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An Overview of Health Co-operatives

A Case Study Perspective Using Canadian and International Examples

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About the BC Institute for Co-operative Studies ~

Based at the University of Victoria, the British Columbia Institute for Co-operative Studies (BCICS) is a catalyst for research, learning, and teaching about co-operative thought and practice. We seek to understand how the co-operative model functions within different communities and economic contexts to empower people to meet their economic and social needs.

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Abstract

Health co-operatives are not a new phenomena in Canada; however, they are not widely known. The first health co-operative in Canada was formed in 1944 in Québec city. It is now known as *Services de santé de Québec,* or SSQ, and serves the entire province of Québec. Two years later in British Columbia the first health insurance co-operative, CU&C Health Services Society, was officially incorporated in 1946. It was formed to provide prepaid, low cost medical-hospital plans. In 1962, a group of concerned, pro-medicare citizens and doctors in Saskatoon founded a health co-operative called the Community Health Services Association Ltd. Saskatchewan now has 5 provincially funded and supported co-operative health care associations in operation. Since these early beginnings there are now over 100 health co-operatives in Canada.

This paper provides background information on the variety and breadth of health co-ops in Canada, as well as a few examples from other countries. Short case studies are presented on different types of health co-ops including community clinics, a health brokers' co-op, ambulance co-ops, and home care service providers.

The paper concludes with a summary of some of the challenges of researching health co-operatives and points the reader to various resources for more information on this sector.

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Introduction

In April 2008, I attended a public health care forum held by the Victoria Community Health Co-operative - Victoria's first health co-operative. When the public was invited to express their views on the current state of our health care system, people responded with comments such as the following:

- *We do not have a health care system; we have a sick care and quick fix system. The current system deals with treatment over prevention.*
- *Health professionals such as physical therapists, naturopaths, nutritionists, acupuncturists, massage therapists, dentists, general practitioners and specialists do not collaborate enough and they are not accessible for everyone, especially if you live on social assistance.*
- *Socio-economic determinants have an impact on the availability and quality of health services received and this is not universal medical coverage.*
- *Our public health care system does not incorporate the mind, body, and spirit as one.*
- *There is a lack of empowerment. We need to provide education and encourage people to be responsible for their own health.*
- *We have a top down approach with our health care system. We view the doctors as solely being responsible for our health and our doctors view us as not having any knowledge of our health.*

After hearing people in my community articulate their frustrations, I realized that I was not alone in feeling dissatisfied with aspects of our health care system. Without dwelling too much on negatives, during the forum our community began discussing and exploring what our idea of an ideal health care system looks like and what we would like to see. This is a prime example of how and why health co-operatives develop and why health co-operatives are so successful in addressing the needs of community - it is the community that envisions them, creates them, and operates them.

Health co-operatives across Canada and around the globe have been able to fill in missing gaps in health care systems by addressing the explicit needs of their communities. In countries such as Brazil and Japan, and in some regions of Spain, the United States, and Canada, health co-operatives are a significant part of the health care systems. However in many other communities, health co-operatives are not a recognized concept and there is a general lack of knowledge of their potential role.

In a report for the International Health Co-operative Organization, Frigon (2002) states that there is a lack of education and knowledge on health care co-operatives. Following a similar view, the primary purpose of this report is to provide the reader with a general understanding of health co-operatives, review some examples, consider opportunities for development of health co-ops in the north and put forth suggestions on how to improve access to information on health co-ops.

In order to provide a picture of health co-operatives, I have drawn on many independent and public reports of health co-operatives and contacted health co-operatives directly. For this report, I have compiled the following information:

- a definition and brief introduction to co-operatives,
- Set out some defining characteristics of health co-operatives,
- A brief history of the development of health co-operatives in Canada,
- A summary of current trends in Canadian health co-operatives,
- Several case studies of Canadian and international health co-operatives,
- Information on opportunities for development of health co-operatives in northern communities, and
- Sources of additional information on the subject.

I hope this report will not only inform and inspire more research, but also empower people to become involved with their local health co-operative and consider the health co-operative model as a viable option for improving health care systems in their communities.

What is a Co-operative?

The International Co-operative Alliance (ICA) defines a co-operative as "an autonomous association of persons united voluntarily to meet their common economic, social, and cultural needs and aspirations through a jointly-owned and democratically-controlled enterprise" (ICA, 2007, pp. 3). Co-operatives are organizations owned and run by their members who purchase shares. Unlike for-profit corporations, their primary purpose is to meet the common needs of their members and contribute to the quality of life in their communities. Although it must be financially viable, the co-operative model differs considerably from the traditional business model in that its purpose is not only economic but also social. The ICA's definition of co-operatives further notes, "co-operatives are based on the values of self-help, self-responsibility, democracy, equality, equity and solidarity. In the tradition of their founders, co-operative members believe in the ethical values of honesty, openness, social responsibility, and caring for others" (ICA, 2007, pp3). Co-operatives are thus an important part of the social sector, as well, they play a significant role as economic organisations.

Although in general co-operatives follow the same underlining principles and motives, there are many kinds of co-operatives. There are, for example, financial co-operatives (such as a credit union or insurance co-ops), community development co-operatives, consumer co-operatives (such as Mountain Equipment Co-op), housing co-operatives, agricultural farm supply co-operatives, childcare co-operatives, and health co-operatives.

Co-operatives are guided by seven fundamental principles.[1] The seven universal principles as set out by the ICA are:

1. Voluntary and open membership

[1] For more information see: http://www.ica.coop/al-ica/

2. Democratic member control
3. Member economic participation
4. Autonomy and independence
5. Education, training, and information
6. Co-operation among co-operatives, and
7. Concern for community.

Defining Health Co-operatives

According to the *Health Co-operative Startup Guide*, community health co-operatives have four common characteristics, they are: "team-based medical practice; preventive medicine; periodic payment; and consumer control" (Co-operative Secretariat, 2008, section 1.3). Further, health co-operatives build social capital and increase community control of conditions affecting their members. Health co-operatives emphasize user responsibility, thus empowering people to take responsibility for there own health as much as possible (Frigon, 2002).

Health co-operatives take many shapes and forms. The types of health co-operatives that are represented in Canada and abroad include, but are not limited to, any combination of: primary health clinics, integrative health clinics, ambulance services, home care, information and education, health promotion, group purchasing of health supplies, mental health facilities, and health insurance. Some examples of the different models are presented as case studies in this report.

Four Models of Membership

Membership in a health co-operative may take various forms. In Canada there are four common forms (Craddock, 2004). These different types provide insights into both who benefits and how the co-op is developed. The four groups are:

1. Worker,
2. Consumer or User,
3. Producer, and
4. Multi-stakeholder.

As the title implies, *worker* co-operatives are owned by the workers/staff of the co-operative and are usually formed as a result of professionals wanting to create jobs and/or secure better working conditions (for example: pay, benefits, hours, working conditions, delivery of service, etc.). Most ambulance co-operatives in Québec follow this model (Craddock, 2004).

Consumer or user co-operatives are developed and owned by concerned community members. They are often created in rural remote communities where clinics and/or hospitals have been closed down because of the lack of public funding and/or medical

professionals. Many home care co-operatives operate under this model. Using the *consumer or user* model, the clients can influence how services are provided, as well as the type and quality of health care services in their community (Craddock, 2004).

The members of *producer* co-operatives include professionals whose business and operations may benefit from goods and services the co-op provides. For example, they may wish to form a co-operative to join their purchasing power and save on costs. Some examples of health co-operatives that utilize this model are residential facilities, shelters, hospitals, and labs (Craddock, 2004:8).

In *multi-stakeholder* co-operatives, the members can include: workers, users, providers, suppliers, and any other individual, business, or organization with a stake in the co-operative's achievements, or interested parties who just want to support the co-op. This model has an open membership policy. Many community health co-operative adopt the *multi-stakeholder* model (Craddock, 2004).

The Difference between Co-operative Health Centres and Community Centres?

