unions, community broadcasters, health clinic co-operatives – all are examples of consumer/member co-ops.
- **WORKER CO-OP** People who work co-operatively to develop and market their own services, such as home care and health brokering, or to create and sell their own products, such as clothing or furniture. Care Connection in Mission, B.C. is a worker co-op, as are the Multicultural Health Brokers in Edmonton and the CETAM ambulance co-operative in Québec.
- **PRODUCER OR MARKETING CO-OP** A co-op that processes, distributes, and markets the products of individual producers. The classic example is farmers who co-operate in the marketing of their grain or dairy products, but other marketing co-ops are for health practitioners and artists.
- **MULTIPLE STAKEHOLDER CO-OP** A co-op with more than one class of member. A childcare co-operative that includes both parents and workers is one example. Social co-ops often have several membership classes, such as the people who use the services, their family members, the workers, and other groups or individuals with a stake in the co-op’s success. Nevertheless, the principle of one member/one vote still applies.

- **SHARED-SERVICES CO-OP** A co-op comprising a group of organizations that wish to jointly acquire services (e.g., training, insurance, legal, accounting) or goods (office furniture, food, fuel, medical supplies). The organizations can include private businesses, public sector entities, co-operatives, or non-profit societies. Shared-services co-ops enable the individual organization to:
  - get more done (e.g., pursue activities they could not do alone);
  - save money (e.g., buy in bulk);
  - break isolation (e.g., network, share research, and meet informally);
  - exercise greater control (e.g., own the distributor of products and services); and
  - wield more influence (e.g., respond collectively to pressures from the marketplace, regulators, or funders).

An example of a shared-services co-op in the health care sector is the Co-opérative des services regroupés en approvisionnement de la Maurice et du Centre-du-Québec, formed in 1989. The co-op purchases goods and services for its membership, which includes residential facilities, hospitals, women's shelters, and youth centres (Craddock). Another example is the United Community Services Co-op in British Columbia, which provides bulk purchasing and other services to non-profit, community-based social service groups.

## What is distinctive about a co-op?

A co-op is owned by its members. As owners, the members are able to engage directly with issues such as planning, programming, and workplace democracy. In this regard co-ops are very different from public institutions, government agencies, private firms, and non-profit societies.

In a co-op, members have a direct say in decision-making. A co-operative can also advocate for changes at the policy and political levels, on their own and their community's behalf.

### How are co-ops run?

Ownership and control of a co-operative are vested in the membership. Each member has one vote, regardless of their number of shares, level of investment, or amount of business with the co-operative.

Democratic member control is a core principle of the co-operative movement. Members elect the board of directors that manages the co-op's affairs, approve the rules that determine the co-op's operations, and vote on policies and resolutions at annual general meetings. In theory, all significant decision-making flows from the membership.

### What is the status of workers in a co-op?

It depends on the type of co-op (see above). In a worker co-op, the workers are usually member-owners. However, worker co-ops can also employ non-members, often in a part-time capacity. In other types of co-ops, the workers are like employees in other organizations or enterprises, with one exception: they can also be members of the co-op. For example, many staff at the Saskatoon Community Clinic are also members of the co-op, which entitles them to be involved in the clinic both as union activists and as members.

Democratic member control is a core principle of the co-operative movement. In theory, all significant decision-making flows from the membership.



## Can co-ops be unionized?

Yes. There are no legal or regulatory barriers to unionizing a co-operative in Canada. Social co-ops such as the health clinics in Saskatchewan and Quebec have unionized staff, as do consumer co-ops such as the East End Food Co-op in Vancouver.

Small worker co-operatives are not usually unionized, however, mainly because the member-workers are satisfied with their ability to democratically control their own workplace. But there are important models of large, unionized worker co-ops (notably, the Quebecoise ambulance services profiled in Chapter xx). Some worker co-operatives have unionized to show solidarity with the labour movement; for example Press Gang Printers, the feminist printing co-op that operated in Vancouver until the early 1990s.

In general, worker co-ops are unionized when members believe that their working conditions and wages are a significant issue. They recognize the role of organized labour in advocating for these issues, and choose to be a part of the labour movement.

Some consumer and producer co-ops are unionized, others are not. Those that are unionized can play a positive role in setting desirable labour standards for their industry.

## How do co-ops differ from ordinary businesses?

Most co-ops are involved in transactions. They create, market, deliver, or sell products and services. Like any other organization, they must be economically viable. Co-ops seek to satisfy their customers and clients, who are sometimes also members; to harness the skills and goodwill of their staff (again, often members); and to tap into reliable sources of revenue in the marketplace or through government funding and contracts.

**“The role of the union is to primarily look after the interests of the workers as workers, whereas the role of the co-op is primarily to look after the interests of the co-op...”**

**CANADIAN WORKER  
CO-OP FEDERATION**

Most social co-ops are incorporated as non-profit entities; for example, the Multicultural Health Brokers in Edmonton. Other co-ops are incorporated as for-profit. Yet even a for-profit co-operative differs from a conventional business in important respects:

- Voting power rests with the co-op membership, based on one member/one vote. In a conventional company, power (and hence control) rests with the owner or majority shareholder.
- Democratic governance is required in a co-op, but not in other businesses.
- In a worker co-op, profits are distributed according to the amount of work done, not the amount of money invested. In other types of for-profit co-ops, profits are distributed based on the number of shares owned (but the principle of one member/one vote still applies).
- Even for-profit co-ops have goals and values beyond mere profit. For example, a worker co-op might commit itself to worker satisfaction, secure employment, and environmentally sound operations. A retail co-op might align itself with fair trade. A social co-op might focus its programs to build confidence in a disadvantaged community.

## What is the legal status of co-ops?

Co-operatives are legally incorporated and regulated under either provincial legislation (i.e., the B.C. Co-operative Associations Act) or federal legislation. Incorporation gives the protection of limited liability: individual members are not responsible for the co-op's debts beyond the value of their shares. (Co-ops have this in common with limited companies.) The law also bestows on co-ops the powers and privileges of “natural persons,” including the right to enter into contractual relationships. For example, a worker co-op

can negotiate with a health authority to provide services (e.g., home-based personal care).

To incorporate, co-operators must sort out important matters such as the co-op's name and objectives, the type and number of co-op shares, the reporting and auditing practices, and the bylaws that will govern the organization. These bylaws establish rules regarding meetings, election and duties of the board of directors, membership categories, disbursement of profits (if any), amending of bylaws, and procedures for wrapping up the co-op.

## What are the “co-operative principles”?

Co-ops have agreed upon a set of principles, which serve as guidelines to make their values visible and operational:

1. **VOLUNTARY AND OPEN MEMBERSHIP** Co-ops are open to anyone who wishes to participate and accepts the obligations of membership.
2. **DEMOCRATIC MEMBER CONTROL** Members actively participate in setting policies, making decisions, and serving as elected co-op representatives.
3. **MEMBER ECONOMIC PARTICIPATION** Members contribute to and control the capital of their co-op and allocate any surpluses in a democratically determined fashion.
4. **AUTONOMY AND INDEPENDENCE** Co-ops enter into relationships with other organizations or with governments on terms that ensure democratic control by the membership and autonomy of the co-op.

5. **EDUCATION, TRAINING, AND INFORMATION** Co-ops are committed to educating and training their members and employees, as well as to informing the public and officials about the merits of co-operation.
6. **CO-OPERATION AMONG CO-OPERATIVES** Co-ops are committed to strengthening their movement by working together, from local to international levels.
7. **CONCERN FOR COMMUNITY** Co-ops work for sustainable development of their communities.



## 5

# Co-ops and health care: A healthy match

Research into co-operative health care has shown the many advantages of the model. In 1990 a study of Canadian community health centres yielded tangible evidence of co-ops' effectiveness and efficiency (Angus and Manga). Compared with conventional primary care – a family physician in private practice, fee-for-service – co-operative and other community clinics had:

- 13 to 17 per cent lower costs per patient;
- a 25 to 30 per cent reduction in hospitalization rates (i.e., fewer days in hospital); and
- a savings in per-patient drug costs of between 11 and 21 per cent.

