Come Together Now

Building Union Support for Community Health Care Co-operatives

By Nancy Pollak

It's time for a conversation between unions and co-operatives. The topic: how these two social movements can collaborate in the delivery of health care services.

Getting the conversation going will take patience and good will. Some union activists are uncertain about co-ops, just as some co-operators are wary of unions. Yet the movements are kindred spirits, rooted in traditions of mutual aid and community action. And the need for collaboration is acute.

The Canadian social safety net is being torn apart by privatization and contracting out. In this market-driven environment, unionized jobs are disappearing and local needs are neglected. Co-operatives have emerged as a locally controlled, nonprofit alternative to the corporate model. People are exploring how community-based co-ops can deliver publicly-supported health services that respond to community needs and respect the principles of workplace democracy.

The Co-op–Union Dance

History offers some stirring examples of unionists and co-operators working together. The Amalgamated Clothing Workers of America were instigators of housing co-operatives in New York City. The scenario? In the late 1920s a group of workers found themselves exploited as tenants yet unable to get credit to buy their own homes. Their plight was noticed by some savvy labour organizers. The result? A labour-sponsored housing network that still provides secure, decent co-op housing to thousands of low- and middle-income people.

Yet unionists and co-operators have also clashed. On the coast of British Columbia, a poisonous feud played out for half of the 20th century between the Prince Rupert Fishermen's Co-op, representing small independent trollers, and the United Fishermen and Allied Workers' Union.

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. And neither movement believes that the commodification of social needs and privatization of health care are inevitable or desirable.

The issue of workplace democracy is also crucial to both movements. Unions are a means of injecting some balance into power relations in a workplace. A collective agreement seeks to protect workers from arbitrary actions, insecurity, discrimination, undue exploitation, and hazardous conditions. Worker co-ops address these issues by dissolving the boundary between worker and owner. Democratic member control is a core value of co-ops of all stripes, so the idea of workplace democracy has resonance among co-operators, at least in principle.

Longstanding collaborations between labour and co-operative movements exist in some parts of the world, including Québec and Italy's Emilia Romagna. The International Labour Organization (ILO) has worked with the International Co-operative Alliance (ICA) since the 1920s.

In June 2002, after consultations with the ICA, the ILO adopted Recommendation 193, "Promotion of Co-operatives," which affirms that workers' organizations (labour unions) should be encouraged to:

(photo) CETAM paramedics attend a major accident in -20C temperatures. Credit: Philippe Serafino.

"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." [1]

Friction, too

Conflict between organized labour and the co-op movement is also evident. There are several sore spots.

For one, unionists *can* distrust the entrepreneurial nature of 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 obscure the fact that many co-ops play a progressive role as social entrepreneurs.

Co-operators can, in turn, distrust the adversarial nature of collective bargaining. Unfortunately, an adversarial relationship between workers and management is considered normal in a capitalist system. Traditionally, unions try to defend their members against job loss due to technological change, work speed-ups, unilateral changes to job duties, and other measures intended to improve (or sustain) a company's profitability. Market and technological forces apply to co-operatives, too. 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?

Co-ops are not automatically good employers. 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.

Co-op members can fall into the trap of being self-exploiters. Members might be willing to work for poor wages and no benefits. Small co-ops are often under-capitalized, insecure, and flying by the seat of their pants. Voluntary self-exploitation is untenable in the long run. 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.

This relates to the phenomenon of "sweat equity," on which many co-operatives rely. Voluntary work is vital in their birthing stages and beyond. Members who create a co-op or 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.

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. But conflict is not insurmountable. 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. A co-op should be amenable to a more co-operative relationship with its unionized workers, based on shared values – and vice versa. (See profiles, below and p. 46.)

Unionized workers can also view co-ops as the unwitting instrument of governments that are shedding public services. This fear arises when governments privatize programs or download them to the community without sufficient funding.

Profile: The Saskatoon Community Clinic

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.

Founded during the 1962 doctor's strike, the SCC is a strong advocate of public health care. As co-operators and activists, the clinic exemplifies the difference between a bureaucratic health care model (top-down, with passive consumers) and a participatory model (collaboration between care recipients and care providers). 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.

Co-op clinics are seen as an attractive option by some regional health authorities in Saskatchewan. Their effectiveness in delivering specialized services to high-risk communities is especially appreciated. The SCC's Westside Clinic has a proven track record with the inner-city Aboriginal community, who make up 90% of its clients.

The Saskatchewan labour movement is supportive of the province's co-op clinics, which are mainly unionized 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 one unionized staff person. "We are bonded to these values, they are part of our culture."

Unionized employees of the SCC perceive the clinic as less hierarchical and more democratic than a conventional workplace. The co-op structure enhances their sense of ownership and commitment. Almost all staff affirm 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.

"There seems to be no reason why unions & worker co-ops cannot share common ground along the basic lines of solidarity: dedication to worker's rights, economic justice, & dignified labor." [2]

But unionists need to guard against this negative knee-jerk response. In fact, most co-op organizations endorse the need for stable core funding for public programs and a strong social safety net. When privatization and contracting out are unavoidable, a co-operative service provider may be preferable to a corporate one.

Finally, 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 (i.e., reinforcing sexist or racist barriers in society). Co-ops can be very commercialized, and the movement as a whole can be guilty of regressive internal practices (i.e., reinforcing sexist or racist barriers in society).