It is important to outline the distinction between a co-operative health centre and community health centre. A health co-operative can be a community health centre but a community health centre is not necessarily a health co-operative. The main difference is that a community health centre is not owned by its members. Instead, it will likely be owned by just a few people or managed by a government agency. This is a major difference because a health co-operative is owned and run by its members and any profits that are made are put back into the centre or paid to its many members. Thus, the motives between the two can be quite different. For the co-operative, the motives are to serve its members, build a healthier community, and improve the social determinants of health in the broader community.

The Growth of Health Co-operatives in Canada

The co-operative movement in Canada has had a long and successful presence. According to a report of the Co-operative Secretariat (2007), in 2004 there where 5,753 non-financial co-operatives. In Canada co-operatives are incorporated and registered with a provincial government if they operate in a single province, or they are registered under federal legislation if they operate in more than one province. In British Columbia, co-operatives register under the British Columbia Co-operatives Association Act. In Canada co-operatives have over 5.6 million members, this means about one in five Canadians are members of a co-operative (CCA, 2008). Co-operatives are an integral part of our Canadian economy.

Canadian health co-operatives have been around for over 60 years. The first Canadian health co-operative, *Coopérative de santé de Québec,* was established in 1944 in Québec city. It is now known as *Services de santé de Québec* or SSQ, Mutuelle d'assurance-groupe. This Québec health co-operative still exists but it now serves the entire province of Québec (Co-operative Secretariat, 2008).

A few years later, in British Columbia the first health insurance co-operative, CU&C Health Services Society, was officially incorporated in 1946. It was formed to provide prepaid, low cost medical-hospital plans. Although it is no longer operating as a co-operative (in 1997 it merged with the Medical Services Association to form the Pacific Blue Cross), it is still the only health insurance co-operative to have operated in Canada, (Craddock, 2004).

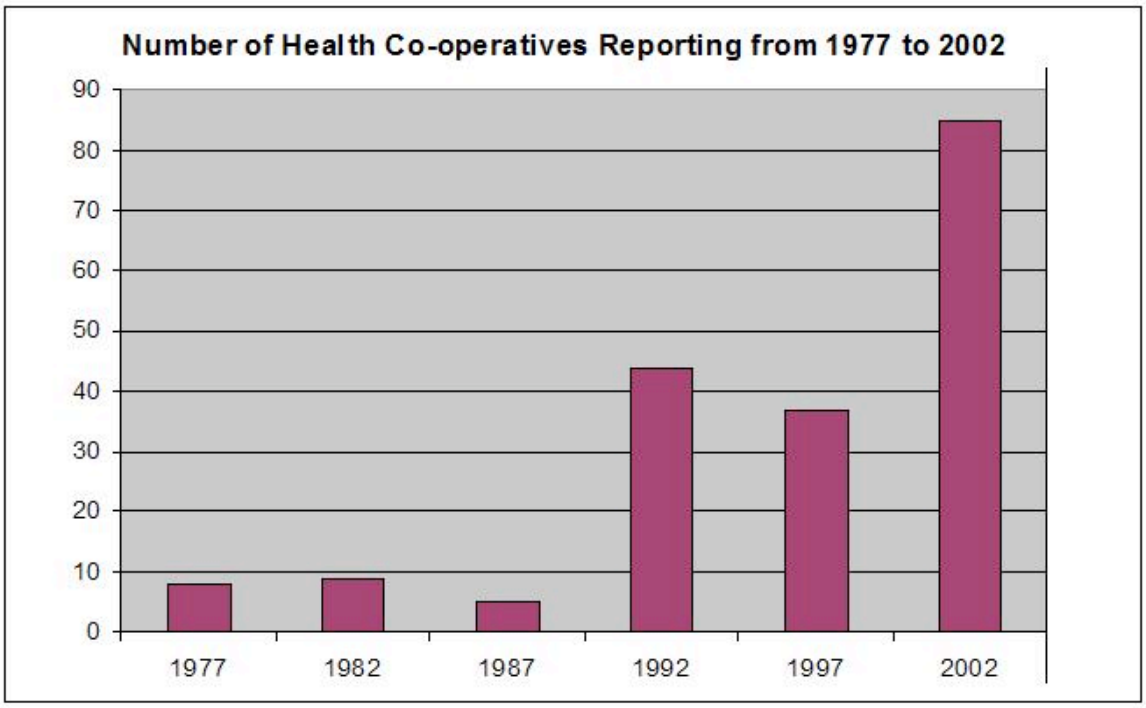
As well as being a leader in the development of Canada's universal health care system, the province of Saskatchewan also has a long and significant history in health co-operative development. In 1962, 90% of the doctors in Saskatchewan closed their offices in opposition to the introduction of Canada's first universal health care system. As a result of this strike, the doctors won the right to bill patients and to charge more than would be reimbursed to the patients under the provincial health insurance plan. In 1962, in response to this, a group of concerned, pro-medicare citizens and doctors in Saskatoon founded a health co-operative called the Community Health Services Association Ltd (Hurtig Publishers Ltd., 1985). This collaboration of concerned Canadian citizens demonstrates the essence of a co-operative. Saskatchewan now has 5 provincially funded and supported co-operative health care associations in operation (Saskatoon Community Clinic, 2008).

Health co-operatives are not developed to undermine government provision of health services. Governments across Canada often fund health co-operatives because they know health co-operatives have success in meeting health care needs which governments may be unable to effectively address. Thus, there can be a natural union between health co-operatives and the public sector.

Trends in Canadian Health Co-operatives

As highlighted in Figure 1 and Figure 2 below, health co-operatives are playing an increasing role in the Canadian health care system. You might be surprised by the multitude of health co-operatives that have been developed in some parts of the country. Along with other countries, Canada offers many examples of health co-operatives developed by citizens, for citizens. Although health co-operatives have been around for some time, there has never been the level of support from individual Canadians and governments for health co-operatives as has been seen in the last decade.

Figure 1[2]



(Source: Craddock 2004)

Figure 1 clearly demonstrates the large increase in the number of health co-operatives in Canada in the last decade and a half.

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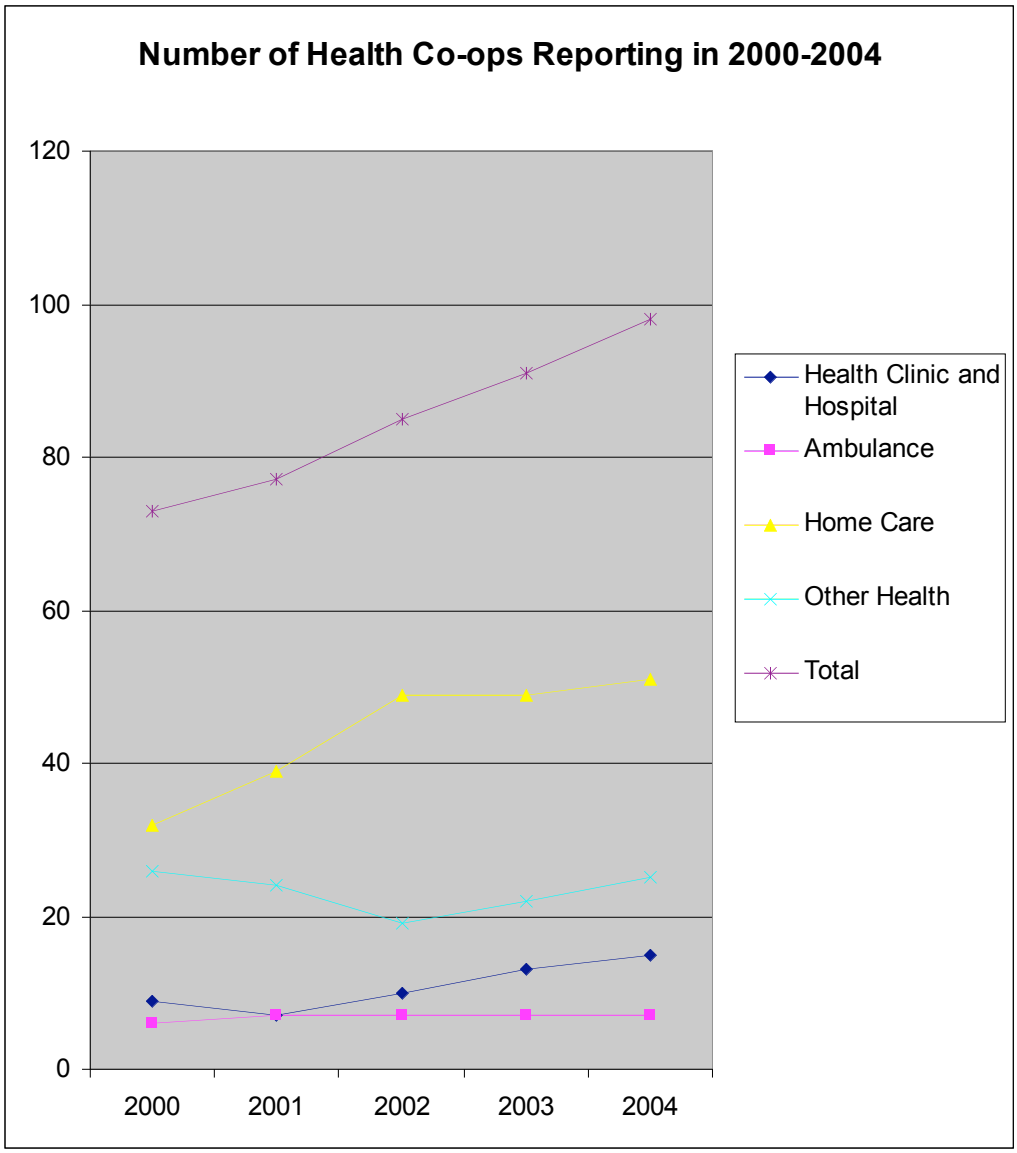
[2] *Data presented in the Figures used in this report represent only health co-operatives that reported to the Co-operative Secretariat. This is as Craddock and Vayid estimated in 2001, there were 26 health co-operatives across the country that did not report to the Secretariat*.