This fiscal effectiveness is nothing magical. It derives from values and practices intrinsic to co-operative social care and member control. When concern for community and accountability to members/consumers are embedded in your *raison d'être*, the result is a high-performance service based on multiple bottom lines – including the fiscal one.

But the benefits are not just economic. Research on Canada's public health care system shows that Canadians share broad agreement about the best approach to care. The key ingredients are care delivered close to home by a multidisciplinary team, coordinated across the gamut of primary, preventive, and follow-up services. At its finest co-operative health care meets all these criteria.

**“People’s health needs are best met by an active partnership between the people who use health services and the people who offer them.”**

**SASKATOON  
COMMUNITY CLINIC**

Consider these characteristics of the Saskatoon Community Clinic:

- a preventive and holistic model, actively promoting health through education and targeted programming;
- multidisciplinary teamwork, breaking down the barriers between professionals;
- a full basket of primary care services and programs;
- salaried physicians and health professionals, unfettered by fee-for-service payments;
- specialized services for vulnerable groups such as youth and First Nations communities;
- accountability to members and local community through democratic decision-making;
- advocacy on broad issues relating to the community’s social and economic health;
- support for publicly funded health care and the principles of the Canada Health Act;
- a progressive union contract that gives staff training opportunities and input into how their work is organized.

Teresa MacNeil, a professor at St. Francis Xavier University in Nova Scotia, lists five elements that contribute to the delivery of positive social services: affordability, accessibility, accountability, flexibility, and community responsiveness (MacNeil). The co-op model, she believes, has the power to succeed in all five areas:

1. **AFFORDABLE** With no pressure to siphon off profits to shareholders, co-operatives are able and motivated to offer affordable services.
2. **ACCESSIBLE** Open and voluntary membership accords with accessibility; members help to ensure that their co-op’s services are within reach.



3. **ACCOUNTABLE** Member ownership and democratic structures lead to member control and influence.
4. **FLEXIBLE** Programming, hours of operation, location, and working conditions – all can be adapted to the diverse needs of members.
5. **RESPONSIVE TO COMMUNITY** Co-operatives are intrinsically committed to community development and participation.

## Innovators and advocates

Co-operatives also play a role as innovators in social and health care. They have a bottom-up orientation, rooted in community and guided by local participation. Their nature is to create programs that are sensitive to the needs of their clients/members. For example, the Multicultural Health Brokers Co-operative in Edmonton helped to spur the development of prenatal classes in many different languages. The MHBC understood their role as advocates for ethnic communities within the mainstream health care system, and had the independence to advocate effectively.

Worker co-ops are also well-suited for innovation. Front-line staff are able to directly influence how their work is organized. Their sense of ownership and mutual responsibility leads to an active stake in improving the workplace. A empowered workforce, with a commitment to community service, can test creative solutions and flexible approaches. The ambulance co-operative, CETAM, was the first in Quebec to use a defibrillator monitor. Their innovation prompted the government to introduce the life-saving device throughout the province's system.

Finally, co-operatives are a way of responding to local needs and speaking out when local services are threatened. In the same vein, co-op members can be strong advocates for public health care and defenders of Medicare.

## Good work, steady work, committed work

Co-ops also engender loyalty and a spirit of community service in their workers. Co-operators deliver care to their neighbours and contribute to their own social development. As workplaces, co-ops rank high on the “meaningful work” register. In contrast, corporate service providers have no allegiance to a particular community and often have very high turnover of staff.

Health care providers with a built-in local commitment and record of continuity will work *as partners* with other providers: coordinating research, dovetailing programs, and planning together for the long term.

Finally, a co-op is a resource that belongs to the community. This proprietary interest encourages volunteer participation and represents another boost to health promotion.

## Progressive, member-focused health care continues to thrive

The Saskatoon Community Clinic (SCC) is a distinctive presence in English-speaking Canada: a 5,500-member health care co-operative serving over 25,000 people at three locations. The clinic offers a full range of primary health services plus many specialized programs, delivered by a multidisciplinary team of family physicians, nurses, physiotherapists, nutritionists, optometrists, and counsellors. The SCC is also unionized, with 94 full- and part-time workers affiliated with Local 974 of the Canadian Union of Public Employees.

Officially named the Community Health Services Association (Saskatoon) Ltd., the SCC co-op was founded in 1962 when physicians went on strike over the province's new medicare scheme. Community-based health care was nothing new to Saskatchewan. Since 1914 citizens had pioneered their own physician and hospitalization plans, public health programs, and union hospitals. During the medicare crisis of 1962, the province's instinct for co-operation led to the creation of Community Health Services Associations in Regina, Saskatoon, Prince Albert, and several smaller towns.

When a settlement with the doctors was reached, however, the provincial government agreed not to promote the co-operative clinic model. As a result only five co-operative clinics exist in Saskatchewan's larger centres today. Nevertheless, these co-ops are thriving examples of a progressive, member-focused approach to health care.

The SCC is a strong advocate of public health care and takes a stand on issues that affect the well-being of its community. The co-op is well aware of the social determinants of health, as evidenced in its values statement:



“People should have a role in both their own health and in the health of their whole community.”

*We recognize that social and economic factors such as racism and poverty can profoundly compromise the health of the people we serve. We will act socially and politically to eliminate the negative effects of these factors on people's health. (SCC)*

As co-operators and community activists, the SCC also endorses the power of “an active partnership between the people who use the health services and the people who offer them.” The co-op exemplifies the difference between a bureaucratic health care model (top-down, with passive consumers) and a participatory model (active collaboration between care recipients and care providers).

In Saskatchewan, co-op clinics are viewed as an attractive option by regional health authorities. Their effectiveness in delivering specialized services to high-risk communities is especially appreciated. The SCC's Westside Clinic has a proven track record with Saskatoon's inner-city Aboriginal community, who make up 90 per cent of its clients. The clinic has pioneered innovative ways to keep the Aboriginal programs going, such as offering door prizes at parenting classes.

The SCC sees itself as a partnership between users and providers. The partnership expresses itself in an ownership mentality that is fostered by participatory structures. These include members' representative on the board, strategic planning and program design that involves members, and member surveys. Diversity is another strength. The co-op draws members from inner city and middle-class neighbourhoods in Saskatoon. A person need not be a member to use the co-op's services, but many clients choose to be.



## The union/co-op connection

The Saskatchewan labour movement is supportive of Saskatchewan's co-op clinics. Four of the province's five clinics are unionized, mainly by the Canadian Union of Public Employees. The union is an active presence in the Saskatoon clinic. Relations between unionized staff, administration, board, and membership are generally positive.

The province's history plays a role here. Most workers are familiar with the far-reaching vision of co-op health care. "There is a strong history of co-ops in this province," says a unionized staff person. "We are bonded to these values, they are part of our culture" (Knudson).

Involvement in union activities is higher than in comparable workplaces, according to CUPE, but still only 20 to 25 per cent of the SCC bargaining unit participates in union meetings.

## Worker participation

Unionized employees of the SCC perceive the clinic as less hierarchical and more democratic than a conventional workplace. Their sense of ownership and commitment to the clinic is enhanced by its co-op structure. Almost all staff say that they have a say in how their work is organized, and CUPE representatives observe that the grievance process at the SCC is less confrontational than elsewhere (Knudson).

On an operational level, clinic departments hold regular staff meetings, though the degree of staff consultation varies among departments. The clinic also has several working committees. The Labour Management Committee meets monthly and is committed to problem-solving on the usual agenda of issues, such as safety, personnel matters, and internal communications.

“A lot of success is determined by people choosing to work as a team. There has to be healthy attitudes, lots of team-building, and positive thinking.”

LORNA KNUDSON

Importantly, hiring committees have a union representative, and the staff have input into job descriptions.

