



Global Mapping of the Provision of Care through Cooperatives

Survey and Interview Findings



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International Labour Organization

Cooperatives Unit (COOP)
Gender, Equality and Diversity Branch (GED)

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Preface

“ [One] commonly identified source for future job growth in both developing and industrialized countries [is] the **care economy**, given the ageing population in much of the world... What will it take to realise that potential? Already, many existing needs for care either go unmet because of financial constraints or are covered by resorting to underpaid or unpaid carers. ”

ILO Director General Guy Ryder, The Future of Work Centenary Initiative¹

How quality care will be provided to the world's population is rapidly becoming one of the most important elements on the development agenda, representing a daunting challenge worldwide. Caring for infants and children is at the core of life itself, for families, communities and nations. It is also one of the central tensions to harnessing the productivity of women, as they are universally the main providers of care. At the same time, longevity is one of the most positive and relevant demographic phenomena to emerge in recent decades. The ageing of populations and the new inter-generational relationships radically affect the human landscape. Globally, the number of older people is expected to exceed the number of children for the first time in 2047. The proportion of people aged over 60 in the population is projected to grow to 22 per cent by 2050, amounting to 2 billion.

Therefore, the world is changing in vast and profound ways, driven by unprecedented demographic shifts. In addition, jobs are becoming increasingly flexible and new entrepreneurial opportunities are emerging in diverse sectors. However, while the fragmentation of the labour market may create some employee autonomy, it may also put vulnerable and disadvantaged workers at risk of exploitation. This may also infringe on caregiving responsibilities.

As these parallel and often mutually reinforcing shifts in the world of work and care continue, it is clear that new prospects, as well as new vulnerabilities, are on the horizon. The impact on business, society, work and gender roles in caregiving will need to be considered when reshaping policies and priorities. With this, innovative solutions for points at which care and work intersect are clearly needed. Cooperative enterprises are one option to meet this need.

In an effort to understand the ways in which cooperative enterprises manifest in the care sector, the ILO Cooperatives Unit (COOP) and the Gender, Equality and Diversity Branch (GED) undertook the present joint initiative: a global mapping of the provision of care through cooperatives. The broad objectives of this mapping were to assess the

¹ The Future of Work is one of the ILO Director General's seven centenary initiatives, which, centred upon key challenges and opportunities in labour markets, aim to carry the ILO forward through its centenary in 2019.

global landscape of cooperatives that provide care, identify the challenges and opportunities that cooperatives face, and determine the resources that cooperatives need in order to be viable care providers, enterprises and employers.

This initiative grew out of two recent ILO initiatives: the mapping of domestic worker cooperatives, which identified over 40 domestic worker cooperatives worldwide; and *Advancing Gender Equality: The Cooperative Way*, the Beijing+20 joint publication with the Alliance, which assessed the impact and interplay between cooperatives and gender equality.

The present mapping complements other current ILO programmes and research, particularly those concerning domestic workers, migrant workers in the global supply chain of care and transitioning from informal-to-formal economy. By setting forth original data which explores an innovative solution for work in an emerging sector of employment, the provision of care through cooperatives mapping diversifies and extends current initiatives of the ILO. This mapping is also timely in regards to recent developments in the cooperative movement, the care economy and the gender equality movement on issues such as the global care chain and equitable opportunities for women in labour markets.

Furthermore, this mapping feeds into the larger forward-looking framework of the ILO Director General's Future of Work Initiative. As the Director General so poignantly asks in his *Future of Work Centenary Initiative*, what will it take to realise the potential of care, given that so much of care work is underpaid or unremunerated? Cooperatives have emerged as one innovative solution to this inequity. The present mapping initiative seeks to understand how and why.

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Authors

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Acronyms

The Alliance	International Co-operative Alliance
CICOPA	International Organisation of Industrial, Artisanal and Service Producers' Co-operatives (a sectoral organization of the Alliance).
COOP	ILO Cooperatives Unit
GED	ILO Gender, Equality and Diversity Branch
ILO	International Labour Organization

Summary

The provision of care is changing in vast and profound ways, driven by demographic shifts such as the growing ageing population and an increasing number of people living with non-communicable diseases. Today, care work is found in various forms, from child care to eldercare to long-term care for people living with disabilities and chronic illness. It is most often women rather than men who do care work, and do so in both paid and unpaid manners. As care needs continue to expand and diversify, the care economy has enormous potential for employment generation in the coming years. However, care work across the world remains characterised by a void of benefits and protections, low wages or non-compensation, and exposure to physical, mental and, in some cases, sexual harm. It is clear that new solutions to care are needed on two fronts: in regards to the nature and provision of care services, and the terms and conditions of care work.

Preliminary evidence from the field suggests that cooperatives have been closely engaged with these issues from various angles. However, much remains unknown about how the cooperative model manifests itself in the care economy, both as a provider of care and an employer of care workers. In response to these gaps, the ILO Cooperatives Unit (COOP) and the Gender, Equality and Diversity Branch (GED) have embarked on the present joint initiative: a global mapping of the provision of care through cooperatives.

This report sets forth key findings from the preliminary research phase of the initiative, which consisted of an online survey and key stakeholder interviews. The findings suggest that cooperatives are emerging as an innovative type of care provider, particularly in the absence of viable public or other private options. The findings also suggest that cooperatives generate access to better terms and conditions of work in the care sector (e.g., access to benefits, more bargaining power, regularized hours) – especially for female employees. In addition, findings set forth that compared to public, other private and even non-profit care providers, cooperatives provide care in distinct and preferred ways. Cooperatives foster interdependency in care by privileging equitable inclusion and democratic decision-making across the care chain. As such, care workers, care beneficiaries and their families and other stakeholders have a voice in the nature of service provided and the operations of the care provision enterprise.

Despite these added values, cooperatives in the care sector face various challenges which hinder their sustainability and viability. Issues such as limited access to capital and start-up revenues, a lack of cooperative know-how and knowledge gaps across the care sector impede cooperatives' potential. Opportunities to overcome these challenges include sharing information, developing focused training initiatives, and building strategic alliances and partnerships across the care chain and cooperative movement.

Introduction

Across the world, care needs are growing in unprecedented ways. Global demographic shifts such as the expanding ageing population and rising rates of non-communicable diseases are requiring more people worldwide to seek assistance with day-to-day living. Today, care work is found in myriad forms, from childcare to eldercare to long-term care for people living with disabilities and chronic illness. Caregiving takes place in both the formal and informal economy, and in both paid and unpaid manners. By and large, it is women who take on care work—be it paid or unpaid. Women across the world spend two to 10 times the amount of time men spend each day on care (UN Women, 2015), meaning that working women everywhere must reconcile the “double burden.”

For the purposes of this report, care is:

Looking after the physical, psychological, emotional and developmental needs of one or more other people, namely the elderly, children and people living with disabilities, physical illness and/or mental illness

Adapted from ILO (2015), Women and the Future of Work: Taking Care of the Caregivers.

With the growing demand for care, the care sector is a key source for job growth. Despite this potential, paid care work remains characterised by low wages, long hours, a lack of contracts and unsafe working conditions. If the world’s evolving care needs are to be managed in a sustainable way, innovative solutions for (1) the provision of care and (2) the terms and conditions of care work are clearly needed. With this the question emerges: through what mechanisms can the care economy become an equitable job provider, particularly for women and other groups often excluded from the workforce?

A cooperative is:

An autonomous association of persons united voluntarily to meeting their common economic, social and cultural needs and aspirations through a jointly owned and democratically controlled enterprise.

International Co-operative Alliance and ILO R193: Promotion of Cooperatives Recommendation, 2002 (No.193)

Rooted in values of social justice, equity, democracy and decent work for all, cooperatives have emerged as an innovative type of care provision, particularly in the absence of viable public and private options. Looking ahead, cooperatives appear to be well-positioned to (1) serve as vehicles that generate access to the labour market and (2) be responsive, community-based providers of care. Nevertheless, much remains to be understood about the provision of care through cooperatives, and about cooperatives as employers of the care sector workforce.

Across research and practice literature, various case studies have been set forth, providing a foundational understanding of the functions of care cooperatives and the barriers they face. These studies, however, tend to focus on childcare and, to a lesser extent, eldercare, and most discuss cases from Western Europe and North America. As such, the broader understanding of care cooperatives across geographic regions and populations has been lacking. Furthermore, while case studies provide insight into the mechanisms of an organization, findings and implications are difficult to extrapolate and apply to other contexts and regions. Across extant literature, aggregate analyses on emerging programmatic models and policy directions are particularly few.