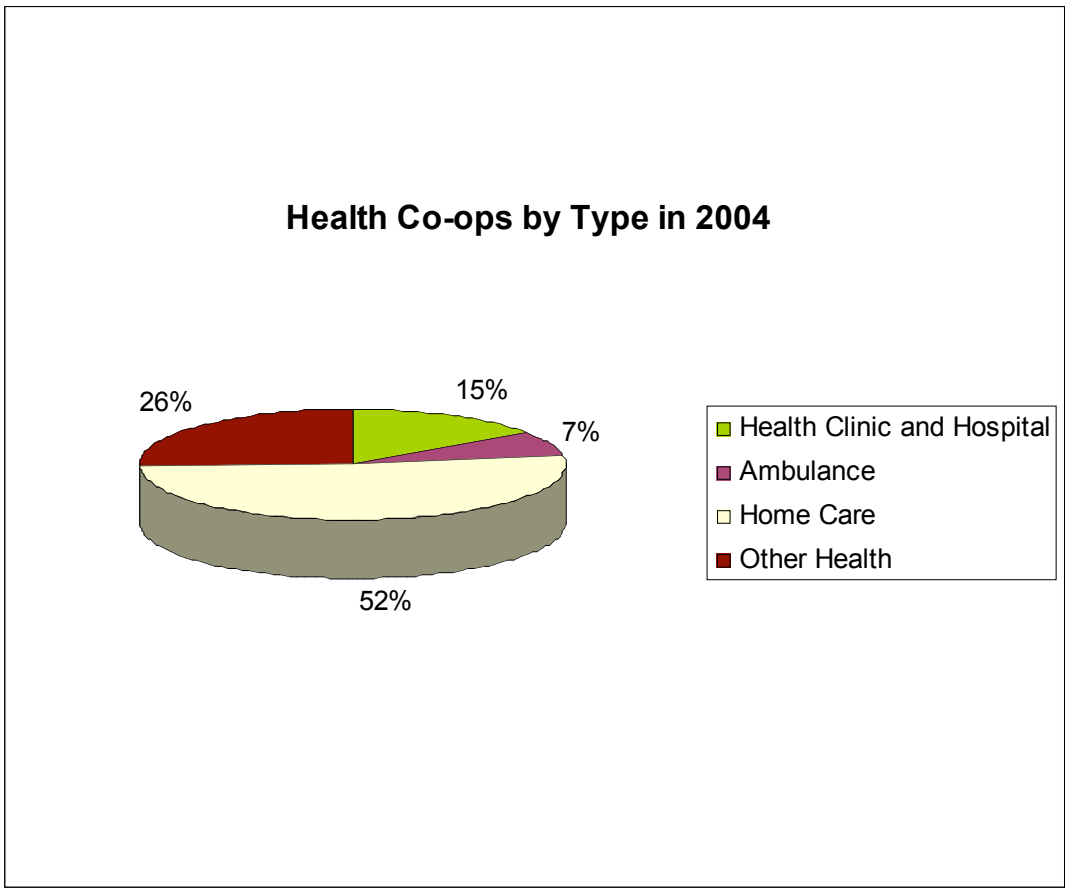
Figure 2



(Source: Craddock 2004)

Figure 2 demonstrates the growth in development of different types of health co-operatives. The category labelled "Other Health" includes health services such as holistic clinics, education, information resources, mental health facilities, and insurance.

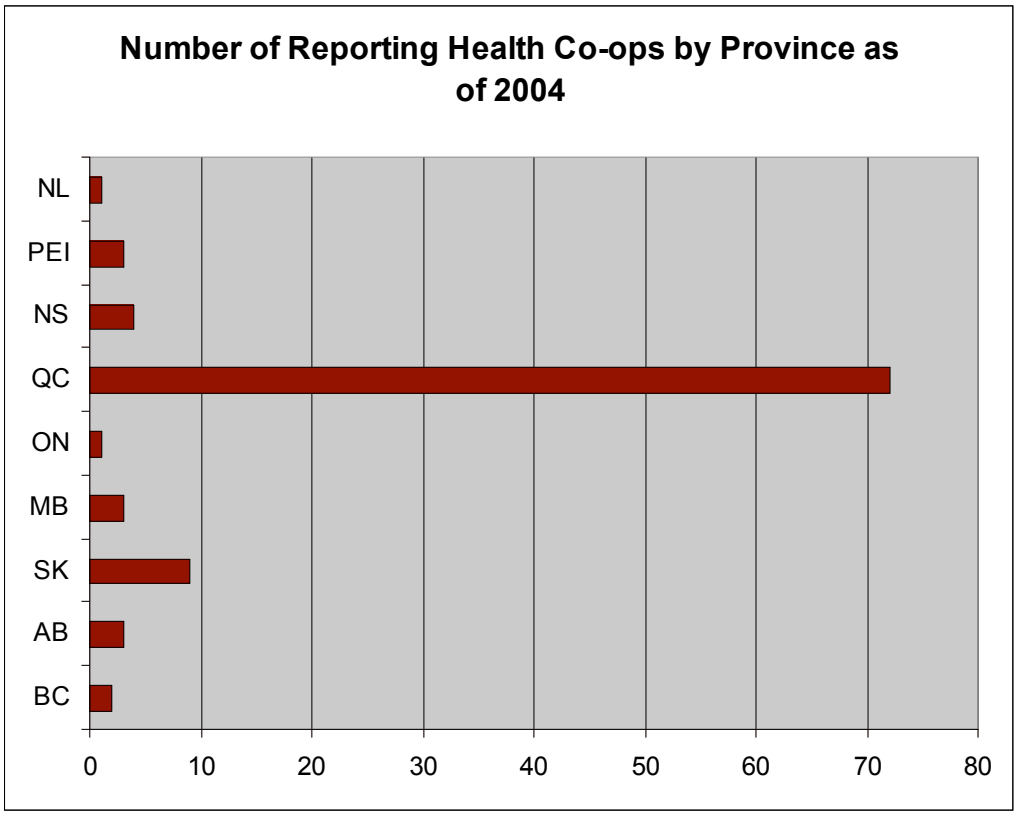
Figure 3



(Source: Craddock 2004)

Figure 3 illustrates the prevalence of the different types of health co-operatives that exist in Canada. Notice the high number of home care co-operatives.