The union has a non-voting position on the SCC board. Many employees are also members/users of the co-operative and are entitled to run for the board. If elected, however, they must adhere to a conflict of interest policy that limits their involvement.

The SCC’s collective agreement reflects a concern for balancing work and family life. Indeed, the SCC was an early adapter of progressive policies on job sharing, flexible use of sick time, union representation on hiring committees, and other measures. Wages are slightly lower than the market standard. But compared with contracts in Saskatchewan’s non-profit sector, the SCC collective agreement has better-than-average provisions on:

- job sharing;
- flexible work hours;
- short-term disability;
- compassionate leave;
- job security;
- training related to technological change; and
- funds for staff development and union education.

Sicktime and disability provisions at the SCC add up to unlimited coverage for unionized employees. The clinic’s supportive and secure work environment has translated into a low rate of sick time, according to the executive director. In 2004 the sick rate among staff was 6.3 days per year compared with a regional rate of approximately 12 days per year. And if a worker is exposed to an infectious agent, the clinic will cover all medication and immunization costs over and above those provided by Workers’ Compensation.





## Employment equity practices

The Westside Clinic was the impetus for SCC's Employment Equity Program. The clinic recognized the power of having Aboriginal role models on staff, serving Aboriginal clients.

In the mid-1990s a joint management-union-board committee was struck to work on the affirmative action issue. The aim was to employ care providers who reflected the diversity of the co-op membership. It was not an easy sell to the union or the physicians. Some older non-Aboriginal staff were concerned that they would be denied placements at the Westside Clinic. Their concerns were accommodated in a grandmothers clause. Newer hires, however, were covered by affirmative action provisions.

Since 1996 the CUPE contract has given preferential hiring to people with disabilities, Aboriginal people, women, and people of colour. The measures have led to visible changes in the nature of services and the face of who delivers those services. The SCC has made major strides towards achieving its employment equity goals, and consistently exceeds its targets for women and women in management positions.

This is an example of co-op and union values finding common ground on a social justice issue: breaking down historical barriers, putting the community first, and respecting workers' rights.

## 6

# Come together now: The co-op-union dance

Like the desire to join a union, the desire to form a co-operative arises from a mixture of motives – some defensive, some creative. Both co-operators and unionists spring into action to protect themselves from losses, threats, and unmet needs. And both movements are proactive in initiating projects that express their values and shared goals.

History offers some stirring examples of unionists and co-operators working together to create locally-controlled, democratically-run solutions to social problems. The Amalgamated Clothing Workers of America were instigators of union-housing co-operatives in New York City. The scenario? In the late 1920s a group of working people found themselves exploited as tenants and unable to get credit to buy their own homes. Their plight was noticed by some savvy labour organizers, who had self-help on their minds. The result? A labour-sponsored housing network that still provides secure, decent co-op housing to thousands of low- and middle-income people. In British Columbia, too, unions have extended support to housing co-operatives.

It is also true that union and co-operative traditions have clashed. The historical record includes competition, misunderstandings, and distrust. On the coast of British Columbia, a feud played out for half a century between the Prince Rupert Fishermen's Co-op, representing small independent trollers, and the United Fishermen and Allied Workers' Union. Although both co-op and union grew out of a shared "resistance to the corporate agenda of

private capital” (Menzies), their separate agendas proved to be incompatible, with poisonous results.

Nevertheless, unions and co-operatives often have a great deal in common. Both have historical roots as critics of unbridled capitalism. Both emphasize the merits of mutual aid among people who live (and work) in community together. Both movements are opposed to the current fascination with an unrestrained market economy. And neither movement believes that the commodification of social needs and privatization of health care are either inevitable or desirable.

## Social solidarity

Unionists and co-operators have a generous social vision, with a distinctive moral logic and positive premises about human nature:

*The market pits neighbour against neighbour, community against community, and nation against nation.... The logic of co-operation invites neighbours, communities, and nations to work together.*  
(Pobihushchy)

Social solidarity is a key strength of both movements, at least theoretically. Solidarity comes in many forms:

- providing mutual protection, interest, and benefit;
- redistributing wealth in an equitable fashion;
- challenging the destructive concentration of capital;
- injecting social values into the economic sphere;
- upholding democratic member control;
- educating, training, and informing members;
- acting in coalition with like-minded organizations;

**“There seems to be no reason why unions and worker co-ops cannot share common ground along the basic lines of solidarity: dedication to workers’ rights, economic justice, and dignified labor.”**  
**MINNESOTA WORKER CO-OPERATIVES**

- promoting the values and benefits of co-operation/unionism to others; and
- working for social justice, starting with responsibility for co-members and spreading out to community and nation.

## Workplace democracy

Unions and co-ops pose a challenge to a blindspot in our society’s liberal, democratic tradition: the fact that democratic values are largely ignored in workplaces and the marketplace. Canadian society claims to embrace the sanctity of the democratic political process, yet is silent on the issue of democracy at work.

For the majority of working Canadians, the day-to-day details of our economic lives – how we work, what we produce, how we are rewarded – are not under our control. Similarly, as consumers of goods and services, we are usually obliged to adapt ourselves to what is offered, rather than having the power to determine whether it meets our needs or supports our goals.

Moses Coady was one of the founding giants of the Canadian co-operative movement. A Nova Scotian, he viewed co-operation as inseparable from adult education. They were two prongs of a grassroots movement that would enable people to be powerful participants in their own society. Coady summarized the enormous gap between the political and economic spheres in his 1939 book, *Masters of Their Own Destiny*:

*... if we ask our people to run the biggest business in the country – the country itself – we cannot then, in the next breath, turn around and say to them that they are not competent to run their own grocery store. We cannot grant the privilege of political democracy, and at the same time withhold the opportunities for economic democracy on which it should be founded.*

Unions are a means of injecting some balance into the power relations in a workplace: to protect workers from arbitrary actions, insecurity, discrimination, undue exploitation, and hazardous conditions. Worker co-ops address these matters from a different angle, by dissolving the boundary between worker and owner. And because democratic member control is a core value of co-ops of all stripes, the drive for workplace democracy has resonance among co-operators, at least in principle.

### Do co-ops contribute to the erosion of unionized public services?

To answer this question, other questions must be asked: Is the public sector already providing the health and social services that we need? If not, is the government making any moves to offer this service in the foreseeable future?

If the answers are no, the next question is: How can we – a community or a group of workers – best fill our needs? The political and social landscape helps to determine which strategy should be emphasized: 1) a campaign for public sector provision, or 2) a community-based initiative such as a publicly funded co-op. Both options reflect a belief in collective solutions to public concerns. The first does so via the mechanism of direct government services. The second does so via the mechanism of community-based services, albeit funded by government. Both options can be pursued simultaneously – they are not mutually exclusive.

Is the public sector already providing the health and social services that we need? If not, is the government making any moves to offer this service in the foreseeable future?

But the issue *is* knotty, and it can a source of tension between the labour and co-operative movements. Labour is identified with unionized public services that are, at the very least, funded by government and administered through ministries or health authorities. The social co-op movement is associated with local governance and relatively small-scale operations, sometimes though not always directly funded by the government, and still relatively untested in most of Canada.

The co-op approach *per se* does not erode public services. But there are circumstances where a community-based delivery model can be exploited by authorities who intend to dismantle or neglect public services. Political rhetoric about community control – about bringing services “closer to home” – can be little more than an offloading of state responsibilities.

At the same time, the co-operative option can also be a positive strategy in the face of privatization, lost services, and persistently unmet needs. Unlike commercial firms, co-ops are fundamentally committed to public service and local governance. And as community-owned assets, they can neither be expropriated nor unilaterally closed down by governments or health authorities. The story of Nelson and its Community First Health Co-operative is both a cautionary tale and an inspiring example of the co-op possibility (see page xx).

## Collaborations...

There are longstanding collaborations between the labour and co-operative movements in some parts of the world, including Quebec. The International Labour Organization (ILO) has worked with the International Co-operative Alliance (ICA) since the 1920s. Both bodies, headquartered in Geneva, make efforts to undo misconceptions about and build respect for their respective movements.