Nevertheless, literature as well as insights from practitioners in the care sector and the cooperatives movement have provided a foundational understanding of cooperatives in care. This knowledge base suggests that cooperatives are responding to myriad care needs, including eldercare, childcare and care for persons living with illness and/or disabilities, among other groups. Early evidence also suggests that cooperatives are emerging in diverse forms—as stand-alone care cooperatives, as “add-on” services to existing cooperatives and as “out-growths” from other types of organizations, like trade unions.

In an effort to address the gaps in research and expand the extant knowledge base, the ILO Cooperatives Unit (COOP) and Gender, Equality and Diversity Branch (GED) embarked on the present research initiative: a global mapping of the provision of care through cooperative enterprises. Using an approach that melds primary and secondary research, this mapping aims to:

- Determine the landscape of cooperatives that provide care, including their beneficiaries, members, objectives and scope;
- Ascertain the legislative, social and economic contexts that drive care through cooperatives;
- Identify the challenges and opportunities that cooperatives face in initiating and sustaining care provision and decent employment;
- Determine the resources that cooperatives need in order to be viable care providers, enterprises and employers;
- Assess how well cooperatives affect the livelihood of care beneficiaries, workers and the larger community, compared to private and public care provision options; and
- Determine whether and under which form care cooperatives are registered.

The present report sets forth key findings yielded from the primary research phase of the mapping. The first section presents the methodology employed in the primary research phase, which included an original online survey and interviews with key informants. The following section sets forth the key findings and analysis. Conclusions on the main takeaways are then discussed. Finally, next steps for policy, practice and research are suggested.

Methodology

Research Questions

This study aimed to address the following research questions:

- Why do cooperatives emerge to provide care?
- Within what social, economic and legislative contexts do cooperatives emerge to provide care, and sustain that provision?
- What is the landscape of the provision of care through cooperatives (e.g., cooperative beneficiaries, members, objectives and scope of care)?
- In what ways do cooperatives affect the livelihood of care beneficiaries, care workers and the larger community?
- What challenges and opportunities do cooperatives face in initiating and sustaining care provision and decent employment?
- What resources would enable cooperatives to be viable care providers, enterprises and employers?

Research Methods and Design

The methods employed in this study include an in-depth review of literature, an online survey disseminated to targeted networks in the care sector and cooperatives movement, and semi-structured interviews with key informants. This report focuses on the latter two, which together comprise the primary research phase of the initiative.

Survey Design and Data Collection

The online survey explored the opinions and experiences of practitioners, activists and experts from the care sector and the cooperatives movement.

Survey respondents answered approximately 50 questions, most of which were close-ended, multiple-choice questions and three of which were open-ended. The survey required approximately 20 minutes to complete. Respondents were allowed to skip or respond “I do not know” to most questions.

The survey was designed as such that after answering several broad questions, respondents were then split into two groups based upon whether the cooperative the respondent knows best provides care. This categorised respondents into two groups: (1) respondents who were directly connected to a care cooperative, thus were able to speak to specific experiences of that enterprise; and (2) respondents who were not directly linked to a care cooperative, but were able to speak to the general landscape of cooperatives and care.

The survey was produced in English, French, Spanish and Italian and administered online through Survey Monkey, a credible web-based survey platform. The survey was circulated widely to gender, cooperative and care networks across Europe, North America, Latin America and the Caribbean, Asia and the Pacific and Africa. The survey was disseminated via various web-based and social media outlets, including email, LinkedIn,

Facebook, Twitter and links posted on various organizational websites (e.g. ILO COOP, ILO GED, CICOPA, Alliance, and Cooperative News). Ultimately, 182 respondents completed the survey.

Interview Design and Data Collection

To triangulate survey data, semi-structured interviews with key informants from the care sector and the cooperatives movement were conducted. These interviews aimed to expand the survey findings, explore discrepancies in data and gain insight into explanatory mechanisms of themes identified.

Interviewees were contacted through three modes: self-selection (i.e. indicating interest in participating in an interview after completing the online survey), referral by other participants and referral by ILO research team members. Interviewees were invited to choose one of two interview formats: verbal or written. Identical questions were asked in the two formats. The verbal interviews were conducted via Skype or telephone and lasted between 25 minutes to 90 minutes. Written interviews were submitted via email to the ILO research team at the participants' convenience. Ultimately, 29 key informants participated in an interview.

Study Sample

Survey Sample

The survey sample consisted of 182 survey respondents from the care sector and cooperatives movement. Most respondents (55 per cent) participated in the English version of the survey (see Figure 1). These respondents came from a variety of regions, namely North America, Europe, Sub-Saharan Africa and Asia and the Pacific. One third of respondents (34 per cent) completed the survey in Spanish, with respondents representing Europe, namely Spain, and Latin America and the Caribbean.

Seven per cent of survey respondents completed the Italian version of the survey. Compared to the other languages in which the survey was offered, Italian reached fewer and more homogenous respondents. However, given the long history and advanced development of care cooperatives in Italy, the research team deemed that tapping into the Italian experience was imperative.

Figure 1
Language of Survey Response

Language	Count	Per cent
English	101	55
Spanish	61	34
Italian	12	7
French	8	4
Total	182	100

Figure 2

Survey Respondent Region

Region	Per cent
Europe and Russia	31
Latin America and the Caribbean	23
North America	15
Sub-Saharan Africa	11
Asia and the Pacific	12
Other	7
North Africa	1
Total	100

Four per cent of respondents participated in the French version of the survey. These respondents came from Europe and North Africa. The low response rate for the French version and the relative lack of responses from Sub-Saharan Francophone countries could be due to issues such as unfamiliarity with care cooperatives in this region, or the depth and nature of relationships between potential respondents and the organizations which disseminated the survey.

Over half of the respondents came from the cooperatives movement, followed by academia or research institutions, and then NGOs and international organizations. Although fewer in number, practitioners from the care and health sectors outside of the cooperative movement also participated in the survey (see Figure 3). The overall survey sample was almost evenly split between sexes (see Figure 4).

Figure 3

Survey Respondent Institution Type

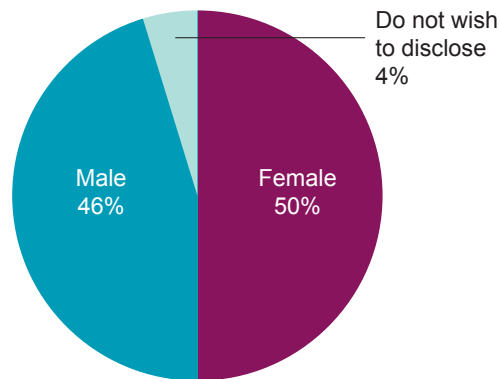
Institution Type	Per cent
Primary cooperative	27
Cooperative support institution	25
Academic or research institution	16
NGO	13
Other	7
International organization	6
Government ministry	3
Care provision institution that is not a cooperative	3
Healthcare institution that is not a cooperative	1
Total	100

Interview Sample

Interviews were conducted with 29 key informants. Of these participants, 27 also completed the online survey; the remaining two were contacted by referral and chose not to participate in the survey.

Sixteen of the interviewees were female and 13 were male. Most interviewees came from Europe (8), followed by Asia and the Pacific (7) and Latin America and the Caribbean (7), then Africa (4), and finally North America (3). Interviewees represented a diverse array of countries including Italy, Uganda, Mexico, Sri Lanka, Japan and Canada, among many others. Collectively, the interviewees represented all regions surveyed.

Figure 4
Survey Respondent Sex Ratio



Interviewees were equally divided between experts from care cooperatives and the general cooperatives movement. Interviewees included board members and directors of care cooperatives, practitioners from the broader cooperatives movement and academics specialising in the provision of care through cooperatives.