After this litany of potential pitfalls, it's good to recall that unions and co-operatives have much 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. The two movements have cultivated different strengths over their long histories, strengths that can be knit together to deliver health care services that genuinely *serve* both the community and workers.

To bring the two movements together, both the government and unions must be brought on side.

Getting the Government on Side

A vital co-operative sector needs a good degree of state support. Unfortunately, most of Canada lacks the infrastructure of laws, regulations, and policies that kindle rather than inhibit the growth of co-ops.

These supports make a big difference. The Italian state of Emilia Romagna actively promotes co-operative practices,

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 issues, such as safety, personnel matters, and internal communications. 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 nonprofit sector, the SCC collective agreement has better-than-average provisions on job sharing, work hour flexibility, compassionate leave, job security, and training.

Sicktime and disability provisions 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. ■

(Photo) SCC's Westside Clinic became the impetus for the SCC Employment Equity Program when staff recognized the power of having Aboriginal role models on staff, serving Aboriginal clients. 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. Photo courtesy of Saskatoon Community Clinic.

[1] "Report IV(1): Promotion of Cooperatives," International Labour Conference, 90th Session, 2002 (Geneva: International Labor Office), pp. 9-10.

[2] Minnesota Worker Cooperatives, "What about unions and worker co-ops? Is there potential for collaboration?" July 13 2007 <http://www.mncooperate.org/unionFAQ.html>.

On a simple financial level, co-operative health care is more efficient than conventional, fee-for-service primary care. On a deeper economic level, co-ops deal in the social determinants of health: poverty, participation, equality, & solidarity.

(left) A CETAM paramedic comforts an elderly patient on the way to the hospital. Credit: Philippe Serafino.

hence the predominance of co-op enterprises and social services throughout the region. 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.

In Québec the co-op sector is recognized as valuable player in the economic and social spheres. The province understands the benefits of co-operative solutions to social needs and has encouraged the sector's growth through incentives and direct aid. The Co-operative Investment Plan, 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 viable co-operatives. Since the mid-1980s, over $331 million has flowed to Québec co-ops thanks to the program.

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

- "incubator funding" for consultants during the start-up phase.
- grants to subsidize training and administrative salaries in co-operatives that employ people traditionally excluded from the workplace (e.g. people with mental health or developmental disabilities).
- partnerships with educational institutions.

Profile: The Montérégie Ambulance Workers' Co-Op

La Coopérative des techniciens ambulanciers de la Montérégie (CETAM) was the first of Québec's six ambulance co-operatives. These co-ops are distinguished by being worker-owned, unionized, and very successful. They provide 30% of the province's ambulance services, employ over 700 worker-members (plus hundreds of non-member staff), serve 70 municipalities on the south shore of the St. Lawrence River near Montréal, and in 2002 earned revenues of $50.4 million.

The co-op's history is closely linked to the Québec labour movement and its largest labour central, the *Confédération des syndicats nationaux* (CSN). The labour federation was itself co-founded by the *Mouvement des caisses populaires Desjardins*, Québec'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.

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. Several owners then decided to get out of the business. This created an opening for workers to buy the operations. MCE Conseils, a CSN consulting body, stepped up with material and technical support, guiding the ambulance employees in their transition to worker-owners of the CETAM co-op.

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 3-5% that are reimbursed upon retirement or leaving the co-op. Other financial support came from union and government sources, as well as the Montréal *caisse populaire*.

Québec's ambulance co-ops have a master service contract with the government, as well as income 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.

Voting rights are confined to full-time members (30 hours a 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.

- recognition of women's core role in health and social co-ops, and eliminating the economic and social barriers to their participation.
- removal of red tape and barriers for marginalized people (e.g., ensuring people do not lose social assistance or disability benefits when they work part time).
- procurement practices that give preferential treatment to co-ops.

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. 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.

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.

Getting Unions on Side

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

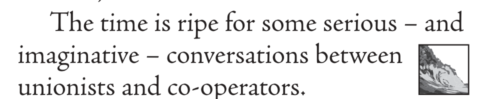
First, new thinking is needed to deal with the erosion of public health care in Canada. The trend towards privatization is strong. The corporate sector is eager to market its for-profit services. The commodification of health care and social programs is a threat to health care employees, both as workers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

Second, working people face the continuous challenge of exercising some real power over their lives. 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. They 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's Ministry of Agriculture. Canadians have a track record 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.



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CETAM's general assembly meets three times a year. Participation in general assemblies is quite high, drawing 50% of members on average – impressive given that ambulance work runs around the clock. CETAM's board has nine worker-members, elected by secret ballot 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 not in the bargaining unit. Like most of the office staff, managers are usually former ambulance technicians.

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. As one paramedic reflected, "Before [the worker co-op], you did not change the light in the ambulance if it burned out. Now we change the light and do the small repairs."

CETAM units are harmonious workplaces, and formal grievances are very rare. The co-op's members are committed to "wearing the two hats," yet recognize that the dual role of worker/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.
- *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 Québec were largely untrained, uncertified (often employed through funeral homes), and very poorly paid. Unionized co-ops have steadily pushed for the professionalization of the occupation, as well as for upgraded and innovative equipment, better vehicle maintenance, and ongoing training.
- *Innovation in service*: Worker co-ops are open to ideas from the shop floor, even when the shop floor is a moving ambulance or a bedside. CETAM pioneered the use of mechanized defibrillators in Québec'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.■