Figure 4



(Source: Craddock 2004)

Figure 4 *(Craddock, 2004)* shows the distribution of health co-operatives across provinces. Québec and Saskatchewan's long history of health co-operatives explains the high prevalence of current health co-operatives in these provinces. As of 2004, all ambulance health co-operatives were in Québec with the exception of one in Newfoundland (Co-operatives Secretariat, 2007). With regard to home care co-operatives, a similar picture is painted when you look at the distribution across Canada. The majority of home care co-operatives are found in Québec, with the exception of one in each of British Columbia, Saskatchewan, and Nova Scotia.

Seven Short Case Studies of Health Co-operatives in Canada

The objective of this section is to illustrate the range of health co-operatives across Canada. In each example, the type of health co-operative, the membership model and the funding arrangement will be given if this information was available. While these case studies are not an in-depth analyses of the health co-operative movement in Canada, they will provide an introduction to some of Canada's best known and unique health co-operatives. They also suggest the wide variety of arrangements that exist.

1. Saskatoon Community Clinic, Saskatchewan

The Saskatoon Community Clinic was one of the first health co-operative clinics developed in Saskatchewan. It is one of five Saskatchewan clinics sponsored by the Community Health Services Association. According to its website, this clinic has more than 10,000 adult members, most of them living in Saskatoon and surrounding area. The Saskatoon Community Clinic has three clinics that operate throughout the Saskatoon area (Saskatoon Community Clinic, 2008).

The Saskatoon Clinic provides the following services: family physicians, pharmacy, nursing, physical therapy, occupational therapy, nutritional services, diagnostic services (including x-rays, laboratory and electrocardiogram), counselling services, community mental health services, and a health information centre. It also works with organizations in advocating for addressing social and economic issues that affect health. Like most health co-operatives, it assists and empowers individuals to take the initiative of caring for their own by encouraging them to partake in their health promotion programs and participating on the board of directors (Saskatoon Community Clinic, 2008).

Membership
The Saskatoon Community Clinic has adopted a *multi-stakeholder* structure for membership; thus membership is open to individuals, staff, or community groups who wish to be involved. It offers a lifetime membership for $15 for an individual or $30 for a family. Although anyone can use the services of the health clinics, the benefits of becoming a member of the co-operative are: you can run for the board of directors, you can serve on committees, you can volunteer, and you can receive their newsletter (Saskatoon Community Clinic, 2008).

In addition, the health co-op encourages its members to purchase the co-op's *Annual Assessment Fee*, which provides members with the following benefits: a reduction on prescription drug costs, delivery of prescription drugs free of cost, and a reduction on non-insured services (Saskatoon Community Clinic, 2008).

Reflecting the seventh core principle of co-operatives, *Concern for Community*, the co-op does not discriminate against non-members in terms of use of health clinic services. At the same time, they acknowledge that it is important to have the community sign up for

membership that provides both financial and social support. Incentives to becoming a member are important for encouraging people to join.

Funding
In 2007, the Saskatoon Community Clinic had an operating budget of $9.2 million. The main reason this health clinic has been so successful is because it, along with the other four Saskatchewan clinics, has strong financial support from the Saskatchewan government. Although they do receive funds from membership fees, as well as fees they charge for various services and donations, the majority of their funding comes from the provincial government (Charles, 2007). The Saskatoon Clinic is a prime example of a co-operatives working in union with the government.

Web Address: http://www.saskatooncommunityclinic.ca

2. Pacific Rim Health Services Co-operative (PRHSC), Port Alberni, BC

Pacific Rim Health Services Co-operative (PRHSC) developed in order to gain local control over the health care system in Port Alberni. In 2002, when "the government of British Columbia amalgamated the province's 52 health boards into five large health authorities" many smaller communities lost essential health services (Smecher, 2008, pp. 7). Port Alberni experienced the shut down of their hospital laundry services, a loss of a quarter of its acute care beds, and the replacement of registered nurses by practical nurses and care aides. Port Alberni residents also found it very difficult to attract and retain general practitioners (Smecher, 2008). Between 1998 and 2005, seven family practitioners retired (PRHSC). New practitioners found it difficult to establish themselves because family physicians in Port Alberni were individual practitioners. They faced high start up costs and burdensome administrative responsibilities. There were no temporary medical professionals to provide them with needed time off.

In order to recruit family physicians, the community knew it had to help new family physicians overcome some of the barriers they would face in becoming established. Their solution was to create the PRHSC (Smecher, 2008). The co-operative was officially incorporated in October 2006 and quickly organized a co-operative run family clinic called the Alberni Family Medicine Clinic (PRHSC, 2008). It opened its doors in the fall of 2006 and is now still operating successfully. It currently has two full-time family practitioners, one part-time family practitioner, and one general surgeon operating in the clinic (B. Denning, Personal Communication, May 5, 2008).

Membership
PRHSC follows the *multi-stakeholder* model of membership. They have four different types of members. Individual membership costs $10, founding membership is $100, group membership is $350, and a professional membership is $1000. Professionals are obliged to buy 100 shares at $10 per share in order to meet their $1000 requirement (PRHSC, 2008). All share purchases are for lifetime memberships. PRHSC follows the primary characteristic of all co-ops, despite various individuals and groups having

multiple shares, each individual or organization is only entitled to one vote. The co-operative serves non-members but it does not extend any additional benefits to non-members. (B. Denning, Personal Communication, May 5, 2008).

Funding
Although the Alberni Family Medicine Clinic started off with no money, it was fortunate in having strong support from community members. They found a building owned by the city of Port Alberni, which agreed to provide a building lease of $1 for the first two years. The local Health Authority financed the renovations and a retiring doctor provided furniture and supplies (Smecher, 2008).

The clinic finances its operations through its membership fees and especially through the rent doctors pay in order to operate out of its premises. When the clinic opened with its first doctor, it was able to use the rent money for purchasing equipment and then to undertake expansion so another family doctor could practice in the clinic. As it received rent payments from their second doctor, it was able to further expand. In their 2007 financial report PRHSC reported that it was free of debt, and in fact, had a surplus that it used to purchase new computers (PRHSC, 2008).

According to Denning, any future profits made by the co-operative (either through rent payments or membership fees) will be used for the purchase of the building (as it is still owned by the city of Port Alberni), to renovate/maintain the site, and to incorporate other health services as determined by the members (B. Denning, Personal Communication, May 5, 2008).

Contact Information:
Pacific Rim Health Services Co-operative
4711-B Elizabeth St.
Port Alberni, BC V9Y 6M1

3. Community First Health Co-operative, Nelson, BC

Like the community of Port Alberni, the community of Nelson, British Columbia, found their community losing control of health care services after the major rearrangement of the provincial government's health care system in 2002. Given the already strong presence of co-operatives in Nelson, it only seemed natural to develop a health co-operative. On February 27th, 2003 the Community First Health Co-operative was incorporated (CFHC, 2008). According to Doug Stoddart (their communication chair), the co-op's mandate is to provide education and information on health and wellness to the community. As Stoddart stated in an interview on *Each for All* (the radio show of the BC Institute for Co-operative Studies): "society is responsible for providing information, but everyone is responsible for their own health" (Martin and Puga, 2007).

Because seniors were seriously affected by provincial health cutbacks, the steering committee decided that one of their main focuses would be on senior's health and well-

being (CFHC, 2008). The co-op is committed to opening an affordable housing centre for seniors, but due to elevated construction costs, it is still searching for a location that will provide housing seniors can afford. Like many cities in the province, Nelson is experiencing rising housing costs and Community First is also searching for community co-operative housing projects for young singles, families, and students. It currently has two housing project proposals. One project would decrease the cost of rent by utilizing the ground floor of the complex for commercial space (D. Zeeben, Personal Communication, May 2, 2008).

According to Stoddart, one of Community First Health Co-operative's goals was to bridge the gap between traditional/mainstream health care and alternative medicine (Martin and Puga, 2007). In 2005, Community First was able to purchase the former Forestry building in Nelson to open the Nelson and Area Wellness Centre. This centre follows an integrative medical clinic model in that it provides general practitioners, an acupuncturist, a registered massage therapist, a registered traditional Chinese medicine practitioner, physiotherapists, occupational therapists, early childhood development programs, and Aboriginal family support programs. It is also planning to have a Community First Day Care Centre and a community resource centre (CFHC, 2008).