In June 2002, after consultations with the ICA, the ILO adopted Recommendation 193, "Promotion of Co-operatives." In part, ILO R193 states:

*Workers' organizations [labour unions] should be encouraged to:*

*(a) advise and assist workers in co-operatives to join workers' organizations;*

*(b) assist their members to establish co-operatives with the aim of facilitating access to basic goods and services;*

*(c) participate in committees and working groups at the national and local levels to consider economic and social issues having an impact on co-operatives;*

*(d) participate in the setting up of new co-operatives with a view to the creation or maintenance of employment, including in cases of proposed closures of enterprises;*

*(e) participate in programmes for co-operatives aimed at improving productivity and promoting equality of opportunity; and*

*(f) undertake any other activities for the promotion of co-operatives, including education and training.*

These recommendations are an acknowledgement that, just as unions play an indispensable role in advancing workers' rights, co-operatives are a means by which working people can secure their needs and livelihoods.

## ...and friction

Conflict and misunderstandings between organized labour and the co-op movement can arise from a number of flashpoints.

► Unionists can distrust the entrepreneurial nature of some co-operatives. The profit motive in a for-profit co-op *can* pit the interests of labour against

the interests of capital, even though the capital is co-operatively amassed and administered.

However, this wariness should not get in the way of recognizing that many co-ops play a progressive role as social entrepreneurs. Further, most co-op organizations endorse the value of stable core funding for public programs and support the need for a strong social safety net.

► Co-operators can distrust the adversarial character of unions. Workers' demands raised during collective bargaining and union challenges to management can be seen as unsympathetic to – even at odds with – the co-op's goals.

Of course, an adversarial relationship with management is normal in a capitalist environment: it *is* a contest of interests and energies, not a collaboration. But a co-op could and should be amenable to a less antagonistic relationship with a union, based on shared values, though this is not always the case.

► Unionized workers can view co-ops as a kind of Trojan Horse: the unwitting instrument of a government that wants to shed public services. This fear arises when governments privatize programs or devolve them to the community, a devolution that is often an ill-disguised abandonment of state responsibilities.

Most co-op organizations endorse the value  
of stable core funding for public programs and support  
the need for a strong social safety net.



But the fear can be groundless in other cases. Unionists need to guard against a negative knee-jerk response to co-operative initiatives. And in a political environment when privatization and contracting out is unavoidable, a co-operative service provider may be preferable to a corporate one.

► Co-ops are not automatically good employers. A co-op can be more or less respectful and fair towards its staff. Financial troubles can lead to business decisions that disregard workers' needs. Workers' rights can be violated by arbitrary actions. These difficulties can arise even in a worker co-op, where members must play the twin roles of owner and worker.

► Co-op members can fall into the trap of being self-exploiters. Members might be willing to work for poor wages and no benefits. This problem is real. Small co-ops are often under-capitalized, insecure, and flying by the seat of their pants. (They share these dilemmas with other community organizations and small businesses.) While a conventional business might simply fold under the weight of these obstacles, a co-op might keep going on the strength of its ideals.

Voluntary self-exploitation is untenable in the long run. It can drive down wage scales and benefits, hurting workers and communities. At the same time, co-ops need a grace period at the beginning and a good chunk of time to build decent pay scales, full-time work, and other desirable conditions. It is unreasonable to expect high-level wages and benefits in the start-up years of a co-op.

► Unions worry that worker-owners might be more willing than other kinds of workers to make concessions that ensure the survival of their enterprise. Such concessions can put the squeeze on workers in competing firms. The problem is viewed as a rupture in worker solidarity: the co-operators get caught between loyalty to their co-op and loyalty to their sisters and brothers in other workplaces.

► Unions are also concerned about choices a co-op could face as it stabilizes its economic viability over time. Traditionally, unions try to defend their members against job loss due to tech change, speed-ups in production, arbitrary changes to job duties, and other measures intended to improve (or sustain) a company's profitability. Workers and conventional employers understand that they might have competing interests in these matters. Labour-management relations and collective bargaining are the fields on which these contentious issues get hammered out.

Co-operatives are not immune to market and technological forces. The question arises: How does a co-op balance its obligations to workers (sometimes the members themselves) with the pressures of a restless market economy? For example, should a co-op modernize its equipment if it means eliminating jobs? Should a co-op make a low bid to secure an important contract if it means paying low wages?

In short, co-ops are subject to economic realities whether the co-op is explicitly entrepreneurial or explicitly non-profit. Workers in co-operatives are just as vulnerable to these forces as workers in conventional settings. Some observers on the Left believe this to be a structural weakness of co-ops: they are either doomed to fail in the hostility of the capitalist environment or are compelled to play the capitalist game and degenerate into orthodox businesses.

In this context, an important ingredient of union-co-operative collaboration is to work towards government support for co-ops, so they can flourish on co-operative, not competitive, terms (see more in Chapter 8).

► As socially engaged organizations, many co-operatives rely on sweat equity. Voluntary work is especially vital in the birthing stages of a co-op, yet it is also indispensable throughout the co-op's life. Members who dream up and create a co-op, members who serve on boards of directors

and committees – all are donating huge amounts of their time and talent in the spirit of community service. They are strongly *identified* with their co-operative.

Unions need to appreciate that co-ops are a distinctive creature. An employer, yes, but also a community of volunteers with goals beyond profit, efficiency, and market share. Conflict can arise between the sweat-equity ethos and the paid-worker reality. To some extent, this is a built-in clash of motives and needs. The conflict is not insurmountable. But workers must recognize the role of volunteer labour in a co-op, just as co-op members must recognize the importance of good wages and working conditions.

► Both unions and co-operatives can be criticized for failing to walk the talk of their ideals. Unions can be undemocratic, narrowly self-interested, and inequitable (e.g., reinforcing sexist or racist barriers in society). Parts of the co-op movement can be very commercialized, and the movement as a whole can be guilty of regressive internal practices (e.g., reinforcing sexist or racist barriers in society).

## Building on the best of both worlds

After this litany of possible conflicts, it is good to recall that unions and co-operatives have a great deal in common, philosophically and practically. As self-help organizations they share a commitment to social solidarity – to serving the interests of the many rather than the few. They have a deep concern for social well-being – to creating a body politic that is healthy, equitable, and dynamic. The two movements have also cultivated different strengths over their long histories, strengths that can be knit together to deliver health care services that genuinely *serve* the community and workers.

LA COOPÉRATIVE DES TECHNICIENS AMBULANCIERS  
DE LA MONTÉRÉGIE (CETAM) | QUEBEC

## Ambulance workers' co-op benefits from stable support

La Coopérative des techniciens ambulanciers de la Montérégie (CETAM) was the first of Quebec's six ambulance co-operatives. These co-ops are distinguished by being worker-owned, unionized, and very successful: they provide 30 per cent of the province's ambulance services, employ over 700 worker-members (plus hundreds of non-member staff), and in 2002 earned revenues of \$50.4 million.

The co-op's history is closely linked to the Quebec labour movement and its largest labour central, the Confédération des syndicats nationaux (CSN). The federation was itself co-founded by the Mouvement des caisses populaires Desjardins, Quebec's influential credit union movement. The CSN has a longstanding sympathy for co-operatives and, since the 1970s, has devoted strategic and financial resources to worker and housing co-ops. Today CETAM serves 70 municipalities on the south shore of the St. Lawrence River, near Montreal.

Importantly, the CSN's support for worker co-operatives is balanced with its strong advocacy for public services. Quebec's ambulance co-ops did not arise in response to government downsizing or privatization, but an exodus by business owners. In short, the ambulance workers were not laid-off public servants, but insecure employees in a commercial market. In 1986, when the Quebec government tried to convert state-run liquor outlets into worker co-operatives, the CSN opposed the move. The labour movement in Quebec has shown a dual commitment: to unionized public services *and* to unionized worker co-ops.