Data Analysis

Thematic analysis was used to analyse the survey and interview data. Explored in detail in the next section, ten themes emerged from this analysis:

- Recent trends
- Cooperative structure
- Key actors
- Nature and scope of care
- Employment issues
- Legal and policy frameworks
- Finance issues
- Cooperative value-added
- Gender issues
- Challenges and opportunities

Study limitations

This study has certain limitations which must be acknowledged. First, because the sample stemmed from the ILO and the Alliance networks, it may not be representative of the entire population of cooperatives that provide care. In other words, cooperatives beyond the reach of these professional networks may have been unintentionally excluded from the sample pool. Second and as mentioned earlier, all survey respondents and interviewees self-selected into the study. Because the respondents were not-randomly chosen, the data reported may be skewed and perhaps not represent the opinions of the broader population of cooperatives in care. Third, the data collected was primarily subjective (e.g., opinion-based) rather than objective (e.g., fact-based or hard data-driven). Finally, English and Spanish speakers from Europe, Latin America and the Caribbean and North America comprised most of the sample. While not necessarily a limitation, it must be noted that due to the sample composition, findings may not generalizable to all regions.

Findings

Recent Trends in the Provision of Care through Cooperatives

According to study participants, cooperatives are emerging as significant players in the care sector, both as care providers and as employers. Over 37 per cent of survey respondents shared that the number of cooperatives that provide care increased over the last ten years, and another 14 per cent reported that the number remained the same. Participants also reported that cooperatives are very new actors, and while they have great potential in the care sector, they also face myriad barriers which affect this potential.

Interviewees from diverse regions expanded on these findings. While survey respondents evidence a growth in care cooperatives, some interviewees stressed that cooperatives are either very new care providers or do not yet even exist in their country. As interviewees from Uganda and the U.K shared:

““ In Uganda, we don’t have care cooperatives. Care services are mostly provided by other types of organizations, mostly NGOs. ””

Rhona Nyiraneza, Uganda Cooperative Alliance, Uganda

““ In the UK, care cooperatives remain under developed. Mental health, older peoples’ services, home care - cooperatives are very few. It’s in the early stages, certainly across England. ””

Mervyn Eastman, Co-director and founder, Change AGEnts Cooperative, UK

Survey respondents identified various reasons why cooperatives have emerged to provide care. Among respondents who state the cooperative they know best is a care cooperative, 44 per cent reported that cooperatives emerged because care needs were not being met by private and public providers. Another 23 per cent of these respondents stated that cooperatives emerged because the other care providers are too expensive. An interviewee from Zimbabwe explained this as related to nursing cooperatives in his country:

““ Cooperatives indeed fill the gap created by government and private sector. That is the reason why some care cooperatives formed nursing cooperatives. People were not able to pay the high cost of health fees charged, and the health services provided by public and private sources are sometimes inadequate. ””

Albert Vingwe, Chairman, Chitsvachirimurutsoka Farming Co-op Society Ltd., Zimbabwe

Other participants shared that their cooperative grew out of existing organizations and partnerships.

““ Our cooperative stemmed out of a government programme. Older people decided to form and register a cooperative. It took two years to consolidate as a cooperative. We’re a multi-stakeholder cooperative of workers, older people and eight organizations who are members.””

Mervyn Eastman, Co-director and founder, Change AGEnts Cooperative, UK

According to study participants, the number of beneficiaries receiving care through cooperatives has also increased. Over 40 per cent of all survey respondents reported that the number of cooperatives that provide care in their communities has increased over the last ten years. Furthermore, about 42 per cent of survey respondents reported a rise in community demand for care through cooperatives over the last decade. These respondents came from a variety of regions, including Latin America, Europe and the Russian Federation, and Latin America and the Caribbean.

Study participants also believe that membership in cooperatives that provide care has also risen over the last ten years. Almost 40 per cent of survey respondents reported an upsurge and another 13 per cent shared that membership remained steady over the same period. Despite this reported growth, several interviewees discussed problems with recruiting members, especially early on. According to a female program manager of a cooperative support organization in Kenya:

““ There are financial constraints when it comes to mobilisation and getting people to participate, especially when establishing cooperatives. And growth is dependent on membership. We need more capacity at the organization level to help in capacity building of our member cooperatives to help them grow.””

Anonymous programme manager, cooperative support organization, Kenya

Despite the overall growing demand for care through cooperatives, survey respondents suggest that government support for care cooperatives is less secure. This finding is concerning, given that 50 per cent of respondents directly involved with a care cooperative reported that support from national and local governments is critical for care cooperatives to thrive and sustain.

Less than seven per cent of respondents shared that government support for the provision of care through cooperatives increased over the last ten years, while over a quarter

reported that government support for cooperatives that provide care decreased. More supportive governments were identified in Asia and the Pacific, parts of North America and Europe. Less supportive governments were identified in Africa, as well as parts of North America and Europe. Contradictions in the data warrant further investigation going forward, particularly as the survey design limited geographic disaggregation only to regional, rather than national or subnational, levels.

Cooperative Structure

Over 70 per cent of respondents directly associated with a cooperative that provides care reported that their cooperative was registered. Respondents identified a variety of forms under which cooperatives are registered, including worker cooperatives, social cooperatives, users' cooperatives and multi-stakeholder cooperatives. Respondents also identified other non-cooperative forms under which their enterprise is registered due to legislative and other reasons. These forms include limited liability companies (LLC's), non-profit institutions and non-government organizations (NGOs). Responses for both cooperative and non-cooperative registrations emerged across all regions; this invites further investigation at the national and sub-national levels.

As one survey respondent from Canada discussed, registration options are in large part determined by national and subnational legislation, and how supportive that legislation is of cooperatives. Overall, the variation in registration data suggests that the cooperative approach and principles are used by different types of care providers, even those which cannot or choose not to register as a cooperative.

According to study participants, most cooperatives that provide care are small enterprises. About a third of the survey respondents directly connected to a care cooperative reported that their cooperative employed less than 50 people, with approximately 15 per cent reporting that their cooperative employed between 1 and 10 employees.

Key Actors

When asked to identify the key actors involved in cooperatives that provide care, study participants discussed a number of micro, meso and macro-level actors. According to most survey respondents, by definition, the main stakeholders in cooperatives that provide care are members. Other key stakeholders include beneficiaries and workers –or the immediate actors involved in care provision and service use.² Other stakeholders mentioned include the local government and community partner organizations, like local NGOs.

Survey respondents were asked to identify the members of care cooperatives. When referring to worker cooperatives, respondents noted that worker members may use the

² Per the survey terminology, beneficiaries are the individuals who use the care services offered by a cooperative. Depending on the cooperative's beneficiary may also be a user-member and a worker. Workers are individuals employed by the cooperative. They may or may not use care services themselves, or have family members who use provided services. Cooperative members are the individuals who, being a worker, user, or another type of stakeholder, co-own and control the cooperative together with other members.

care services provided by the cooperative and/or their family members may use the services. Study participants suggested that the primary beneficiaries of cooperatives are the members themselves, although non-member paying customers also use cooperative care services.

Figure 5

Types of Beneficiaries Receiving Care Services from Cooperatives

Beneficiary Type	Per cent
Cooperative members:	45.3
• Workers who or whose family members use care services provided by the cooperative	31.9
• Beneficiaries (i.e. those who use the services of the cooperative)	22.5
• Multi-stakeholders (e.g. workers, beneficiaries, local and/or national government, etc.)	14.3
• Other types of cooperative members	6.6
Clients:	
• Who pay for care services through public social assistance	36.0
• Who pay for care services out-of-pocket	29.1
• Who pay for care services through private insurance	17.4
Other types of beneficiaries	5.8

Per all survey respondents. Respondents permitted to select more than one response.

This discussion of key actors suggests that main actors involved in care cooperatives are often fluid and not clearly delineated, particularly at the micro level. The nature of these relationships varies from enterprise to enterprise. As one interviewee stated:

“In some coops the workers are the member-owners. In others it is the people who are receiving the services. In many the member-owners include workers, clients, families, community supporters. Each cooperative is unique because each responds to the needs of its community.”

Vanessa Hammond, Chair, Health Care Co-operatives Federation of Canada

Study participants also discussed support institutions, or the meso and macro-level actors which influence the broader context in which cooperatives provide care. Two types of supportive institutions were identified as being particularly important: local governments and cooperative-representative entities (e.g., consortia and federations). Participants from various countries, including Canada and Italy, found local governments to be

particularly important in extending opportunities for funding and provision opportunities (e.g. RFPs), as well as in developing supportive legislation. Cooperative-representative entities were identified as critical lobbyists, advocates and sources of knowledge exchange and resource sharing. As an interviewee from the United States discussed:

““ Expanding training and support opportunities through local/national federations and state-sponsored organizations is critically important and deeply needed, as these entities are well-suited to richly inform, for example, training efforts, by-law development, and provide emergency financial assistance.””