Recently, Community First Health Co-operative established a community nursing outreach program that operates five days a week. The nurses work in the same space as three physicians in the building. According to Debby Zeeben (the project development chair), physicians are very involved with the patient education (Personal Communication, May 2, 2008).

Membership

Community First follows the *multi-stakeholder model* that allows their memberships to be open to anyone in the community. It offers various costs for memberships, including, individual membership at $10 and a corporate membership at $100. It recently introduced "Enhanced Memberships," ranked at different levels: Copper ($50), Bronze ($100), Silver ($200), Gold ($500), and Platinum ($1000) (CFHC, 2008). Although there are different membership fees, each person only gets one vote. The reason for the different fees is to ensure accessibility to all and to leverage increased financial support for the co-operative. According to Zeeben, the co-operative has explored the idea of having additional benefits, other than the right to vote, but they have yet to establish what those benefits would be (D. Zeeben, Personal Communication, May 2, 2008).

For both members and non-members, a fee is charged to the client for services that are not covered under MSP; however, all of the professionals work on a sliding scale. Depending on the clients' ability to pay for the services, clients pay various rates for the services. This also helps insure that the co-operative's services are accessible to all members of the community (D. Zeeben, Personal Communication, May 2, 2008).

Funding

The Community First co-operative was fortunate to be located in a community where co-operatives are common and familiar. Reflecting the sixth internationally recognized principle of co-operatives, *Co-operation among Co-operatives*, local co-ops and co-

operators provided very valuable support. Nelson District Credit Union provided extensive support, thus ensuring greater probability of success (CFHC, 2008). The Credit Union provided the co-operative with a substantial grant to purchase the former Forestry building for the wellness centre, however, "it was the partnerships [the co-operative] had built in [their] community that allowed [them] to build the business case that would see VanCity carry [their] mortgage" (D. Zeeben, Personal Communication, May 2, 2008). One can learn from Community First Co-operative that community interest and support are vital to the successful development of a health care co-operative.

Web Address: www.healthco-op.ca

4. Multicultural Health Brokers Co-operative, Edmonton, AB

The Multicultural Health Brokers Co-operative began as part of a public health initiative to improve maternal and infant health in the immigrant and refugee populations in Edmonton. In 1998, it was officially incorporated as a worker co-operative (J. Kon, Personal Communication, June 18, 2008).

This co-operative now provides linguistically and culturally relevant health education and information, connects women and their families with health and social services, supports collective action to address health issues, and advocates for practice and policy shifts at the provider and institutional levels. As listed on their website, their programs include: prenatal education, post-natal support, bi-cultural parenting education, early childhood developments support, linguistic and cultural interpretation and translation of health education materials. It performs a wide range of activities, including: home visits, education in the community, tours of hospitals, and community organizing (MCHB, 2004).

The co-operative has an extensive list of multicultural brokers who collectively include a number of language groups, including: Arabic, Cantonese, Mandarin, Filipino, Punjabi, Hindu, Urdu, Spanish, Vietnamese, Amharic, Tigrigna, African-French, Swahili, Lingala, Tshiluba, Kirundi, Kinyarwanda, Kurdish, Afghani, Iranian, Somali, Sudanese, Bosnian, Croatian and Serbian (MCHB, 2004).

Membership
The Multicultural Health Brokers Co-operative is a *worker* co-operative. The members consist of health brokers who have worked with the co-operative for at least 2 years. As of June 2008, fees were $100 for a lifetime membership; however it is reviewing its membership application. It is considering forming different levels of membership and having annual fees, thus securing more funding for the co-op (J. Kon, Personal Communication, June 18, 2008).

The majority of the brokers are part-time workers and there are volunteers and students who help out with projects. The Multicultural Health Brokers Co-operative currently has 26 members. The key incentive for becoming a member is that members are decision

makers, have voting privileges, and have first priority when there is a job vacancy - provided the members' qualifications match the job (J. Kon, Personal Communication, June 18, 2008).

Funding
In 1998, the co-op signed a contract with Public Health, which allowed brokers to work part-time. It was not until 2002, when they received another source of funding, from Alberta Children's Services, that they were able to establish an office and hire administrators. Currently 60% of their funding comes from Alberta Children's Services with the rest derived from smaller grants and membership fees. The co-operative struggles to cover the costs of running its office and operating some of its programs. Its challenges demonstrate the importance of co-operatives learning from other co-ops about funding approaches and for researchers to pay special attention to funding issues (J. Kon, Personal Communication, June 18, 2008).

Web Address: www.mchb.org

5. La Coopérative ambulance technicians de la Montérégie, Montreal, QC

CETAM was founded in 1988 by 12 people who wanted greater control over the operations of the ambulance service within which they worked. CETAM is one of six ambulance co-operatives in Québec (Craddock, 2004). These co-operatives "account for 30% of all ambulance services in Québec" (Craddock, 2004, p.15). CETAM provides services to 675,000 citizens, across 70 municipalities on the south shore of Montréal (CETAM, 2008).

Its mandate is: "working together to provide the best services to the population while socially involved in our community"(CETAM, 2008).

Membership
Like most ambulance co-operatives, CETAM operates under the *worker model*. The co-operative is made up of nearly 280 members, who are both the owners and employees of the ambulance service. The board of directors is made up of 7 members who are employees and 2 non-members. Thus, this model allows for a democratic workplace, which ensures the best possible working conditions, allows for greater control over benefit packages, and strives to meet the specific needs of the workers/members (CETAM, 2008).

Funding
CETAM funding operates through direct payments for services. It charges each resident who receives its services $125 plus $1.75 per kilometre traveled. According to its website, however, some clients are excused from payment because the provincial government covers their costs. These include people injured in road accidents, welfare recipients, people injured in the workplace, people being transported between health centres, and certain qualified people aged 65 and older (CETAM, 2008).

In 2002, it was reported that the six ambulance co-operatives in Québec earned a total of $50.4 million dollars in combined revenue. They possessed $31.7 million in combined assets (Craddock, 2004).

Web Address: www.cetam.ca

6. Coopérative de services à domicile de l'Estrie, Sherbrooke, QC

Founded in 1989 by a group of senior citizens, Coopérative de services à domicile de l'Estrie was the first home care co-operative to be established in Québec (CCA, 2004a). Now it is one of 46 home care co-operatives in Québec and part of a network of 32 home care co-operatives that form the Fédération des coopératives de services à domicile du Québec (FCSDQ, 2008a). The co-operative's mission is "to allow older people to continue living at home and to improve the quality of life for the entire population by offering a range of home-care services that meets people's needs and to create stable, reliable, quality jobs for the underprivileged, the most vulnerable people in the labour market" (CCA, 2004a, p. 1).

As in the rest of the country, Québec has been facing an increasing aging population, which imposes a large burden on the health care system, creating shortened hospital stays and a greater need for home care. As baby boomers age, this situation will only worsen. According to a report of CCA (2004a.) home care co-operatives are a practical solution to the challenges associated with an aging population in Québec and the rest of the country.

Home care co-operatives also offer important benefits for workers in the home care industry due to regulations and formalities within the co-operative. Without appropriate benefits and regulations, underprivileged workers can join "the black market in home-care services," thus becoming susceptible to poor working conditions (CCA, 2004a, p. 1). The co-operative is able to regulate working standards and benefits for employees, as well as give their employees proper training to develop the skills needed to deliver quality home-care services (CCA, 2004a).

Membership
This co-operative adopts a *consumer or user* model because its members are the clients. This allows for the clients to regulate what types of services they receive. As of 2004, the Coopérative de services à domicile de l'Estrie had over 3,400 members (CCA, 2004a).

Funding
The co-operative charges for its services, thus it receives some of its funding from client/ members. But seeing as the Régie de l'assurance maladie du Québec (The Commission of Health Insurance of Québec) provides funding for home care assistance through its Exonération financière pour les services d'aide domestique programme general (financial aid for domestic aid program), much of its funding also comes through the provincial government. Depending on the individual, this program will fund up to $10 an hour per person utilizing a co-operative or non-profit home care service. This support from the

provincial government, therefore, allows for a reduced cost to clients and members (FCSDQ, 2008b).