The seed of CETAM was planted in the mid-1980s. Exploited ambulance staff, working at an assortment of private companies, formed a union and affiliated themselves with the CSN. Faced with the newly unionized workforce, several owners decided to get out of the business. This created an opening for workers to buy the operations. During the same period the CSN launched a consulting body – MCE Conseils, dubbed “Le Groupe” – to provide expertise to would-be worker co-operatives. Le Groupe stepped up with material and technical support, guiding the ambulance employees in their transition to worker-owners of the CETAM co-op:

*Many obstacle had to be surmounted, not least of which was overcoming the apprehensions of workers with modest incomes and minimal savings that they could take on the new role of ownership. (Quarter).*

To capitalize the new co-op, full-time members each invested an initial \$1,000 (in “social shares”) and then purchased “privileged shares” via a mandatory payroll deductions of 3 to 5 per cent (reimbursed upon retirement or leaving the co-op). Other financial support came from union and government sources, as well as the Montreal caisse (credit union).

Quebec’s ambulance co-ops have an advantage that other health care co-operatives might not enjoy: a reliable source of public revenue. Ambulance operators have a master service contract with the government, and other income flows from hospitals, residential care facilities, and individuals. These revenues are based on a reimbursement model, and payment levels have not always been adequate. Nevertheless, CETAM is embedded in a publicly funded system, which translates into a degree of financial stability.

Pierre Lamarche, a manager of CAM, the ambulance co-op in Trois-Rivières, observes that a co-op member is also a worker and can therefore “be a victim of arbitrary or discriminatory decisions and so has rights that must be asserted. That’s why a union has its place in a co-operative” (Aubry).

## How does the co-op run?

Voting rights are confined to full-time members (30 hours per week or more). Part-time workers are deemed auxiliaries; they too invest in the co-op by purchasing shares (at a different level), but have no vote in the co-op’s affairs.

CETAM’s general assembly is the major opportunity for members to exercise their governance. The assembly meets three times a year. It elects the board of directors (by secret ballot), debates major policy changes and business decisions, and amends by-laws when necessary. CETAM’s board has nine worker-members, elected in staggered years and serving for two years. The board meets at least once a month to address broad operational and financial matters and to develop general policies.

Day-to-day operations are handled by CETAM’s general manager and director of finance, both of whom are co-op members, but are not in the bargaining unit. Traditionally, managers are former ambulance technicians, as are most of the office staff. As finance director Mario Gagne observed in a 2002 interview:

*As a manager you have to be aware that the general assembly has the power to change the board and the co-op if they don’t like the way things are going. You have to be diplomatic ... and be committed to making decisions by consensus as much as possible even though this can be time consuming and occasionally frustrating.*

CETAM operates in several locations. Each station has some autonomy – for example, a budget for minor equipment and plant expenses – and workers are welcome to show initiative in running their unit. One paramedic reflected on the change brought on by becoming worker-owners: “Before, you did not change the light in the ambulance if it burned out. Now we change the light and do the small repairs.”



Like other co-ops, CETAM faces the challenge of keeping its many members engaged, informed, and actively involved with co-op affairs. Members receive written reports every month outlining CETAM's actions on its goals (as set by the general assembly) and discussing problems and accomplishments. Participation in general assemblies is quite high – an average of 50 per cent of the members – which is impressive given that ambulance work runs around the clock.

## The union's role

A unionized worker co-op is a rare hybrid. Yet both traditions – unionization and co-operation – share the values of workplace democracy and social responsibility.

At CETAM as at other unionized environments, the terms of the collective agreement are monitored by shop stewards, who represent workers with complaints. CETAM units are harmonious workplaces, and formal grievances are very rare. Philosophically, the members are committed to “wearing the two hats.” Yet they acknowledge that the dual role of worker and owner has both strengths and complications. Three points exemplify the benefits of CETAM's unionized status:

- **DEFENDING THE INDIVIDUAL** A primary function of any union is to defend the individual worker. Even in a co-operative, the rights of a worker can be violated, either by oversight or prejudice. The union at CETAM serves as a watchdog against such abuses (Quarter).
- **ENHANCING THE PROFESSION** CETAM paramedics believe the unionized co-op structure has enabled them to vastly improve the status of their vocation. Prior to CETAM, ambulance workers in Quebec were largely untrained, uncertified (often employed through funeral homes), and very poorly paid. Since the 1980s, unionized co-ops have steadily

pushed for the professionalization of their occupation, as well as for upgraded and innovative equipment, better vehicle maintenance, and ongoing training (Aubry).

- **ACTING ON INITIATIVES** Worker co-ops are open to ideas from the shop floor (even when the shop floor is a moving ambulance or a bedside). An example was CETAM's idea to introduce mechanized defibrillators – they pioneered this equipment in Quebec's ambulance fleet. Interestingly, the actual introduction of the equipment was delayed while the union successfully demanded that all ambulance companies make a similar change (Quarter).

The complications lie in this area:

- **NEGOTIATING THE COLLECTIVE AGREEMENT** CETAM is a very small part of a very large local of the union RETAQ (Rassemblement des employés techniciens-ambulanciers du Québec), which bargains on a province-wide basis with the government and employer association. As such, CETAM members often feel unheard and unheeded within the union and during bargaining. They are conscious of their unusual status as workers with an “employer interest” – unlike others in the local, CETAM members have full knowledge of their workplace's financial position, and they have significant influence over work policies and decisions. As a result, they can be frustrated by the hardline “us versus them” scenario that typifies collective bargaining and union/management relations.

Some CETAM members have called for forming an independent local. Others believe the difficulties with RETAQ must be addressed through education. CETAM's support for unionization, however, is steadfast.





# 7

## The co-op challenge: Not for the faint hearted

Co-operatives are not without complications. Members can feel pulled in many directions regarding their role, rights, and responsibilities. For example, a member of a housing co-op might feel like both a home owner and a tenant. A member of a worker co-op must think and act like both an entrepreneur and a worker. All co-ops, and especially new ones, need to stay on top of this role confusion. This chapter briefly considers some of the common hazards for co-operatives.

### Starting out

A co-op is always a daring venture. Not only will people face the uncertainties of launching a new organization, they must do so while juggling economic, interpersonal, and co-operative goals.

The ideals of co-operation are not enough. People also need a realistic assessment of the market, a solid business plan, a lot of volunteer time and energy, a willingness to take risks, and an appetite for collective decision-making.

In short, co-operators must find a good fit between their beliefs, capabilities, and real-life circumstances. And they must be able to picture some concrete benefits for themselves. The question, "What's in it for us?" is not just legitimate, it's necessary. Tangible benefits might not be right around the corner, but they should be within reach.

Outside supports in the form of partnerships, consultants, and funding are also essential. Most of the co-ops profiled in this book – Care Connection, CETAM, and the Multicultural Health Care Brokers – had significant and sustained help from a variety of sources.

## Generating a sense of ownership

One of the most crucial issues for new and established co-ops is encouraging members to embrace their role as owners. This is true for all types of co-ops, but an extra layer is added when people are from backgrounds that did not stress the identity “owner” or “manager.” Historically disadvantaged groups – poor people, recent immigrants, people with developmental disabilities – can find themselves in this situation.

Women are often the prime movers behind social co-operatives. As mothers they have vivid experiences of the importance of health and social services. They are often the care providers in their homes and communities, either paid or unpaid. And they are frequently attracted to co-operative approaches. In many ways, a co-op member has to think like a mother *and* a neighbour: taking care of your own and other people’s needs.

Working-class women do indeed hold up “half the sky” in our society, making decisions and keeping things running in their families’ lives. But

**A co-op is always a daring venture.** Not only will people face the uncertainties of launching a new organization, they must do so while juggling economic, interpersonal, and co-operative goals.