Rebecca Matthew, Assistant professor, School of Social Work, University of Georgia, United States

Cooperative-representative entities were also seen as fusion points across the cooperative movement which augment the voice and power of individual cooperatives.

““ In Italy, cooperatives are a concrete reality. However at the same time there is also a high level of fragmentation. In order to overcome this challenge, cooperatives unite based on geographic regions (strengthening of local structures) or large businesses (economies of scale in organizational processes). Consortia are, in this sense, a desirable solution. They give weight to the cooperatives and help them to be recognized as major players.””

Davide Lo Duca, Business Development Manager, Omnibus Cooperative Consortium, Italy

While there is clearly an overlap between cooperative alliances and different levels of government, there are also tensions. As one interviewee stated:

““ We need provincial governments to recognise that the cooperative approach to care is a very valid option and to provide some targeted support. We also need financial support at the national level for cooperative federations. We also want to be sure that government works effectively with cooperative federations.””

Vanessa Hammond, Chair, Health Care Co-operatives Federation of Canada

Hence, there is a concern that alliances which are too strong may dis-incentivise government assistance vis-à-vis resources and funding, and may also shift the care responsibility too heavily to cooperative—an expectation, which, due to capacity and resource constraints, cooperatives are unlikely to be able to address in full.

It is interesting to note that many respondents seemed to expect or desire more engagement from government but did not voice concern over too much interference from government—indeed a concern from cooperatives in other sectors. The difference in relation to the care sector may be due to the relative nascent nature of cooperatives in the care sector. It may also be due to care provision being seen as an integral part of government social responsibilities.

Nature and Scope of Care

Participants shed light on the nature of care provided, sharing that compared to other types of providers, cooperatives are providing care in markedly different ways. Rooted in the cooperative principles and values, cooperatives tend to approach care through methods of inclusion and empowerment—both of workers and of those receiving care. As one interviewee stated:

“Public services are by and large predicated on dependency, sickness and deficit. In our multi-stakeholder cooperative, we say “older people are first and foremost an asset contributing to society and to the economy and through the values and principles of the cooperative commonwealth they become part of governance and not ‘othered’.”

Mervyn Eastman, Co-director and founder, Change AGENTS Cooperative, UK

At the same time, cooperatives' capacity in the provision of care is constrained. This is due to budgetary, resource and human capital limitations which many cooperatives endure, particularly during start-up phases. Such constraints suggest an opportunity for cooperatives to collaborate with care providers with larger economies of scale and resources (e.g., public health centres and private care providers) and with other cooperative enterprises that provide care or complementary services.

The Seven Cooperative Principles

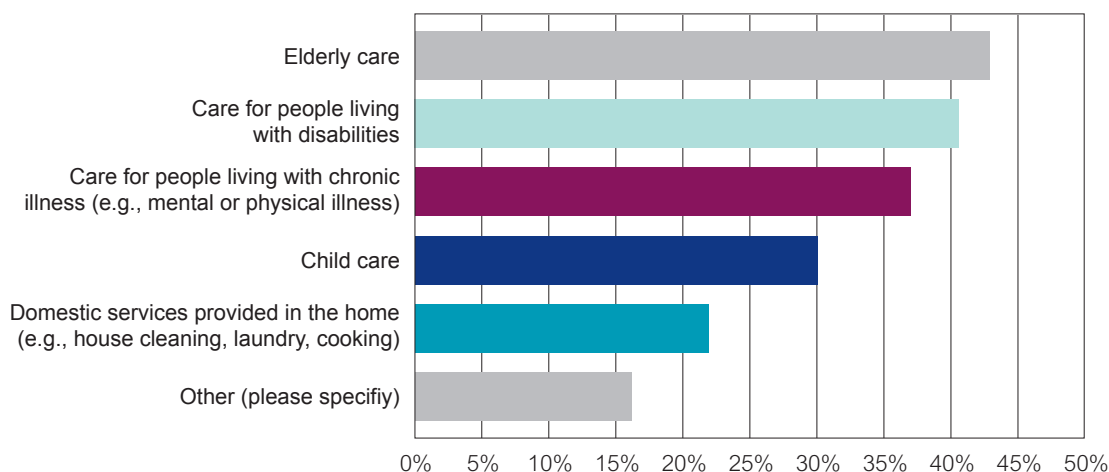
1. Voluntary and open membership
2. Democratic member control
3. Member economic participation
4. Autonomy and independence
5. Education, training and information
6. Cooperation among cooperatives
7. Concern for community

Source: International Co-operative Alliance

According to study participants, cooperatives provide care services to myriad populations. Across these populations, there are many types of caregiving demands which require diverse employees, skills and facilities to meet recipients' needs.

Figure 6

What type of care does your cooperative provide?



Per survey respondents directly affiliated with a care cooperative.

Respondents permitted to select more than one response.

Among all types of care services provided by cooperatives, eldercare was the most cited. As participants discussed, eldercare is provided in a variety of ways and through numerous types of services: eldercare facilities, elder “day care” and nursing cooperatives, among others. Survey data suggests that the potential to serve elders will only increase, as 64 per cent of survey respondents reported that the growing ageing population is an important care concern that will affect their community over the next 10 years.

Interviewees expanded on the nature of care with this growing ageing population, discussing various challenges associated with eldercare that providers must navigate. As a respondent from a cooperative in Uruguay stated:

“It’s difficult because sometimes people, especially elders, think they don’t need care. They say they don’t need help. But then the nurses get there, and the list of health and care needs is massive. Or sometimes they’re not sick, but they need assistance. For example, they need someone to take their blood pressure, help them around the house. Their family can’t do this day-to-day.”

Alicia Martínez Rey, Co-director, Cooperativa Caminos therapeutic assistant cooperative, Uruguay

Over 30 per cent of survey respondents directly affiliated with a care cooperative identified childcare as a service provided by cooperatives. Childcare clearly takes on different formats depending on the country context. In industrialized states (e.g., the United States and Sweden), childcare cooperatives were often identified as being a solution for middle-income families. As participants discussed, this may be a function of these families' relatively higher disposable income, more free time and greater access to cooperative information and networks.

According to participants, cooperatives provide care services in a variety of spaces, ranging from the formal (e.g., hospitals, nursing homes) to the informal (e.g., caregivers' and beneficiaries' homes). Thirty-seven per cent of respondents directly involved in a care cooperative reported that services are most likely to be provided in a care cooperative centre or facility. Yet almost as many participants (33 per cent) shared that care is most likely to be provided in homes. This is important to note, as workplace violations in the care sector are most prevalent in home-based work.

Figure 7
Where do cooperatives provide care?

Location of Service	Per cent
Care cooperative centre or facility	37.2
Multiple locations (e.g., homes and a centre)	34.9
Homes	32.6
Housing facility	20.9
Hospitals	16.3
Facility of another cooperative	11.6
Other	4.7

Per survey respondents directly affiliated with a care cooperative. Respondents permitted to select more than one response.

According to study participants, the spaces in which care is provided can be a constraint, as well as a catalyst for innovation. As described by the aforementioned interviewee whose cooperative in Uruguay operates out of clinics and health facilities, as well as in private homes:

““ The poor quality of the facilities we work in are a challenge to our services and our working environment. Also, a lot of facilities closed in 2001 [following the local economic crisis]. Now we're exploring new opportunities. Recently we piloted two projects that provide care in a special living facility setting. ””

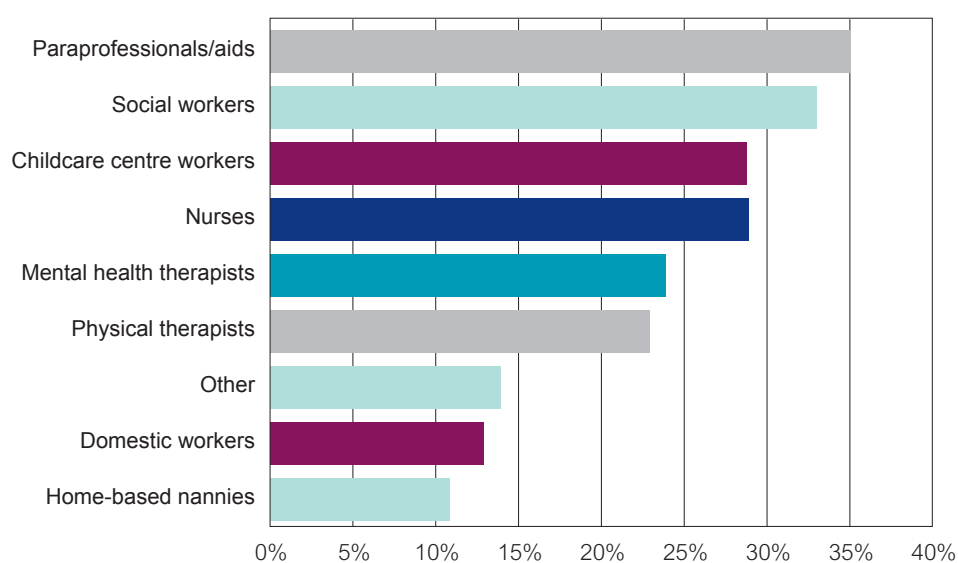
Alicia Martinez Rey, Co-director, Cooperativa Caminos therapeutic assistant cooperative, Uruguay

Employment Issues

Study participants discussed the type of care workers that provide services through cooperatives. Survey respondents reported that paraprofessionals and trained aids and assistants are the most likely to be employed by care cooperatives. This group was followed by social workers, and then nurses and childcare centre workers.