In 2007, an individual over the age of 70 was able to claim up to $15,000 worth of expenses and would receive a tax credit of up to $3,750. This demonstrates the Québec Government's commitment to co-operatives such as Coopérative de services à domicile de l'Estrie. In fact, as reported by the Fédération des coopératives de services à domicile du Québec, the provincial government is planning on continuing to demonstrate its support for home care programs by slightly increasing its financial aid to home care aid users. They estimate that each client can receive an extra $23 per person. Although this is not a large increase it does demonstrate the government's confidence in home care co-operatives (FCSDQ, 2008b).

Reflecting the sixth principle of co-operatives, this co-operative is fortunate to be able to follow the principle of *Co-operation among Co-operatives* by sharing a building, services, and other appropriate costs with four other co-operatives operating in the area. Another benefit is that the Coopérative de développement régional de l'Estrie actually owns the building, which helps to allow these collaborations among co-operatives while cutting down on the co-operative's costs. Being part of the Fédération des coopératives de services à domicile du Québec allows for further financial benefits through the shared costs of advertising and other expenses (Fisette, 2007).

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7. The Victoria Community Health Co-operative (VCHC), Victoria, BC

This health co-operative is very new to the city of Victoria; it was officially incorporated in April 2008. At their first AGM in July 2008 they had over 70 members. Although, it does not yet own a facility, members are planning to obtain a building in early 2010. Currently, they hold community forums not only to inform the community about VCHC but to also learn more about the specific needs and interests of the community. VCHC also hosts health education classes for the public and in the near future the co-op is planning to develop a Birthing and Women's Health Centre (M. Sherman, Personal Communications, May 13, 2008).

The vision for the VCHC centre is one of an integrative model of health care. This means that VCHC wishes to provide a broad spectrum of services such as: family practitioners, meditation classes, cooking classes on healthy eating, gardening mentors, support programs for single parents, and whatever other health services the community desires and the co-operative can supply. It embraces "a broad definition of health that includes social and environmental determinants of health, in addition to the mind, body, and spirit of individuals and communities" (Sherman, 2007, p. 1). Like other co-operative clinics,

VCHC wishes to encourage self-responsibility for one's health, provide health education, and focus their services on preventative healthcare (M. Sherman, Personal Communications, May 13, 2008).

Publicly insured health services will be provided to everyone, but VCHC will attempt to subsidize non-insured health services in order to make these services more accessible for co-op members. Doing so requires finding ways to finance its development and sustain its operations. The steering committee of the VCHC has developed an original idea of not only how to overcome this financial barrier, but to encourage community involvement. Their initiative is to have a credit system, where, if one chooses, one could contribute volunteer hours to receive points that could be put towards the cost of a health service received. According to Dr. Mark Sherman, the philosophy behind this approach is to require modest fees so as to discourage abuse of the services offered (M. Sherman, personal communications, April 14, 2008).

Another goal they have for their co-operative is to put emphasis on group care as opposed to our system of traditional individual care that we are all so used to (M. Sherman, personal communications, April 14, 2008). The idea behind group care is similar to the successful *Han* groups in Japan (See: *Han Groups,* Japan in the next section).

Membership
The VCHC operates under the *multi-stakeholder model* of membership. At this point, there are two levels of membership within the co-operative: a regular membership costs $50 and an investor membership costs $100. Both are lifetime memberships, and, as with other co-ops, regardless of how many membership shares you purchase, one person has one vote at the annual general meeting. And every member is entitled to run for the board of directors (M. Sherman, Personal Communications, May 13, 2008).

Anyone in the community will be able to utilize the services of the co-operative. The co-op is planning to have additional benefits for members in order to encourage people to join. These benefits might include: discounts for health practitioner services, access to an online account (giving access to health articles and information), and access to educational events (M. Sherman, Personal Communications, May 13, 2008).

Funding
VCHC is still in an early stage and funding sources have yet to be established. The co-op is exploring multiple sources of funding from the co-op and credit union sector, various levels of government, and community organizations. Services of doctors and midwives or physiotherapists, massage therapists, and other services can be covered under Medicare and/or extended health plans as determined by service eligibility (M. Sherman, Personal Communications, April 14, 2008).

Web Address: http://www.victoriahealthcooperative.ca/

Health Co-operatives: Three Case Studies from Abroad

In some countries, health care systems rely heavily on health co-operatives. While there are a variety of health co-operatives within Canada, there is an even larger range and need for health co-operatives throughout the world. The three examples below illustrate some different health co-operatives models than exist in Canada.

In some developing countries, where local governments have not provided the most basic primary care facilities, health co-operatives have been started to secure medical services for low socio-economic populations. These co-operatives educate communities about infectious diseases and provide services in remote villages. In Japan, health co-operatives are highly supported by the government and they have shown the positive benefits of preventative health measures. It is an approach that Canadians might examine more closely (Kurimoto, 2005).

1. Han Groups, Japan

The Japanese Health Co-operatives Association has a membership of 129 individual health co-operatives; including clinics, hospitals, and welfare organizations (Graeme, 2007). The primary objectives of health co-operatives in Japan are to encourage people to take responsibility for their own health and to promote preventative medicine. Interestingly, the majority of health co-operative members are healthy individuals who want to avoid health risks, such as diseases and accidents, and who want to lead healthy lifestyles.

The Japan Consumer Co-operative started the now well known example of health co-op delivery through a unique model using *Han* groups. The co-operative members are encouraged to participate in these small groups, which usually have 9-10 members in each group. Typically, each *Han* group gathers regularly at one member's house to talk about their health and learn from a nurse, nutritionist, or health advisor. This group approach takes some of the burden off healthcare practitioners (who traditionally practice one-on-one counselling); it encourages peer support, and it empowers some individuals as healthcare leaders. Members are encouraged to participate in courses that will enable them to become health advisors and thus become leaders in their communities (Kurimoto, 2005). "Members also learn to do self-health checks such as testing and keeping records of their blood pressure and testing their urine for sugar and salt contents" (Kurimoto, 2005, p. 314).

The *Han* group approach has been very successful. In 2006, there were over 25,731 *Han* groups in Japan (Kurimoto, 2005). The World Health Organization recognizes the success of this initiative and believes that it can save thousands of lives (Martin and Puga, 2007).

2. The Uganda Health Co-operative, Uganda

The Uganda Health Co-operative is an example of successful efforts to increase health care in a country where life expectancy is only 43 years, where there are more than 1 million AIDS orphans, and where half of the children do not survive to their fifth birthday. The co-op started in 1997 through the efforts of the American dairy co-operative Land O' Lakes and with $750,000 from the US Agency for International Development. It was developed through the assistance of dairy co-operatives in rural Uganda and was based on the establishment of prepaid healthcare programs. In March 1999 the first members joined and now over 30,000 Ugandans, who had previously little access to health care, have benefited from the healthcare co-operative (CHSC, 2007).

The co-operative encourages farmers to pool their resources in order to save on the operating costs for heath delivery, to set aside money for pre-pay healthcare, and to encourage preventative health treatment. For a very small yearly fee, the farmers and their families are able to receive basic medical services, such as malaria treatment, pregnancy care, and accidents, free of cost. The pre-paid healthcare allows farmers to receive more affordable and timely treatments in the case of illness. The co-operative also exercises preventative care programs through community education in nutrition and self-help. For example, it provided and encouraged the farmers and their communities to use bed nets to decrease the risk of malaria, a potentially fatal disease, especially for children. This means that medical emergencies are less likely to create economic and personal crises for members of the co-operative (CHSC, 2007).

This healthcare co-operative also benefits the health care professionals in Uganda. It is common for patients to use fake names and then to sneak away in the middle of the night from the hospital in order to avoid having to pay. The medical professionals who provide their services through the co-operative are ensured that they are going to receive payments (CHSC, 2007).