**“Developing a  
co-operative requires  
careful nurturing  
and time to build an  
enormous amount of  
mutual trust.”**

**TERESA MACNEIL**

they are rarely supported to be owner-operators of ventures, co-operative or otherwise. And many women face credit barriers, inflexible income support programs, inaccessible child care, family obligations, and other obstacles that keep them in a precarious economic state.

Some co-ops have addressed these issues head on. An inspiring example is the Cooperative Home Care Associates (CHCA) in the South Bronx, N.Y. Like Care Connection in Mission, B.C., except on a much larger scale, CHCA provides home support to seniors and people with disabilities.

The co-op employs over 550 African-American and Latina women, most of whom were formerly on social assistance. Since its origins in 1985 CHCA has committed itself, in their own words, to “creating high-quality paraprofessional jobs for low-income women, empowering them with greater skills and self-confidence, and improving the quality of home health care.” They are an industry leader – a “yardstick corporation” recognized by regulators, unions, administrators, and consumer groups as a superlative model of home care services.

A key part of CHCA’s success is their attention to their members’ need for leadership and business skills to run their own co-op. Fostering personal confidence, encouraging participation in decision-making, and generating that all-important sense of ownership were identified as goals early in the co-op’s history. The challenge was real. Co-op members worked alone and in isolated settings – such is the nature of home support services to individuals in scattered private homes. And the members were women of colour from working poor families, backgrounds that did not prepare them for ownership or leadership roles.

The co-op experimented with a number of ideas. They ran after-hours socials for members, facilitated group discussions, and offered informal peer learning to help people acquire co-operative skills and self confidence.



Today CHCA specializes in ongoing, learner-centred training that “emphasizing critical thinking, problem solving, and co-operative team building.”

Co-operatives face other internal challenges, many of which will have a familiar ring to unionists.

**BEING GENUINELY DEMOCRATIC** The ideal of a member-controlled organization is easier said than done. Co-ops often struggle to achieve broad-based member participation in elections, committees, and boards. They can also struggle to be genuinely responsive to their members’ diverse needs.

**BEING TOO DEMOCRATIC** Not everyone in a co-op needs to make decisions about everything. Involving members in long-term planning and major business decisions is essential. Involving them in the choice of office decor or work scheduling is not.

**CONFUSING GOVERNANCE AND MANAGEMENT** Governance of a co-operative is by the members, who determine the overall direction, values, and goals of the organization. The actual management of a co-op – e.g., scheduling, planning, supervising, planning, hiring – is by staff (often but not necessarily members), not by the board of directors. These lines can become blurred in a co-operative.

**UNREPRESENTATIVE LEADERSHIP** Traditionally, the leadership of the co-op movement has been white and male, which does not reflect the diversity of the membership or the community at large. In particular, women and people of colour are often under-represented.

**“The slippery intangible – a sense of ownership – derives from a feeling of belonging to the co-op’s social community, not its co-operative legal structure.”**

**FRANK ADAMS**

**NEGLECT OF MEMBER AND PUBLIC EDUCATION** Like union activists, co-op members can get caught up in their day-to-day work, which can often seem endless, and lose sight of the need to educate themselves and their community about co-op values. Co-operatives have a low profile in mainstream Canadian society. And the mainstream ideology – individualistic, hierarchal, and profit-oriented – is at odds with principles of mutual aid and democratic control. Co-ops cannot assume that their members know or grasp the benefits of co-operation, and so educating and informing them are essential tasks.

**FREE RIDERS** Some members enjoy the benefits of the co-operative, but do not pull their weight. A co-op needs its members to participate in its affairs by serving on committees and board or by contributing to other co-op and community-building activities.

**LIVING UP TO THE CO-OP VISION** The seven co-op principles are enshrined in an international declaration and are even part of British Columbia’s co-op legislation. Yet there is no actual mechanism or body to enforce these principles. It can also be difficult to keep focused on the movement’s broad vision of social justice and political transformation.

Some co-operators believe that their movement has watered down its social change potential and that some large co-ops do not do enough for the local community. The good news is that the co-op movement has a lively tradition of honest debate. The contradictions and shortcomings of the co-operative path are frequently thrashed out – the movement is neither complacent nor entrenched.

## Women create well-paying, secure, and respectful jobs

Care Connection Co-operative (CCC) is a non-profit worker co-op that provides home support to seniors and people with disabilities in Mission, B.C. The co-op was formed by a small group of very determined women in early 2004. Like thousands of other Hospital Employees' Union (HEU) members, the five women found themselves cut adrift when the province eliminated job security in their collective agreement. Positions they had held for up to 20 years in a Mission long-term care facility were privatized.

Although devastated by the loss, the women had qualities that made a social co-op possible: a deep loyalty to their local community, a wish to earn a living doing what they loved, a commitment to personalized health care, and a concern for one another.

And they did what women often do in a shared crisis: they started a support group and started talking about how to work together.

"Even though we were losing our jobs," says Laura Rath, a co-founder of CCC, "no one could take away our skills and passion as caregivers." A chance encounter with an HEU staff person planted the idea of forming a co-op. The union put them in touch with a co-op developer, whose services were financed through the federal government's Co-operatives Secretariat.

Meetings, research, skill-building, and months of hard work were to follow. The women chose the co-op route because they wanted more control over their work lives, especially after the helplessness of losing their jobs. They were also drawn to democratic decision-making and to having the power to



create caring relations with their clients – “to offer a service,” in Rath’s words, “that we could take pride in.”

The non-profit choice also reflected their values. Instead of “a money-making machine,” says Rath, the women saw their co-op as an alternative method of providing care and meaningful employment. Any surplus revenues would be reinvested in skills upgrading for their team and in subsidies for low-income clients.

The evolution of Care Connection is a tale of intense effort, multifaceted support, and courage. The hard work comes with the territory of setting up any new enterprise. Co-ops, however, add extra pressures, including the need to squarely face the psychological and financial fact of being your own boss.

Rath describes their personal growth: “At our previous jobs we were institutionalized and there was very little opportunity for personal devolvement. Being involved in a co-op has let us step out of our comfort zones and learn many new skills and cultivate previously untapped talents.”

Indeed, Rath says their ability to “pick themselves up” was the most valuable gift of running their own co-op.

Care Connection was shepherded through its earliest stages by developer Melanie Conn, a seasoned activist in the co-op, community development, and women’s movements. Co-op developers guide people through the soft, visioning stages (to determine whether a co-op is the best model to pursue) as well as the hard-headed stages: financing, skill acquisition, start-ups grants, market research, policy development, incorporation, public relations, community outreach, and other matters.

“At our previous jobs we were institutionalized and there was very little opportunity for personal devolvement. Being involved in a co-op has let us step out of our comfort zones and learn many new skills and cultivate previously untapped talents.”

With Conn and support from their former union, Care Connection tapped into vital supports in their start-up period:

- stipends through the Self-Employment Program (SEP) of the Employment Insurance program, plus business skills training;
- funding through HEU’s Co-operative Development Initiative grant, including stipends, health skills upgrading, and a conflict resolution facilitator; and
- a grant from the Co-operators Insurance Company Economic Development Fund for an RN consultant and marketing campaign.

The members identified gaps in the private-pay home support market in Mission. The large commercial provider, WeCare, did not take new clients on Fridays or weekends, a service that Care Connections was willing to offer. The co-op was also explicitly committed to *continuity* of care provider, a very desirable feature for clients and families who were unhappy about seeing up to seven different workers in a month. By offering these two ingredients, Care Connections was able to gain a toehold in their region. In general, the co-op has stressed flexibility to meet their clients’ needs.

The majority of the co-op’s clients come through Veterans Affairs Canada (about 55 per cent): meals, housekeeping, personal care, nursing foot care, and yard work. The rest are from private-pay clients and, beginning in the summer of 2006, the Insurance Corporation of B.C. To date, CCC has secured registered provider numbers from both Veterans Affairs and ICBC, which entitle the co-op to contract work from these major public bodies. This is a huge achievement – the co-op needed to clear many administrative hurdles – and an essential step toward grounding CCC in publicly funded services. However, they are still without a stable relationship to the Fraser Health Authority or the Workers’ Compensation Board.