Figure 8

What type of care workers provide services through cooperatives?



Per survey respondents directly affiliated with a care cooperative.

Respondents permitted to select more than one response.

Many respondents report that care cooperatives are emerging as important employers in their communities. Just under a third of respondents shared that the number of people employed in care positions in cooperatives increased over the last decade, and another 14 per cent reported that the number of employees stayed the same. Despite evidence of growing staff, some participants shared that cooperatives struggle to employ enough trained care workers.

According to survey respondents, care cooperatives are most likely to employ full-time workers, followed by part-time workers. Less commonly employed workers are temporary short-term, contract and on-call employees, as well as unpaid volunteers.

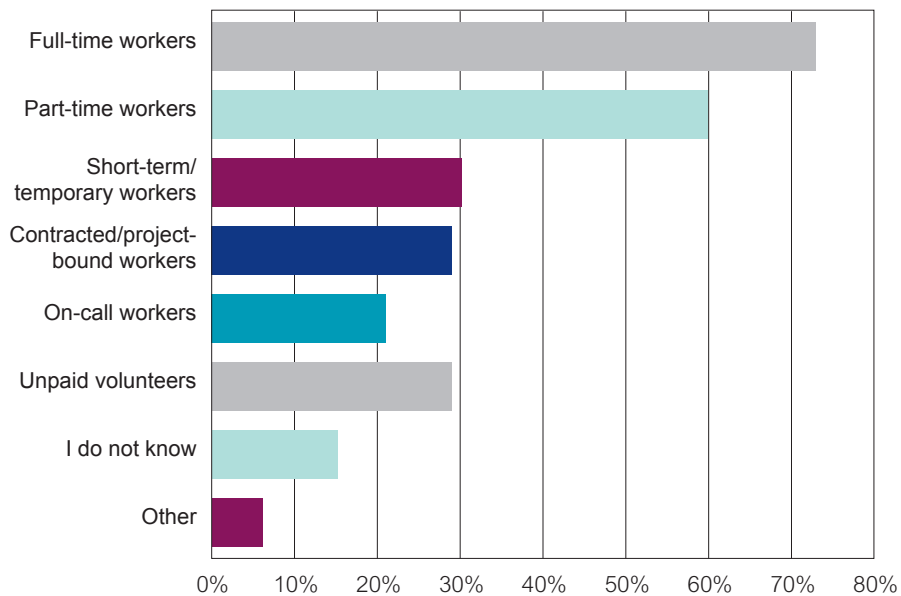
One interviewee discussed how staffing options in cooperatives have impacted the work conditions and personal lives of her female employees:

“ Being a mother, sometimes things happen. Things just pop up. You have to take care of your children. The cooperative helps when this happens. For example, one thing we have in place is an on-call service. If something comes up for one of our workers, we can call other workers and see if they are available. We always have someone on call, and we can always send someone. ”

Ida LeBlanc, Secretary, Service Workers Centre Cooperative Society Limited, Trinidad

Figure 9

What are the most common types of employees working in cooperatives that provide care?



Per all survey respondents.

Respondents permitted to select more than one response.

Overall, employment data suggest that cooperatives are providing more stable and secure employment. However, high rates of part-time work warrants further investigation. Issues deserving particular attention include whether employees opt for part-time work by choice.

Most respondents believed that care cooperatives provide opportunities in the labour market for women. About half of survey respondents directly affiliated with a care cooperative reported that between 50 and 100 per cent of their cooperatives' employees are women, and almost six per cent stated that all of the cooperative employees are women. No respondents reported an all-male staff.

Cooperatives in the care sector are emerging as employers of other populations often excluded from labour markets. For instance, just under 42 per cent of survey

respondents directly affiliated with a care cooperative reported that their cooperative employs persons of age 18-25. This suggests that cooperatives may be providing job opportunities to young adults, a group often burdened by unemployment. Over a quarter of survey respondents directly affiliated with a care cooperative reported that their cooperatives' staff are of racial or ethnic minorities, and almost a third shared that persons with disabilities were employed by the cooperative. The latter finding corroborates previous research, which suggests that care cooperatives simultaneously provide services and access to the labour market for persons living with disabilities.

About 28 per cent of survey respondents directly affiliated with a care cooperative reported that their cooperative employed migrant workers, most often in the areas of domestic work, followed by home-based childcare, nursing, and centre-based childcare. Migrant workers in care are particularly vulnerable to workplace exploitation, especially in home-based and live-in arrangements. One interviewee described how her cooperative addresses exploitation of migrant workers through training and certification opportunities:

“ Lots of workers deal with issues of labour migration. There's a problem here with sleep-in arrangements and concerns about exploitation with these jobs. Migrant workers mostly take sleep-in arrangements because Trinidadians [local workers] don't want those jobs. At the cooperative, we want to help migrants get their CVQ [Caribbean Vocational Qualification]. With this, they are certified. The training and the certification helps them get better jobs and make better money. ”

Ida LeBlanc, Secretary, Service Workers Centre Cooperative Society Limited, Trinidad

Study participants also discussed cooperatives' employment practices, including wages paid. Respondents reported mixed results of whether wages paid by cooperatives were always better than those of other care service actors—variations likely due to different local contexts, as well as unique constraints and management approaches of individual cooperatives. Some interviewees from multiple regions, including Latin America and Europe, expressed that wages are “always better” in cooperatives. However, as one interviewee from Canada noted:

“ Wages that care cooperatives can provide to their workers are low in the Canadian context, due to funding constraints. ”

Catherine Leviten-Reid, Associate professor, Cape Breton University, Canada

Still, almost 42 per cent of survey respondents directly associated with a care cooperative reported that their cooperative pays their country's minimum wage to all employees.

Almost 38 of survey respondents directly associated with a care cooperative reported that their cooperative provided all employees with formal work contracts. This is a critical contribution, given that informality of employment is widespread in the care sector in most countries of the world. The provision of formal contracts is of particular value for informally employed workers and home-based care providers, who are the least likely to enjoy protected terms and conditions of work.

One interviewee from a domestic worker cooperative in Trinidad described the added value of contracts:

“ Things like washing clothes, taking care of kids – this all comes at an extra cost. One of the biggest complaints of [domestic and home-based care] workers is, ‘they hire me for this, but then they add on, and add on, and add on.’ So with the cooperative, we have the contracts to make sure our workers are compensated for any extra tasks. ”

Ida LeBlanc, Secretary, Service Workers Centre Cooperative Society Limited, Trinidad

Participants discussed various other benefits which care cooperatives offer their workers. Over 40 per cent of survey respondents directly associated with a care cooperative reported that all or most employees are provided access to social security through their jobs. Approximately a third of the same respondents reported that in their care cooperative, all employees are granted paid sick leave (34 per cent of respondents), paid maternity leave (31 per cent) and guaranteed-hour work weeks (30 per cent). Some care cooperatives also provide paid paternity leave, although to a lesser extent than other benefits.

In addition to employment benefits, study participants also commented on the types of employee training that care cooperatives provide. Most often, cooperatives in the care sector aim to develop employees’ “hard” skills, or the professional capacities required in the workplace. This training tends to focus on two areas: skills related to care work (e.g., professional care worker skills and education on health-related topics) and cooperative education (e.g., cooperative management skills and training on cooperative management and operations). As the aforementioned interviewee from Trinidad explained, such skills enhance professionalization and augment worker and beneficiary safety.