3. Unimed do Brazil, Brazil

Unimed Brazil is the world's largest health co-operative with 376 local member co-operatives operating throughout the country. It was founded in 1967 by a group of doctors in Santos, Brazil and quickly spread throughout the country. Now there are 103,000 doctors employed by Unimed and 14.5 million users operating in 75% of Brazil's counties (Unimed do Brazil, 2008).

As reported on their website, Unimed is not only committed to providing primary health care, but also to providing services to communities. The member co-operatives focus on the social determinants of health, such as the environment, culture, equality, and poverty (Unimed do Brazil, 2008). As reported on the International Health Co-operative Organization's website, Unimed spends about $300 million (US) on not only health improvement projects but also on social and community projects throughout the country. It is presently involved with over 1,000 of these types of activities. In a country with

serious problems of poverty and very limited health care, Unimed is an example of people coming together to make change (IHCO, 2008).

The Potential for Health Co-operatives in Northern Aboriginal Communities

By learning from the various models of health co-operatives that exist in Canada and in other countries, we can adopt some of these models in our communities.

One pressing issue with the Canadian health care system is multiple health challenges faced by residents in many northern Aboriginal communities, coupled with poor access to treatment and prevention. First Nations communities are often faced with many issues, including isolation and cultural differences, which our standardized healthcare system is not effectively addressing. There is great need for reform in the health care delivery system within Aboriginal communities (CCA, 2004b). According to Health Canada, in 2004 life expectancy was 6 to 14 years less in First Nations communities than in the general population. Infant mortality rates were 3.5 times higher in Aboriginal populations. The rate of diabetes is three to five times higher. As noted in a report by the Canadian Co-operative Association, this rate of diabetes is among the highest in the world. Further, Canadian Aboriginal populations experience higher rates of alcohol abuse, substance abuse, solvent abuse, Chlamydia, hepatitis A, shingellosis, and tuberculosis (CCA, 2004b).

Many Aboriginal organizations recognize that the current health care system in their communities is not sufficient and that pumping more money into the existing health care system will not resolve the problem (CCA, 2004b). According to the Health Renewal Coordinator of the Assembly of First Nations, the co-op model could be a means to "empower Aboriginal peoples to identify and address their own needs and shape their own solutions" (CCA, 2004b, p. 5). As the Canadian Co-operative Association asserts, "populations that have more direct control over their own lives tend to have better health outcomes than those who have little control" (CCA, 2004b, p. 9).

Co-operatives are quite common in northern Aboriginal communities; indeed, "by the mid-1990s there were hardly any communities in the Far North that did not have a co-operative"(Lyall, 2002, 3). Statistics reveal that First Nations people are more likely to be members of a co-operative than non-aboriginals Canadians and residents of northern Aboriginal communities are 4 times more likely to be a member of a co-op than southern populations. Despite these statistics, the concept of a health co-operative is still not well known in northern communities (CCA, 2004b). Therefore, education on health co-operatives is needed, as well as more research to gauge the suitability of health co-operatives in northern Canada.

One promising model for health co-operatives in northern Aboriginal communities may be the Japanese *Han* model. It is a realistic option to address the problem of isolation that many Aboriginal communities face. The *Han* model could not only empower members of

the community to take ownership of their own health, it could also reduce the demand on health practitioners who are vary scarce in northern rural communities. This might also allow the communities to incorporate some of their own traditional healing practices.

Co-operatives are already a familiar concept in northern communities and the sheer number of existing co-operatives in the North might provide an excellent funding opportunity for the development of health co-operatives. The brief prepared by CCA concludes by acknowledging the importance of community control over health care as a way to ensure the maintenance of the principles of universal health care - so important in the Canadian system (CCA 2004b).

Conclusion

Co-operatives can help provide health services both in developed countries, like Canada, and in developing countries, such as Uganda. They can improve services, increase accessibility, and improve working conditions for those who work in the health care system. From my research I put forth several suggestions on how to improve the gaps in access to information on existing health care models.

Information: It would be beneficial if there were a more extensive database on existing health co-operatives in Canada and abroad. To help facilitate this, it is important for Canadian health co-operatives to register with the Co-operative Secretariat and where possible to maintain ties with the ICA International Health Co-operative Organization. The current gaps in research and data on health co-operatives results in an unfortunate misrepresentation of the importance of health co-operatives in Canada and abroad. More research and information sharing among existing health co-operatives regarding funding and other important issues could help new and existing health co-ops from reinventing the wheel.

Detailed Research and Case Studies: More detailed research and case studies would allow for a deeper understanding of the workings of existing health co-operatives. This can include interviews with practitioners, users, and related community organizations; site visits; history; and follow-up details. In this way, we can benefit from some of the hands-on lessons that may not be apparent from reading annual reports, visiting web sites, and communicating briefly with stakeholders. Such research could further explore the possibilities health co-operatives offer and then provide the information and education that will assist communities that wish to develop health co-operatives as a complementary delivery system to our public health care system.

Funding: This is often one of the greatest barriers for the development of health co-operatives. Five common sources of funding for health co-operatives are:

- membership fees;
- rent from health care providers;
- payments by patients who utilize services not covered by health care plans;

- grants from third parties, such as other co-operatives, credit unions, economic development organizations, and charitable organizations; and
- government grants.

Although not-for-profit businesses, health co-operative require a solid financial backbone and multiple sources of funding in order to be able to sustain their operations in the long term. A detailed analysis of funding opportunities and guidelines would be of significant assistance to existing and developing health co-operatives.

Increasing Community Support: As demonstrated by Community First Health Co-operative, in Nelson, BC, strong community support can be vital in influencing community organizations to fund health co-operative projects. In order for a co-operative to be successful, it requires full support from its members. This may require extensive education about health co-operatives and their role in the health of individuals and communities in general.

Readiness in Canada and BC: The health co-operative alternative is currently attracting considerable interest across Canada. Co-operatives can contribute to greater recognition of the value of preventative and alternative treatment methods in the health care system; they can help address some of our health (sick) care system failures. With the health care system financially strained, the time is right for the more intensive development of health co-operatives.

What Works: Although there are many national and international models for health co-operatives, a few issues that could influence the appropriateness of the model include: geographic location and population density, the socio-economic and education levels of participants, the nature of governing regulations, and the impact of public programs in place.

For example, the ambulance co-operative model may not work well in BC, given that all such services are publicly owned and governed by the Health/Hospital System. Multidisciplinary/co-location community centres may be appropriate in larger urban areas but may not be appropriate in northern sparsely populated areas, whereas the *Han* model may be more workable in small communities. The relative readiness of the community may also be a factor where preliminary education and preparedness promotions may need to be established prior to the formation of a co-operative.

Lessons Learned: Lastly, it can be extremely important for health co-operatives and researchers to outline what does not work for health co-operatives as well as what does. Documentation is scarce on what has been tried and found not to be effective but this information can be very useful.

Resources

Following is a list of resources on health co-operatives for people wishing to learn more, or for those who are considering starting a health co-operative.

Co-operative Secretariat
This site is very useful for learning more about many types of co-operatives in Canada – including health co-ops. The site has a number of useful publications, including annual statistics on health co-operatives, a co-operative incorporation kit, and a health care co-operative start up guide.
www.coop.gc.ca

British Columbia Co-operative Association
BCCA provides several publications on starting co-operatives in British Columbia. It also provides relevant information on changes in co-operative legislation in BC and information on the benefits of joining co-operatives.
www.bcca.coop

Canadian Co-operative Association
CCA's website provides examples of co-operatives in each province and provides contact information for provincial associations. These contacts can be very useful in locating co-operatives in your community, thus enabling you to look into recommendations and financial support that may be useful in developing new co-operatives.
www.coopscanada.coop

CoopZone
This site offers many resources useful for both existing and new co-operatives. They provide everything from financing tips, the 7 steps in starting a co-operative, a list of co-operative developers in various communities across Canada, specific provincial resources, and available training opportunities.
www.coopzone.coop

International Co-operative Alliance
The ICA provides many valuable resources on co-operatives around the world. One of their publications, called *ICA Rules, Policies, Procedures and Standing Operation,* clearly demonstrates what each of the seven principles of co-operatives means, information regarding membership, and how co-operatives are governed.
On the site you can also find an overview of co-operatives and a brief history on the development of the co-operatives movement.
www.ica.coop