Some officials seem to have little awareness of the social and fiscal advantages of the co-op model. Yet others have clearly cottoned on. Rath notes that the Continuing Care offices in Maple Ridge/Pitt Meadows and in Abbotsford are now recommending Care Connection to the public. “The professionals are starting to phone us,” says Rath, “because our reputation is very good.”

In its short history Care Connection has withstood difficult patches. Like other co-ops, CCC requires a good deal of volunteer labour, not easy for women with domestic responsibilities. As one member says, “The co-op is not going to just happen – it won’t come and knock on your door. You need to have that drive to be successful.”

The worker/members also faced their fears of indebtedness and being wholly in charge in insecure circumstances. Several approaches to management were considered after a collective management structure proved unworkable. The co-op eventually settled on one member in the role of full-time office coordinator and another as part-time financial coordinator. Two members realized they were uncomfortable with the demands of the co-op and the decision about co-management, and chose to leave. The fact that all the women were close friends was both a strength and a weakness of Care Connection: a strength because they pulled together, a weakness because role confusion is almost inevitable in co-ops and is complicated by friendship ties.

As the business expanded, the remaining members hired workers, some as staff employees, others on contract. The co-op now provides a range of nursing and home support services, delivered via the members and by over 30 other workers. Members earn more than employees (in mid-2005, \$15.50 per hour compared with \$13.50). The co-op is open to having new members, but that step will take time.



Rath says that start-up funding and consultants were essential to the fledgling co-op. Among other things, these supports allowed them to start small and grow slowly. “Slow is better than fast,” she says. “If you get too big too fast, you may not be able to provide a good service.”

As former union activists, the women of Care Connection are aiming to provide well-paying, secure, and respectful jobs for themselves and their employees. They are aware that some things that are helpful to their clients – flexible work hours, good continuity of care – are at odds with traditional union standards. Like other co-operatives, they face the balancing act of community service, workers’ rights, and economic realities. As 2006 draws to a close, they are growing ever stronger.

## 8

# Building support: Getting the government on side

The vitality of the co-operative sector is connected to the degree of state support it enjoys. Unfortunately, most of Canada lags behind in providing an infrastructure of laws, regulations, and policies that kindle rather than inhibit the growth of co-ops.

These supports make a big difference. The people of Saskatchewan were able to develop community health co-ops in part because they had lobbied for the Mutual Medical and Hospital Benefit Associations Act in the 1930s. The Italian state of Emilia Romagna actively promotes co-operative practices, hence the predominance of co-op enterprises and social services throughout the region.

In Quebec the co-op sector is recognized as a valuable player in economic and social spheres. The province understands the benefits of co-operative solutions to meet social needs and has encouraged the sector's growth through incentives and direct aid. The Co-operative Investment Plan (CIP), established in 1985, stimulates growth and investment by offering a tax break to members who invest in their co-op (and further rewards the investment by making it eligible for an RRSP). Capitalization is a difficult issue for many enterprises, and the CIP is a helpful remedy for co-operatives. Since the mid-1980s, over \$331 million has flowed to Quebec co-ops thanks to the program.

## Policies and practices that make a difference

Creative thinking and regulatory changes are needed to make governments more supportive of social co-operatives. Support can take the form of:

- “incubator funding” for consultants during the start-up phase (like other small businesses, co-ops usually need up to five years to get on their feet);
- salaries for training and administrative roles in social care co-operatives;
- partnerships with educational institutions;
- recognition of women’s role in initiating social co-ops, and eliminating the economic and social barriers to their participation;
- removal of red tape and barriers to participation of marginalized people (e.g., ensuring people do not lose social assistance or disability benefits when they work part time); and
- procurement practices that give preferential treatment to co-ops (called “social tendering”).

Some of these measures are subtractive. For example, governments can act to end the exclusion of co-ops from the myriad programs that offer practical and financial support to small businesses. This is not a trifling matter. Federally, at least 18 such programs are inaccessible to co-ops (Sutherland).

**Governments can act to end the exclusion**  
of co-ops from the myriad programs that offer practical and  
financial support to small businesses. This is not a trifling matter.

**“Government, as a custodian of public values, has a central role ... in building up the underlying social structures and social bonds that are the bedrock of thriving economies.”**

**JOHN RESTAKIS, 2006**

And some of these measures are proactive. There are compelling arguments to be made for policy changes that support co-ops. The arguments are economic, practical, and ethical. On a simple financial level, co-operative health care is known to be more efficient and less costly than conventional, fee-for-service primary care. On a deeper economic level, co-ops deal in the social determinants of health: poverty, participation, equality, and solidarity. Co-operative social care helps to build community capacity and engages marginalized citizens. Moreover, the economic well-being of a community has direct (and indirect) impacts on the physical and spiritual health of its citizens. Public investments in local co-ops ensure respectful jobs, community development, and money that stays in town. In contrast, public contracts with multinational service corporations are associated with low-wage jobs and footloose profits.

As a B.C. co-op, Care Connection is not only providing decent employment to local women, it is delivering flexible and compassionate service to care recipients. Yet Care Connection has faced an uphill battle in gaining recognition from health authorities and public agencies such as the Workers' Compensation Board.

Public bodies could be obliged to weigh the potential for community economic development in the awarding of service contracts. Specifically, they could be mandated to assign a specific percentage of those contracts to local co-ops (as in Emilia Romagna). This practice – social tendering – recognizes the link between economic vitality, citizens' participation, and population health.

## IN CLOSING

# Getting unions on side

Why should unions pay attention to the co-operative option? Two reasons stand out.

First, new thinking is needed to deal with the erosion of public health care in B.C. and Canada. The trend towards privatization is strong. The corporate sector, whether home-grown or transnational, is eager to market its for-profit services. The commodification of health care and social programs is a threat to health care employees, both as workers and as citizens who depend on public services.

Second, working people face the continuous challenge of exercising some real power over their work lives. In a unionized setting, the collective agreement is an excellent tool for influencing working conditions and pay, but management remains in the hands of owners and bureaucrats. Outside the workplace, ordinary citizens have very little say in how their local health care programs are shaped or delivered.

Co-operatives are a progressive alternative that addresses these issues of privatization and power. Co-op health care services can:

- offer not-for-profit health care, funded by public dollars;
- keep control of services in the community; and
- promote workplace democracy.

And there is a third reason: Opportunity. At present, considerable resources are available to help in the development of health care co-ops. Technical and financial support, for example, are forthcoming from the Co-operative Secretariat, a branch of the federal government, and from VanCity Credit Union. The co-ops profiled in this publication are evidence that some Canadians are experimenting with different co-operative models, as workers and health care consumers. The mantra of globalization has helped give rise to the opposite message: local services, in local hands.

The time is ripe for some serious – and imaginative – conversations between unionists and co-operators.