“ There is a concern about educating our workers on health issues and their safety. For example, with diseases. Someone in the home might have TB [tuberculosis] or AIDS. We educate on what these things are and how to work safely with the people they are working for. ”

Ida LeBlanc, Secretary, Service Workers Centre Cooperative Society Limited, Trinidad

Cooperatives are also helping employees develop their “soft” skills, or the interpersonal, communication and social skills which affect workers’ relationships with colleagues, clients and other personnel. One third of survey respondents directly linked to a care cooperative stated that their cooperative provides life skills training, such as negotiation skills or a second language, and over 23 per cent reported that their cooperative provides training on gender-based issues, like gender-based violence.

Legal and Policy Frameworks

When asked about the policies and legislation that govern the provision of care, 40 per cent of all survey respondents reported that the policies and legislation in their country allow for care services to be delivered through cooperatives. On the other hand, close to 17 per cent responded that policies and legislation that govern the provision of care in their country do not include cooperatives among types of institutions and enterprises that can deliver care services. Such differences in supportive legislation varied across and within regions, and even within countries (e.g., across Canadian provinces). Two interviewees from very different countries, Sri Lanka and Canada, discussed the contextual factors which contribute to differences in supportive legislation:

““ In Nova Scotia, there is no legislation supporting multi-stakeholder cooperatives, and care cooperatives are increasingly being incorporated in this way in other parts of Canada and the world. In my province [Nova Scotia], there is also a lack of capacity in the cooperatives sector to push for legislative changes. This is due to lack of funds and staff, and to a diminishing cooperatives sector.””

Catherine Leviten-Reid, associate professor, Cape Breton University, Canada

““ Even though there is a need to update and change the 30 year old cooperative legislation and its practices in Sri Lanka, the legislation is very supportive of the cooperatives in works to protect cooperative values and principles. The cooperatives in the country are encouraged to earn surplus by not being obliged to pay taxes to the government but only 10 per cent of the surplus/profit to a cooperative fund in the Department of Cooperative Development. This department uses funds for supporting, monitoring and auditing cooperatives in the country to ensure the transparency and accountability in their operations while protecting the members' rights.””

Subhashi Dissanayake, Country director, We Effect, Sri Lanka

The above question was then reversed to explore cooperative legislation and policies in respondents' home countries. When asked whether the policies and legislation that govern cooperatives allow for cooperatives to provide care services, half of all respondents reported that policies and legislation allow cooperatives to provide care. About nine per cent reported that they do not.

Finance Issues

According to survey respondents, the top three sources of funding for care cooperatives are beneficiary-paid earnings from care services provided, government-paid earnings from care services provided and member fees. Other sources of funding include grants, credit, fundraising efforts and charitable donations, among others.

Figure 10

Ranking of Care Cooperatives' Main Sources of Funding

1. Earnings from services provided, paid for by beneficiaries
2. Earnings from services provided, paid for by the government
3. Member fees
4. Proposal-based grants awarded by foundations, governments, etc.
5. Other sources
6. Credit or loans
7. Fundraising activities
8. Charitable donations
9. Reserve funds
10. Non-banking financial instruments and funds created by the cooperative

Per survey respondents directly connected to a care cooperative.

While funds stem from a variety of sources, financial constraints were among the most discussed issue by almost all participants. Challenges of securing seed capital and accumulating capital were of particular concern. Funding challenges tend to be most prevalent and cumbersome during formative and incubation phases. One interviewee discussed reasons behind funding challenges:

““ Often funders and donors fund non-profits but because of ‘who benefits’ are unwilling to fund cooperatives and in addition have little understanding and awareness of what cooperatives are about. They don’t know about its values and principles and the potential impact on social care and community development. ””

Mervyn Eastman, Co-director and founder, Change AGENTS Cooperative, UK

Several respondents from developing countries suggested that workers may have difficulties paying member fees. Cooperative management have explored practices to help mitigate this barrier, such as loaning new members cash for joining fees and charging an associated lending fee. After the fee is paid back to the cooperative, it is then applied towards other cooperative activities.

Respondents offered other solutions for financing and funding challenges, but noted constraints associated with their suggestions.

““ One way to address funding issues for care cooperatives is zero-to-no interest loans. Another solution is no taxation on capital gain. However, these solutions are often beyond the cooperative’s control. ””

Rebecca Matthew, Assistant professor, School of Social Work, University of Georgia, United States

Gender Issues

The study's data demonstrates that care cooperatives offer employment opportunities to women. According to survey respondents directly affiliated with a care cooperative, care cooperatives' staff members are comprised primarily of women. Half of these respondents stated that women comprise 50-100 per cent of their staff, almost six per cent of whom reported that in their cooperative, all workers are women.

In a closer examination of gender issues, one theme that emerged was the “double burden” and work-life balance that female employees—particularly working mothers—negotiate. Several discrepancies arose from the data on these issues. For example, one interviewee stated that the time required to participate in cooperative activities prevents some workers from joining, particularly those who live in remote areas and grapple with transportation issues.

““ In order to have a cooperative in Trinidad, you must hold regular meetings. That is a law by the government, the Coop Act, which governs all cooperatives. But transportation is an issue for the workers, and it's expensive. Some of the members live outside the city or far away, and have to be at home for their families. They can only come once a month for meetings. But to get things done, we need to have people together more than once a month. This is an ongoing issue.””

Ida LeBlanc, Secretary, Service Workers Centre Cooperative Society Limited, Trinidad

Other study participants reported that cooperatives alleviate time inflexibilities by regularising work hours and providing flexibility in scheduling. The correlation between flexibility and the worker member status is also worth noting in this regard. These features improved work-life balance for women, who were afforded more time for self-care and family life.

““ In cooperatives, women workers have the ability to have more time with their own families. Many are no longer forced to work multiple jobs; hours are sometimes guaranteed with opportunities to earn paid sick leave and vacation days. In cooperatives, collectively and solidarity are foundational: women work together; they support each other; they trade shifts; and, they can go home to their own families at night. If a worker wants to attend a family function or an activity at their child's school, for example, there are built-in, flexible options. The national data suggest that care providers working within other non-profit and for-profit organizations simply do not share this level of workplace flexibility and autonomy.””

Rebecca Matthew, Assistant professor, School of Social Work, University of Georgia, United States

Another complex gender issue to emerge from the data was the issue of worker burnout, or the fatigue that results from jobs which are excessively demanding, both physically and mentally. Burnout is particularly prevalent in the care sector, a field in which practitioners tend to over-commit themselves to clients, and among women workers, who are overrepresented in the care sector, particularly in lower-paying and more demanding jobs. As one interviewee explained:

“Care workers are deeply dedicated to clients and services users. This can lead to burnout for workers and lack of continuity of service for the clients. In coops, the close relationships between workers and clients, especially when both groups are member-owners, leads to good compromise rather than confrontation.”

Vanessa Hammond, Chair, Health Care Co-operatives Federation of Canada

As this data suggests, the very structure and relationships that aim to improve the quality of care services that cooperatives provide may exacerbate quality of work for care providers. To mitigate such effects, cooperatives may consider adopting practices such as mandatory time off and self-care awareness raising and training.

While women are the most likely to be employed by care cooperatives, data suggest that men are also providing care through cooperative enterprises. Over 46 per cent of survey respondents directly linked to a care cooperative reported that men provide care in their cooperative to a large or some extent. Still, the number of men employed remains less than that of women.

According to survey respondents, men tend to hold positions in care cooperatives as paraprofessionals and aids, physical therapists and social workers. About half of the survey respondents reported that beneficiaries are very comfortable or somewhat comfortable receiving services from men in such roles. Historically, men have been scarce in the care sector, except at senior medical professional levels and in management roles. Although further investigation on gender balances in care cooperatives is needed, previous research suggests that having men on the frontline in care may increase the quality and reach of care for certain populations (e.g., young males), and often contributes to raising the overall salary levels in a field.