International Health Co-operative Organization
The IHCO was founded in 1996 and operates under the International Co-operative Alliance. This site provides information on some of the larger international health co-operatives.
www.ica.coop/ihco

British Columbia Institute for Co-operative Studies (BCICS)
BCICS is a research, resource, and educational institute at the University of Victoria in British Columbia. Whether you are new to the concept of co-operatives or you're a veteran, you can find an array of resources on co-operatives on their website.
www.bcics.coop

Bibliography

Canadian Co-operative Association [CCA]. (2008). *About Co-operatives.* Retrieved March 25, 2008, from http://www.coopscanada.coop/aboutcoop/

Canadian Co-operative Association [CCA]. (2004a). *La Coopérative de services à domicile de l'Estrie: Fifteen years of successful service to the community!* Retrieved May 1, 2008, from http://www.coopscanada.coop/pdf/coopweek/2004/Coop%E9rative%20de%20services%20%E0%20domicile.pdf

Canadian Co-operative Association [CCA]. (2004b). Making the Link: Co-operative Health Provision in Aboriginal Communities. *Intersector,* 7 (3), 4-5, 9. Retrieved March 28, 2008, from ttp://www.coopscanada.coop/NewsLetter/InterSector/Winter2004/

CETAM. (2008). *Accueil, But de la coopérative and Facturation.* Retrieved May 9, 2008, from http://www.cetam.ca/

Charles, G. (2007). CoopHealth – Saskatoon Canada. *Co-op Advocacy.* Retrieved March 25, 2008 from, http://www.australia.coop/artman2/publish/Co-op_Advocacy_19/CoopHealth_-_Saskatoon_Canada.php

Community First Health Co-operative [CFHC]. (2008). *About us, Membership, and Wellness Centre.* Retrieved April 25, 2008, from http://www.healthco-op.ca/

Co-operative Health & Social Care [CHSC]. (2007). *The Uganda Health Co-operative.* Retrieved May 29, 2008, from http://www.cooperatives-uk.coop/NewVentures/healthAndSocialCare/resources/international/uganda

Co-operative Secretariat. (n.d.). *Health Care Co-operatives Startup Guide.* Retrieved April 25, 2008, from http://coop.gc.ca/index_e.php?s1=guides&s2=health-sante&page=intro

Craddock, T. & Vayid, N. (2004). Health Care Co-operatives in Canada. *Co-operatives Secretariat – Government of Canada.* Retrieved April 1, 2008 from http://coop.gc.ca/pub/pdf/craddock_e.pdf

Fisette, G. (2007). *Sherbrooke: La Maison de la coopération joint l'utile à l'agréable.* Retrieved May 1, 2008, from http://www.fcfq.qc.ca/nouvelles/2007-06-20.htm

Frigon, V., Mondy, J., & Kean, S. (2002). Co-operatives and Health Care. *Co-operatives Secretariat – Government of Canada.* Retrieved April 11, 2008, from http://www.coop.gc.ca/index_e.php?s1=pub&page=health-sante

Government of Canada. Co-operatives Secretariat. (2007). *Co-operatives in Canada (2004 Data).* Ottawa, Ontario: Anne McMartin.

Government of Canada. Co-operatives Secretariat. (2006). *Co-operatives in Canada (2003 Data).* Ottawa, Ontario: Les McCagg.

Government of Canada. Co-operatives Secretariat. (2005). *Co-operatives in Canada (2002 Data).* Ottawa, Ontario: Les McCagg.

Government of Canada. Co-operatives Secretariat. (2004). *Co-operatives in Canada (2001 Data).* Ottawa, Ontario: Co-operatives Secretariat.

Government of Canada. Co-operatives Secretariat. (2003). *Co-operatives in Canada (2000 Data).* Ottawa, Ontario: Les McCagg.

Government of Canada. Co-operatives Secretariat. (1999). *Co-operatives in Canada (1997Data).* Ottawa, Ontario: Les McCagg.
Government of Canada. Co-operatives Secretariat. (1993). *Co-operatives in Canada (1992 Data).* Ottawa, Ontario: Les McCagg.
Government of Canada. Co-operatives Secretariat. (1989). *Co-operatives in Canada (1987 Data).* Ottawa, Ontario: J.M. Sullivan.
Government of Canada. Agriculture Canada. (1984). *Co-operatives in Canada (1982 Data).* Ottawa, Ontario: J.M. Sullivan.
Government of Canada. Agriculture Canada. (1979). *Co-operatives in Canada (1977Data).* Ottawa, Ontario: J.M. Sullivan.
Graeme, C. (2007). *CoopHealth – Other Countries.* Retrieved May 29, 2008, from http://www.australia.coop/artman2/publish/Co-op_Advocacy_19/CoopHealth_-_Other_Countries.php
Hurtig Publishers Ltd. (1985). Health Insurance. In The *Canadian Encyclopaedia* (Vol. 2, pp. 801). Edmonton: Gurtig Publishers Ltd.
International Co-operative Alliance [ICA]. (2007). *ICA Rules, Procedures & Standing Orders.* Retreived April 25, 2008, from http://www.ica.coop/ica/2007-ica-rules.pdf
International Health Co-operative Organization [IHCO]. (2008). *Unimed moves forward.* Retrieved May 22, 2008, from http://www.ica.coop/ihco/
Kurimoto, A. (2005). What can Co-operative Health and Social Care Offer? In C. Tsuzuki, N. Hijikata, & A. Kurimoto (Eds.), *The Emergence of Global Citizenship: Utopian Ideas, Co-operative Movements and the Third Sector* (pp. 301-319). Rokubancho, Chiyoda-ku, Tokyo Japan: Robert Owen Association of Japan.
La Fédération des coopératives de services à domicile du Québec [FCSDQ]. (2008a). Repertoire. Retrieved May 15, 2008, from http://www.fcsdq.coop/
La Fédération des coopératives de services à domicile du Québec [FCSDQ]. (2008b). *Le Budget du Governement du Québec Repousse la Facture des Services a Domicile a plus tard.* Retrieved May 15, 2008, from http://www.fcsdq.coop/
Lyall, B., Barr, J., & Kelly, J. (2002). The Development of Aboriginal Co- operatives in Canada. *Co-operatives Secretariat – Government of Canada.* Retrieved April 11, 2008, from http://www.coop.gc.ca/index_e.php?s1=pub&page=devabor
Martin, E., & Puga, R. (hosts) (2007). *Health Care Co-operatives: History and Future.* (CD). Victoria, BC: Each for All: The Co-operative Connection.
Medbuy Corporation. (2008). *Our Members, Our Suppliers, FAQ, Annual Report 2006 and Corporate Brochure.* Retrieved May 22, 2008, from http://www.medbuy.com/
Multicultural Health Brokers Co-operative Ltd. [MCHB]. (2004). *Multicultural Health Brokers Co-operative Ltd.* Retrieved May 18, 2008, from http://www.mchb.org/
Pacific Rim Health Services Co-operative [PRHSC]. (2008). *Annual Report 2007.* Port Alberni: Pacific Rim Health Services Co-operative.
Pacific Rim Health Services Co-operative [PRHSC]. (n.d.). *Pacific Rim Health Services Co-operative: A New Way for Health Care in Alberni Valley and the West Coast* [Brochure]. Port Alberni: Pacific Rim Health Services Co-operative.

Saskatoon Community Clinic. (n.d.). *About Us, Services, and Memberships.* Retrieved April 11, 2008, from http://www.saskatooncommunityclinic.ca

Sherman, M. (2007). The Community Health Co-operative of Victoria – A Model whose Time has Come.

Smecher, C. (n.d.). Complete Solutions: How Communities can Work within & around the Established Health System. *Makingwaves, 18 (3), 7-11.* Retrieved March 24, 2008, from http://www.cedworks.com/files/pdf/free/MW180307.pdf

Unimed do Brazil. (2008). *Unimed no Brazil.* Retrieved May 22, 2008, from http://www.unimed.com.br/pct/index.jsp?cd_canal=34393