## Resources

### **B.C. CO-OPERATIVE ASSOCIATION**

230 – 1737 West 3rd Avenue  
Vancouver, BC V6J 1K7  
Website: [www.bcaa.coop](http://www.bcaa.coop)  
Email: [general@bccca.coop](mailto:general@bccca.coop)  
Tel: 604-662-3906

### **CANADIAN CO-OPERATIVE ASSOCIATION**

Co-operative House  
400 – 275 Bank Street, Ottawa, ON K2P 2L6  
Website: [www.coopscanada.coop](http://www.coopscanada.coop) and  
[www.ccc.coop](http://www.ccc.coop)  
Email: [info@CoopsCanada.coop](mailto:info@CoopsCanada.coop)  
Tel: 613-238-6711

### **CANADIAN WORKER CO-OPERATIVE FEDERATION**

Website: [www.canadianworker.coop](http://www.canadianworker.coop)

### **CO-OPERATIVES SECRETARIAT**

1341 Baseline Road, Tower 7  
6th Floor, Ottawa, ON K1A 0C5  
Website: [www.coop.gc.ca](http://www.coop.gc.ca)  
Email: [coops@agr.gc.ca](mailto:coops@agr.gc.ca)  
Tel: 613-759-7193

### **CO-OPERATIVE DEVELOPMENT INITIATIVE**

Website: [www.coop.gc.ca](http://www.coop.gc.ca)  
E-mail: [coops-progr@agr.gc.ca](mailto:coops-progr@agr.gc.ca)  
Tel: 1-888-781-2222 or 613-759-7193

### **B.C. INSTITUTE FOR CO-OPERATIVE STUDIES (UNIVERSITY OF VICTORIA)**

University House 2, Room 109  
PO Box 3060 STN CSC  
Victoria, BC V8W 2Y2  
Website: [web.uvic.ca/bcics/](http://web.uvic.ca/bcics/)  
Email: [rochdale@uvic.ca](mailto:rochdale@uvic.ca)  
Tel: 250-472-4539

### **CENTRE FOR THE STUDY OF CO-OPERATIVES (UNIVERSITY OF SASKATCHEWAN)**

101 Diefenbaker Place, Saskatoon, SK  
S7N 5B8  
Website: [www.usaskstudies.coop](http://www.usaskstudies.coop)  
Email: [coop.studies@usask.ca](mailto:coop.studies@usask.ca)  
Tel: 306-966-8509



## Sources

Adams, Frank et al. 1993. "Worker ownership in a low-paying and decentralized industry." *At Work*, March/April 1993.

Angus, Douglas and Pran Manga. 1990. "Co-op/consumer sponsored health care delivery effectiveness." Toronto: Canadian Co-operative Association.

Aubry, François. 2005. "The union in a co-operative environment: Summary of three interviews at the Coopérative des techniciens ambulanciers de la Montérégie (CETAM)." Unpublished paper.

Thériault, Luc. 2000. "At the loose end of the continuum: A study of two Saskatchewan non-profit organization delivering preventive home care services." Health Transition Fund Project SK123 (Health Canada).

Béland, Claude. 2000. "The future of co-operation." In *Canadian Cooperatives in the Year 2000: Memory, Mutual Aid and the Millennium*. ed. by Brett Fairbairn et al. Saskatoon: Centre for the Study of Cooperatives.

CFV (Co-operative Federation of Victoria Ltd.). 1997. "Opportunities for co-operatives in health care." Discussion Paper No. 3. Melbourne, Australia.

CHCA (Cooperative Health Care Associates). [www.paraprofessional.org/Sections/chca.htm](http://www.paraprofessional.org/Sections/chca.htm)

Community Action Network (UK). [www.can-online.org.uk/se](http://www.can-online.org.uk/se)

Coté, Daniel. "Cooperatives and the new millennium." In *Canadian Cooperatives in the Year 2000: Memory, Mutual Aid and the Millennium*. ed. by Brett Fairbairn et al. Saskatoon: Centre for the Study of Cooperatives.

Cornforth, Chris. 1989. "The role of support organisations in developing worker co-operatives: A model for promoting economic and industrial democracy?" in *The State, Trade Unions and Self Management: Issues of Competence and Control*. ed. by G. Széll et al. Berlin: Walter de Gruyter.

Craddock, Trent and Naila Vayid. 2004. "Health care co-operatives in Canada." Ottawa: Co-operatives Secretariat.

Crooks, Anthony et al. 1995. "Sharing the load: Shared-services co-ops help rural Americans address needs." *Farmer Cooperatives*. November 1995.

CWCF (Canadian Worker Co-op Federation) [www.canadianworker.coop](http://www.canadianworker.coop)

Dunlop, Catherine. 2005. "Mid-project evaluation report [Care Connection Health Services Co-operative]. Building Union Support for Community Health Care Co-operatives." Vancouver: Hospital Employees' Union.

Fairbairn, Brett. 2000. "Introduction." In *Canadian Cooperatives in the Year 2000: Memory, Mutual Aid and the Millennium*. ed. by Brett Fairbairn et al. Saskatoon: Centre for the Study of Cooperatives.

Ferri, Marisa, and Timothy J. White. 1999 (summer). "Regionalism, co-operation, and economic prosperity: Effective autonomy in Emilia-Romagna." *Mediterranean Quarterly*.

Girard, Jean-Pierre. 2006. "The co-op renaissance in Quebec." *The Co-op Perspective*. BC Co-operative Association.

ILO (International Labour Organization). ILO R193: Database of International Labour Standards.

Jönsson, Per-Olof. 1995. "Health services and social care in Europe from a co-operative perspective." KOOPI: Swedish Co-operative Research Institute.

Knudson, Lorna. 2005. "Building union support for community health care co-operatives. A case study of Saskatoon Community Clinic." Vancouver: CDI Research Project, Hospital Employees' Union.

Lindquist, Evert. 1996. "Public sector restructuring in Ontario: Facing the future." Toronto: Canadian Co-operative Association.

MacNeil, Teresa. 1996. "Meeting the challenge of public sector restructuring: The co-operative option." Toronto: Canadian Co-operative Association.

MCHB. "The Multicultural Health Brokers Co-operative: Bridging cultures to achieve equity of access to health." Edmonton: MCHB.

Menzies, Charles R. 2001 (Fall). "Us and them: The Prince Rupert Fishermen's Co-op and organized labour, 1931-1989." *Labour/Le travail* #48.

- Minnesota Worker Co-operatives. [www.mncooperate.org/unionFAQ.html](http://www.mncooperate.org/unionFAQ.html)
- Nadeau, E.G. and David J. Thompson. 1996. *Cooperation Works!* Rochester, MN: Lone Oak Press.
- Ontario Co-operative Association et al. *Co-operation & Collaboration: Melding Tradition with Innovation*. Wardsville, ON: The Duffy Group. Available in CD-ROM (contact [duffy@gtn.on.ca](mailto:duffy@gtn.on.ca)).
- Pobihushchy, Sidney. 2000. "Towards a people's economy." In *Canadian Cooperatives in the Year 2000: Memory, Mutual Aid and the Millennium*. ed. by Brett Fairbairn et al. Saskatoon: Centre for the Study of Cooperatives.
- Quarter, Jack. 1995. *Crossing the Line: Unionized Employee Ownership and Investment Funds*. Toronto: James Lorimer.
- Rath, Laura. 2005. Unpublished paper on Care Connection Co-operative. Vancouver.
- Restakis, John. 2004. "Social co-ops and social care: An emerging role for civil society." Unpublished paper.
- Restakis, John. 2006 (Winter). "Call for a new consensus." *The Co-op Perspective*. BC Co-operative Association.
- SCC (Saskatoon Community Clinic). "The Unique Alternative: Community Health Services (Saskatoon) Association (Ltd.) – Values statements."
- Sutherland, Kate and Tim Beachy. 2004. "Innovative co-ops in the social services sector: A research study to benefit peoples with developmental disabilities and mental illness." Vancouver: United Community Services Co-operative.
- Thompson, David J. 2003 (November–December). "Italy's Emilia Romagna: Clustering co-op development." *Cooperative Grocer* #109. [www.cooperativegrocer.coop](http://www.cooperativegrocer.coop)
- Webb, J. Tom. 2000. "Marketing cooperation in a global society." In *Canadian Cooperatives in the Year 2000: Memory, Mutual Aid and the Millennium*. ed. by Brett Fairbairn et al. Saskatoon: Centre for the Study of Cooperatives.
- Williams, Bob. 2003 (June). "A model of economic democracy: Cooperatives thrive in Emilia Romagna, Italy." *Common Ground*.



**Our medicare system** is under greater threat of privatization than ever before. But there are more effective solutions to the pressures on our health care system – ones that support unions and communities to provide high quality, democratically-run health care services, accessible to all. One of the most promising of these solutions is health care co-operatives.

From the battle for medicare in Saskatchewan in the 1960s to the Save Our Services coalition protesting health cuts in Nelson in 2002, Canadians are carrying on the battle for an affordable, accessible health care system.