Cooperative Value-Added

Another salient theme that emerged from the data was the ways in which practicing the seven cooperative principles set cooperatives apart as responsive care providers. Participants demonstrated how democratic member control fosters a commitment to transparency and accountability, which enhances the beneficiary's role in care—something that other types of providers often lack. As one interviewee from Zimbabwe stated, highlighting worker- member value added:

““ When care cooperatives members provide services to their members, they know they are providing quality services. This is checked through regular meetings that members attend. If there is any deficit or mismanagement of resources, that management committee is removed by popular vote from office and replaced by other competent members. This is different from private or public care providers where the consumers or clients do not sit on the board or attend annual general meetings. It is worse in the private sector, where owners are in most cases interested in profits.””

Albert Vingwe, Chairman, Chitsvachirimurutsoka Farming Co-op Society Ltd., Zimbabwe

In addition, cooperatives bring together multiple stakeholders in decision-making in enterprise operations as well as in the delivery of care. Families, beneficiaries and workers are given a voice in care delivery, which enhances the quality and nature of services provided. An interviewee from a child development cooperative in Canada commented on this effect:

““ Cooperatives are more porous in terms of horizontal integration of services across agencies, and facilitate a true ‘wrap around’ service delivery with the client, child, or vulnerable adult and his or her support network. Cooperatives are family-focused, client-driven responses to an individual’s need.””

Nancy Gale, Executive Director, Cariboo Chilcotin Child Development Centre Association, Canada

As the data suggest, cooperatives are creating a new narrative of care—one which is rooted in inclusion, democratic decision-making and empowerment. Embedded in cooperatives’ distinct approach to care are a shift away from dependence towards inter-dependence, and a focus on wellbeing rather than sickness.

According to study participants, cooperatives are impacting not only the nature of care, but also the terms and conditions of care work. As previously discussed, cooperatives are likely to provide workers with written contracts, a benefit of particular importance for informal workers and home-based care providers. In addition, over 61 per cent of survey respondents directly linked to a care cooperative reported that care cooperatives are either likely or very likely to provide safe working conditions. Improved workplace safety is particularly important in the context of home-based care.

““ When a woman employed by the cooperative talks with families she provides services to, she talks with the power of the cooperative behind her. She can say, ‘any additional work than what was first agreed on, you have to talk to the cooperative about that.’ Also, before a worker is placed in a home, we inspect it and make sure it’s safe.””

Ida LeBlanc, Secretary, Service Workers Centre Cooperative Society Limited, Trinidad

As these data suggests, cooperatives act as mediators between the care worker and the client, and enhance the worker's bargaining power in that relationship. The worker acts with the voice and protection of the cooperative behind her, a function of the fundamental basis of cooperative negotiating.

The cooperative value-added extends not just to employees but also to beneficiaries receiving care services. Over 60 per cent of survey respondents directly tied to a care cooperative reported that care cooperatives are likely or very likely to provide care services that are affordable. Accessibility, affordability, service quality, durability and community participation are key dimensions of service provision that cooperatives often actively promote. Another 58 per cent of survey respondents directly linked to a care cooperative stated that such cooperatives are likely or very likely to provide accessible services—e.g., prolonged hours, disability access, or providing services in an accessible location. However, there may be possible externalities of such extended availability, such as unexpected overtime. This may have disproportionate effects on female workers, who must balance time and manage their own care responsibilities at home. Further investigation of this dynamic is warranted going forward.

Just under half of survey respondents directly affiliated with a care cooperative reported that care cooperatives are likely or very likely to provide care to all people who seek services without turning anyone away. And as most survey respondents reported, cooperatives are able to provide such care in a pragmatic way. Approximately two-thirds of respondents reported that care cooperatives are likely or very likely to provide quality care services in relation to the resources available to the cooperative.

Looking ahead, study participants reflected on practices through which cooperatives may further enhance their value-added in care. Over half of all survey respondents reported that cooperatives could provide training and education for workers and 40 per cent stated that cooperatives can pay all workers at least the national minimum wage. Respondents also suggested that cooperatives could adopt by-laws and policies that guarantee equal employment opportunities for women and men within the enterprise, and employ more people often excluded from the labour market, such as people of racial and ethnic minorities and persons with disabilities. Looking beyond internal practices and towards policy arenas, 56 per cent of all survey respondents stated that cooperatives could advocate to policymakers for policies that support care cooperatives.

Challenges and Opportunities

As previously discussed, study respondents report that the most prevalent challenge that care cooperatives face is finance issues. The second most cited challenge is a lack of knowledge of cooperative management and operations. Particularly among new and developing enterprises, participants believed that cooperative know-how is lacking. Issues of particular concern are cooperative management and legal matters. To address this challenge, survey respondents stated that cooperatives could provide more training and education on cooperative management and operation (e.g., training on articulating the cooperative's vision, defining strategy, planning, and day-to-day operations). Interviewees called for training and education efforts across members and management.

“ Starting at the member level, there should be more awareness and information sharing. At the cooperative level, there should be more knowledge and skills development of the staff and Board of Directors, particularly in regards to planning, management, and new technologies. There should also be system development, good governance promotion, and networking with institutions like other cooperatives and relevant government institutions. ”

Subhashi Dissanayake, Country Director of We Effect, Sri Lanka

Furthermore, interviewees from the cooperatives movement from developing and middle-income countries (e.g., Kenya, Turkey) called on countries with more established care cooperative sectors to share best practices and lessons learned.

Across developing and developed countries alike, almost all interviewees discussed knowledge gaps across constituents and stakeholders. For example, participants noted that is a general misunderstanding across the cooperative movement on the scope of care, and that there must be a better promotion of both care and cooperatives across the public and other stakeholders like trade unions. One interviewee discussed this multi-layered challenge and identified opportunities to address it.

“ Other kinds of organizations don’t understand care cooperatives. They don’t understand that the wellness and health work of each coop is unique, reflecting its community. The lack of support from the medical community is another factor. We need to educate the medical profession, schools of medicine and schools of social work. We also need to connect with the business schools. There is a recent trend that health professionals go on to earn their MBA, but students in these programs don’t hear about cooperatives. This is an opportunity, as is the growing interest at the federal, provincial and local government levels. ”

Vanessa Hammond, Chair, Health Care Co-operatives Federation of Canada

To further address gaps in education, knowledge and funding, respondents called for the need to build alliances and strategic partnerships with other types of care providers and other types of cooperatives. For example, over 51 per of all survey respondents suggested that cooperatives should explore ways to leverage costs of care through alliances with other care providers and cooperatives. One interviewee cited examples of the latter:

“ It may take partnerships between non-care related cooperatives such as credit unions and stakeholders such as seniors’ organizations and hospitals to get care cooperatives off the ground. For example, it is notable that in Quebec, key players in the establishment of health cooperatives have been credit unions; they have offered financial support and also human resources by serving on boards. And in the early days (the 1960s) of the health cooperatives movement in the province of Saskatchewan, start-up funds were provided by an agricultural cooperative. ”

Catherine Leviten-Reid, associate professor, Cape Breton University, Canada

To facilitate cooperative-to-cooperative and cooperatives-to-care provider exchanges, participants called on cooperative support institutions such as federations and consortia to lead the way.

Looking to the demand side of care, another challenge that study participants identified is how to incentivise care recipients away from “cheap” care towards being more ethical and fair users of care services. One interviewee discussed this concern in the context of Asia, a region with high exporting of care labour:

“ We have to think about the scale of the supply and demand for care. There is a big need for care. But in many places, including Asia, it’s very cheap, meaning the economic cost of care labour is inexpensive. And for destination countries, as well as developing countries, the demand is very high. I think it would be very hard for cooperatives to compete with this demand. ”

Fish Ip, Regional Coordinator, Asia International Domestic Workers Federation (IDWF), Hong Kong

A care cooperatives expert from the United States also discussed the issue of demand and ethical consumerism:

“ In thinking about potential consumers of cooperatised care services – many questions remain. For example: Why are people choosing to seek services through cooperatives? Is it based solely on factors, such as cost, location and reputation, or is there a larger commitment to this organizational form and democratised labour more generally? Further research in this area is greatly needed. ”

Rebecca Matthew, Assistant professor, School of Social Work, University of Georgia, United States

While cooperatives must realise such constraints in the supply and demand of care labour, certain practices may incentivise users to turn to cooperatives. Such practices include providing worker training and certification, and promoting the professionalization of care work through workers’ affiliation with an established enterprise – i.e. the cooperative.

Beneficiary outreach issues, such as serving a sufficient number of beneficiaries and matching of services provided to beneficiary needs, were among the challenges discussed. Interviewees discussed opportunities to address this challenge, including innovative uses of social media and information and communication technology (ICT) for outreach and care provision.

““ The use of social media is critical. In our organization, we use it widely for knowledge and to promote cooperative solutions. Over the next five years, the use of social media by people who are ageing will explode, particularly among the ageing baby boomers, many of whom are internet and tech-savvy. Cooperatives and service providers have to start using social media now to reach out to them.””

Mervyn Eastman, Co-director and founder, Change AGEnts Cooperative, UK

As this data suggests, there is massive potential for cooperatives to reach potential service beneficiaries, their families and other stakeholders. In addition to communication purposes, other cooperatives are taking the use of ICT a step further to help deliver services. For example, the iCareCoops eldercare alliance has united various ICT services and cooperatives in an effort to provide higher-quality, lower cost care to elders. SoMedAll, an online platform of ICT-based products, services and systems for elders, is one component of this project. Going forward, engaging in ICT and social media efforts is likely to be not only an opportunity, but a necessity.

A final challenge that study participants discussed is an overall lack of data on care cooperatives, and a dearth of evidence showcasing their social and economic impact. Disaggregated data, such as sub-sector data (e.g., childcare, eldercare, etc.) is particularly lacking. Interviewees discussed the challenges associated with data and evidence scarcity.

““ I strongly believe there is potential for agriculture, credit and financial cooperatives to work together with care cooperatives. But there is no data about how care cooperatives operate. We don't have enough information. We need data showing that cooperatives are a possible selection in care and in partnerships.””

Anonymous programme manager, cooperative support organization, Kenya

Practitioners and researchers alike urged that in order to move forward, more evidence and data must be gathered and made available. Interviewees suggested that qualitative case studies are needed in order to understand the practices, successes and challenges of care cooperatives, and large-*n* quantitative data is needed in order to demonstrate the impact and scope of these enterprises.³ As numerous participants from multiple regions expressed, more data and evidence exchange must happen if funders, governments and the general public are to be convinced that cooperatives are a viable solution for the provision of care.

³ Large-*n* quantitative studies employ datasets with many cases and use statistical techniques of data processing as its primary method of inference.

Conclusions

As the evidence set forth in this report suggests, cooperatives are emerging as important players in the care sector. Cooperatives appear to be well-positioned to act as vehicles that generate access to the labour market, as well as be responsive, community-based quality providers of care.

Key takeaways from this study are:

- **Cooperatives are emerging as an option in caregiving but face significant barriers that limit their potential.** Critical challenges include insufficient and uncertain funding, unsupportive legislation, and limited cooperative and care know-how and expertise.
- **In order to provide quality services and decent work opportunities in the care sector, cooperatives require support from within the movement and beyond.** Strategic alliances and knowledge sharing across the cooperative movement, care sector and other stakeholders are possible ways forward.
- **There is no “one size fits all” cooperative solution for care.** Care needs as well as political, legislative, social and economic contexts in a country and community will determine the nature and viability of a care solution. Sharing good practices and lessons learned will help emerging care cooperatives navigate their own contexts.
- **Evidence suggests that cooperatives generate access to better terms and conditions of work in the care sector (e.g., regularized work hours, access to benefits, more bargaining power), especially for female workers.** However, impacts on areas such as work-life balance and wages require further investigation.
- **The cooperative approach to care is distinct from public, other private and even non-profit providers.** When the seven cooperative principles are engaged, cooperatives foster inter-dependence rather than dependence in caregiving by privileging voice and inclusion.
- **More evidence and data are needed in order to move forward.** Both large-n comparative quantitative assessments and in-depth qualitative case studies are needed in order to ascertain the impact of care cooperatives, understand their operations and identify good practices. More information on the social and economic impacts of care cooperatives are particularly needed, if the impact of care cooperatives is to be conveyed to governments, funders and potential beneficiaries.

Next Steps

Building on the findings set forth in this report, various policy, practice and research initiatives are recommended in order to move care cooperatives forward. In this section, possible next steps are suggested.

Development of Technical, Vocational and Managerial Training

In order to address knowledge gaps, training on care, cooperatives and care through cooperatives are needed at the practitioner and management levels. Technical and vocational training targeting potential and current care workers should be developed, with emphasis on providing quality care services through a cooperative approach. Managerial training on both cooperative know-how (e.g., planning, financing issues, day-to-day operations) and care provision should also be developed. Cooperative management across sectors should be trained on opportunities and needs relating to care, starting with the care demands their own workers face.

Development of Alliance Building Initiatives

Strategic partnerships, knowledge exchange and resource sharing are critical to the development and sustaining of care cooperatives. Efforts to support care cooperatives through alliances across the cooperative movement are particularly relevant. Individual cooperatives, as well as meso and macro level support institutions like federations and consortia, can support care cooperatives. International organizations and other stakeholders also play a critical role in building and supporting such alliances and exchanges.

Development of Pilot Programs

National stakeholders have called for assistance in implementing care cooperatives. Support institutions including international organizations like the ILO and organizations from the cooperative movement can offer knowledge and expertise to assist in the development of such programmes. An initial step in this regard is the development of methodology for country pilot assessments.

Further Research

As was recommended by study participants, more data must be collected and more evidence must be set forth in order to convey the impact of cooperatives in the care sector. New research and evidence from the field and academia are needed. In follow up to this report, additional ILO COOP and GED publications on the provision of care through cooperatives are under way.

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Annex 1:

Survey Questionnaire

To access the provision of care through cooperatives survey, please visit:

http://www.ilo.org/wcmsp5/groups/public/---ed_emp/---emp_ent/---coop/documents/genericdocument/wcms_452323.pdf

Annex 2:

Interview Guide

Mapping of Care Provision through Cooperatives – Interview

1. Please state your current position and organization, country, and the nature and extent of your experience with cooperatives.
2. What is the nature of your involvement with cooperatives that provide care services?
3. In your opinion, why are care services being provided by cooperatives?
 - For example: to fill a gap in services provided by government or private providers, to address a need in the community for a specific kind of care, because care workers are pushing for different work conditions, because cooperative members have asked for care services, etc.
4. What factors facilitate the provision of care through cooperatives? Please explain.
 - For example: supportive legislation, funding, member participation, know-how and expertise, availability of care professionals, coop-to-coop support, etc.
5. What are the challenges to establishing, sustaining, or expanding cooperatives that provide care? Please explain.
 - For example: start-up capital, legislation issues, know-how and expertise, availability of care professionals, member interest, etc.
6. What is needed to address these challenges? Please explain.
 - For example: consortia, supportive policies, institutional and legal support, more awareness, etc.
7. Compared to other types of care providers (e.g. private and public), are cooperatives different in how they provide care? Please explain.
 - For example: different in terms of care services provided; involvement of members, users, or the community; governance structure of the enterprise; financing; etc.

8. Are there any positive or negative consequences of providing care through cooperatives? Please explain.
- For example: changes in care providers' terms or conditions of work, changes in the distribution of who is responsible for care in the community, etc.
9. Do you think that cooperatives influence care workers' working conditions? Such influence could be positive or negative. Please explain.
- For example: terms of work, wages, occupational safety and health, etc.
10. What types of concerns do care workers have?
- For example: concerns relating to gender, race and ethnicity, language, documentation and legal status, economic security, etc.
10. b.) Does the involvement in cooperatives influence the way these concerns are addressed?
If yes, please provide some examples.
11. In your experience, what are the gender issues that care workers face?
- For example: gender-based discrimination, work-life balance, gender-based violence, gender wage gap, etc.
11. b.) Does the involvement in cooperatives influence the way these issues are addressed?
If yes, please provide some examples.
12. In your experience, what are the gender issues that care service users face?
- For example: gender-based violence; stigmatization of receiving certain kinds of care, like sexual health or women's health; gendered care burden; etc.
12. b.) Does the involvement in cooperatives influence the way these issues are addressed?
If yes, please provide some examples.
13. Over the next 5 to 10 years, what is the role that cooperatives could play in the provision of care services? Please explain.
14. Over the next 5 to 10 years, what is the role that cooperatives could play as employers of care workers? Please explain.
15. Do you have any additional thoughts to share on the provision of care through cooperatives?
16. For the purpose of publications which may come from this study, may we quote you?
- Yes No
- If quoted, do you prefer to be named or remain anonymous?
- Named Anonymous
- If your quote is selected to be included in a written study, would you like us to confirm your quote with you by email before publication?
- Yes No

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